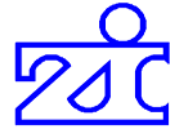




EUROPEAN COMMISSION  
The SANCO Directorate General

Central Institute of Mental Health



Research Project

Mentally Disordered Persons in European  
Prison Systems -  
Needs, Programmes and Outcome (EUPRIS)

Final Report – October 31, 2007

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**Research Project**

**Final Report**

**Mannheim, Germany, October 31, 2007**

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## 1. Introduction

Worldwide more than 9.25 million people are currently being held in penal institutions. As recently assessed, their number is rapidly growing, having increased by approximately a quarter of a million during a period of 18 months (International Centre for Prison Studies 2007). Prison population rates vary considerably between different regions and countries the capacities and overall quality of the penal systems differ likewise.

However, in prisons and penitentiaries worldwide, mentally disordered inmates constitute a serious problem, despite the standard doctrine in most countries that mentally ill offenders lacking criminal responsibility are not to be punished but referred to and detained in forensic psychiatric facilities for specialised care. Complex legal frameworks and judicial procedures have been implemented internationally to regulate this, and forensic psychiatry has been able to provide treatment programmes that are both effective and able to enhance public safety (Salize & Dressing 2006).

Nevertheless, it is confirmed that the prevalence of psychiatric morbidity among prisoners by far exceeds the rate of mental disorders in the general population although international research on this issue is limited. A review of 62 prison studies covering more than 23,000 prisoners worldwide found that 3.7 % of all male and 4% of all female prisoners had a psychotic disorder, 10 % of all male and 12% of all female prisoners suffered from major depression, and 47 % fulfilled the criteria for an antisocial personality disorder (Fazel & Danesh 2000).

Additionally, there is scientific evidence that the number of mentally disordered prison inmates is rising. As a consequence, the World Psychiatric Association (WPA) and the American Psychiatric Association (APA) have repeatedly voiced concern about the increasing number of mentally ill individuals being placed in correctional facilities (Okasha 2004). In the United States, prison services are estimated to house consistently twice as many persons with serious mental disorders as do mental hospitals (Torrey 1995). European prisons face similar problems. Older studies estimated that about 12 % of prisoners needed psychiatric treatment (Gunn et al. 1991).

The reasons for rising proportions of mentally disordered prison inmates are manifold and complex. National conditions and circumstances play a pivotal role, but there are international trends in mental health care or other societal fields, too, that are likely to contribute to the problem.

Rising levels of alcohol abuse and illicit drug use in almost all societies increase exponentially the prevalence of these disorders in penitentiaries or prisons worldwide (Andersen et al. 1996, Bland et al. 1996). Many experts see the growing incidence of mental health problems in prisons as an unwelcome consequence of the deinstitutionalisation process that was and is the basic programme of any psychiatric reform anywhere in the world. According to this hypothesis, closing down psychiatric hospital beds much faster than a sufficient number of community care services are or can be implemented may foster the neglect of non-compliant or violent mentally ill patients in community mental health care and compound the tendency of shifting them towards forensic psychiatric facilities or the prison system (Lamb & Mills 1986, Munk-Jørgensen 1999, Schanda 1999, Müller-Isberner 2002). More globally, an invariant and inverse correlation between the number of psychiatric hospital patients and the number of prisoners has been identified, turning out to be so remarkably robust that it has been labelled with its own specific term, the so-called "Penrose Law" (Brink 2005).

Underlining such interdependencies, the WHO recently stated: "One of the difficulties in keeping mentally ill offenders out of prison is that many countries do not have appropriate facilities to house people regarded as criminal and dangerous. As a result, those with mental disorders are not only forced to stay in prison, but also are deprived of the necessary treatment there." (WHO 2005).

Thus, the rising psychiatric morbidity in prisons may reflect a general trend within societies to tolerate insufficient provision of psychiatric services in the community (Andersen 2004). Particularly poor economies or societies in transition are forced to allocate scarce health care resources to sectors with a wider public recognition. This increases the risk that persons suffering from mental disorders

will be neglected during incarceration. The problem not only imposes a heavy financial burden on acceding or applicant countries, but also on long-term Member States of the European Union. However, in most countries, the budgets for prison mental health care are widely unknown, as are the exact number of lacking staff or other resources.

A study from Finland revealed that in cases of prison suicides, only half of the subjects concerned had been in contact with medical prison services prior to their self-inflicted death (Joukamaa 1997). That long-term prisoners obviously adapt better than either short-term or remand prisoners (Coid 1984) and the early phases of a prison term bear the highest suicide risk (Dooley 1990) may demonstrate the complexity of the problem. Another WHO study from the late 1990s ("Health in Prisons Project") surveyed 13 European countries regarding prison mental health care. Although having assessed ambiguous and incomplete data, the results suggested that none of the 13 analysed prison systems had a sufficient number of specialised beds available to provide adequate treatment for mentally disordered prisoners (Blaauw et al. 2000). Contributing evidence to the assumption of many NGOs or other organisations active in the field that most prison systems are ill-equipped in terms of the mental health care available for their inmates (Human Rights Watch 2003), the study stressed an urgent need for further research.

Both from a professional psychiatric and a human rights perspective, depriving mentally disordered prisoners of any state-of-the-art treatment cannot be accepted. But in European routine care even the most basic requirements for adequate treatment seem to be missing. The scarce research findings suggest strongly that only a small proportion of all mental disorders prevalent in prison populations is diagnosed at all, although a thorough mental state assessment of every new detainee would be an indispensable prerequisite to prison entry. Not only would this be absolutely essential for any adequate psychiatric treatment during the prison term, but combined with regularly repeated screenings it also would allow mental disorders already present prior to the prison term to be distinguished from those acquired during the stay, e.g., whose etiology can be ascribed to unfavourable prison conditions.

Due to the serious shortage of information and data in the field, a systematic descriptive international comparison of the situation of mentally disordered prison inmates and the current state of prison mental health care is overdue – in Europe and worldwide. A standardised description of the concepts and the most urgent problem areas would allow further analyses and provide a basis for identifying models of good practice – if indeed there are any at all in this neglected field. Due to the complex interactions, such an overview must address many influencing factors and methodological pitfalls and, including the organisation of national prison systems, the overall concepts of (mental) health care provision in prisons, separate regulations for prisoners on remand and prisoners, the interaction between general psychiatry, forensic psychiatry and the national prison systems, varying pathways to mental health care, and many more issues.

So far no European overview referring to the above-mentioned problems and aspects has ever been conducted. Thus even the most basic data shortages and information gaps have never been systematically explored or described. This study tries to bridge this gap by collecting structured information on concepts, models, and routine practices in prison mental health care in 24 European Union Member States and other European countries.

By providing most basic information, it is targeted to encourage further research on this crucial issue and contribute to a European mental health policy and common actions in the field of prison mental health care.

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## 2. Study

This study was funded by a grant from the public health programme of the European Commission (Grant Agreement No. 2004106 EUPRIS) and conducted from 1<sup>st</sup> October 2005 to 31<sup>st</sup> October 2007.

It included 24 countries from the European Union and EFTA countries (see below). The study centre was located at the Central Institute of Mental Health (CIMH) in Mannheim, Germany and co-headed by Hans Joachim Salize and Harald Dressing from the CIMH. Coordinator was Christine Kief, CIMH.

The primary study aims were to describe and analyse the concepts of and approaches to the provision of psychiatric services for mentally ill or disordered prison inmates in the included countries and its outcomes (e.g., in terms of the prevalence of mentally ill or disordered persons being incarcerated in the various prison systems). Additional aims were to explore and analyse the availability of information about these issues on an official national level (health reporting or juridical data).

The topic of this study relates in part to two previous research projects funded by the public health or health promotion programmes of the European Commission, which outlined the approaches to civil detention and forensic psychiatric care in Europe. These were the studies “Compulsory admission and involuntary treatment of mentally ill patients – Legislation and practise in European Union Member States” and “Placement and Treatment of Mentally Ill Offenders – Legislation and Practise in EU Member States”. Adopting similar study designs, both projects were conducted by the leaders of this study between 1<sup>st</sup> October 2000 and 1<sup>st</sup> January 2002 (EU Grant Agreement No. SI2.254882/2000CVF3-407) and from 1<sup>st</sup> January 2003 to 30<sup>th</sup> September 2004 respectively (EU Grant Agreement No. SPS.2002448).

Different from the former studies, the focus of this study was on persons suffering from mental disorders and *not* being patients in the general psychiatric or the forensic psychiatric system, but incarcerated in the penitentiaries of the countries included in this study. These persons differ from mentally ill offenders who are detained in the various forensic psychiatric systems, since prison inmates with mental health problems usually were considered during their trial as being criminally responsible for their offences, and whose mental disorder - if at all prevalent prior to the prison sentence - was not found to be associated with the committed crime.

Nevertheless, when suffering from a mental disorder, these persons are in need of treatment and – according to basic human rights principles – should be given treatment on a standard equivalent to that for non-incarcerated patients. This study explores if and how such care is arranged or organised.

This study document provides

- a general outline of the issue,
- a structured presentation of results from a detailed assessment of the issue covering all included countries (including tables and figures),
- 24 chapters (one for each participating country) reporting in a semi-structured way the country-specific approaches to, problems with or policies on prison mental health care,
- an analysis of the similarities or differences across the included countries,
- a synopsis of the current situation in each of the participating European Union Member States and EFTA-countries, and
- a concluding chapter outlining major problems and discussing consequences for action taking.



## Work Plan

The implementation of the project involved the following tasks:

- The Setting up of a network of experts on mental illness in the prison system from each participating country.
- Development of a questionnaire to collect relevant information from the experts of the participating countries in a standardised way (for details, see below).
- Development of guidelines for writing a chapter containing complementary information to the systematic data gathered through the questionnaire. The chapters described specific characteristics, problems or circumstances of each participating country regarding the structure of their prison system, provision of mental health care in prisons, epidemiology of mental disorders in prisons, quality standards etc. The chapters were written by the experts.
- Assessment of the current situation of mental health care provision in prisons in the participating countries by means of the questionnaire.
- Analysis and comparison of the information provided by the experts (chapters and questionnaires). Preparation of preliminary results and a draft synopsis, which served as background papers for an expert meeting.
- Organisation of a meeting to discuss preliminary results, latest developments on this issue, similarities and differences between national concepts, as well as perspectives for future cooperation on a wider European level attended by at least one expert from each participating country,
- Summarising the discussion, results, and conclusions from the expert meeting.
- Writing a study report and dissemination of the results.

## Network of Experts

Experts from 24 countries were subcontracted and collaborated in this study. Almost half of them had contributed to the previous studies on civil detention or forensic psychiatry referred to above, and therefore were familiar with the study design and overall work plan. All experts agreed to fill in the study questionnaire, to write a country-specific chapter on mental health care provision in prisons and to attend an expert meeting to discuss preliminary results. The experts were also obliged to inform their responsible ministries of their collaboration in this study. The board of experts comprised:

- |                   |  |
|-------------------|--|
| • Austria         | Hans Schanda, Göllersdorf  |
| • Belgium         | Paul Cosyns, Roel Verellen, Egedem                                   |
| • Bulgaria        | Toma Tomov, Rumen Petrov, Sofia                                      |
| • Cyprus          | Evangelos Anastasiou, Louis Kariolou, Nicosia                        |
| • Czech Republic  | Jiří Raboch, Prague  |
| • Denmark         | Peter Kramp, Copenhagen  |
| • England & Wales | David V. James, Enfield  |
| • Finland         | Riitakerttu Kaltiala-Heino, Tampere                                  |
| • France          | Pierre Lamothe, Frédéric Meunier, Lyon                               |
| • Germany         | Norbert Konrad, Berlin   |
| • Greece          | Giorgos Alevizopoulos, Athens  |
| • Hungary         | László Lajtavári, Budakeszi  |
| • Iceland         | Jon Fridrik Sigurdsson, Reykjavik                                    |
| • Ireland         | Enda Dooley, Longford  |
| • Italy           | Angelo Fioritti, Bologna   |
| • Lithuania       | Dovile Juodkaite, Virginija Klimukiene, Vilnius                      |
| • Luxembourg      | Georges Rodenbourg, Ellen Bernhardt-Kurz, Ettelbruck                 |
| • The Netherlands | Katy (C.H.) de Kogel, Den Haag                                       |
| • Norway          | Ellen Kjelsberg, Oslo  |
| • Poland          | Andrzej Kiejna, Tomasz Hadrys, Wroclaw                               |
| • Portugal        | Miguel Xavier, Lisboa  |
| • Slovenia        | Andrej Marušič, Vita Poštuvan, Ljubljana                             |
| • Spain           | Francisco Torres-González, Granada, Luis F. Barrios-Flores, Alicante |
| • Sweden          | Orsolya Hoffmann, Stockholm  |

## Assessment Tools and Objectives

The study gathered detailed information on concepts, legal regulations and practise concerning the treatment of mentally disordered prison inmates in the participating countries. The major assessment tool was a detailed questionnaire. The development of the questionnaire and the selection of single items were based upon an exhaustive literature review and the knowledge and expertise of the project staff. Finally, the questionnaire comprised more than 90 specific items, including both structured and unstructured questions, and covered the following topics (among others):

- Responsibility for and availability of information on mentally ill or disordered prison inmates as well as on mental health care provision within the prison system,
- Structure and capacity of the prison system including prison health care,
- Prison population,
- Prevalence and incidence of mental disorders of prison inmates,
- Mental health care capacities within the prison system (including staff, annual budget, specific treatment programmes etc.),
- Screening or diagnostic procedures and treatment programmes for mentally disordered inmates,
- Release planning and aftercare,
- Collaboration of prison system with general mental health care system and forensic psychiatry,
- Outcomes of prison mental health care provision (e.g., suicide rates in prisons),
- National research activities in the field,
- Gaps and shortages of information on these items.

Because of the complexity of the issues concerned, the questionnaire had to strike a balance between questions on empirical data and open questions about specific national characteristics that are hard to describe in a structured way. A major part of the work during the first study phase was devoted to the development of this questionnaire. Additionally, guidelines for the composition of the country-specific chapters were developed. The national chapters were supposed to focus on issues and national particularities that cannot adequately be explored by means of a questionnaire, such as the advantages and the limitations of the current system or practical problems. Both the questionnaire and the guidelines on the national chapters were forwarded to all experts.

## Expert Meeting

A two-day expert meeting was held in Mannheim, Germany, from 15<sup>th</sup> - 16<sup>th</sup> December 2006. From the panel of experts, delegates from 18 countries attended the meeting.

The meeting started with an overview of the study status quo. Afterwards, a summary of preliminary results derived from the study questionnaires filled in by the contracted experts was presented by the coordination team. The following issues were covered:

- Structure of the European prison systems,
- Assessment and treatment of mentally disordered prisoners,
- Psychopharmacological treatment for prison inmates,
- Release planning and aftercare routines,
- Involuntary treatment,
- Psychiatric prevalence in prisons,
- Personality disorders in prison systems,
- Quality standards for prison mental health care,
- Ethics and human rights aspects.

The presentations were followed by the completion of missing information from the included countries, a clarification of queries and an extensive discussion of preliminary results. Among other points, the discussion focussed on key criteria for describing prison mental health care or for defining what constitutes a psychiatric bed in a medical prison ward. There was overall agreement on the complexity of the major issues covered by the study, requiring clear definitions of key concepts, responsibilities,

assessment or treatment procedures. It was agreed that the comparison of epidemiological data, i.e., time series on mental disorders in prisons, requires unambiguous descriptions of included patient groups and diagnoses, which are seriously affected by the rather poor reporting standards on the part of the included countries. The attendees stressed the great need for further research activities.

## Dissemination of Research Results

Dissemination of (preliminary) research results started during the study period and has continued to be an integral part of the group's activities.

At the Annual Meeting of the German Society for Psychiatry Psychotherapy and Neurology (DGPPN), held in Berlin, Germany from 22<sup>nd</sup> November to 26<sup>th</sup> November 2006, a presentation was given on "The care for mentally disordered inmates in the European prison systems – the EUPRIS study". The presentation included an overview of the study design and methods, as well as preliminary results. Another symposium presenting the results of the EUPRIS Study is scheduled for the subsequent DGPPN meeting, to be held in November 2008 in Berlin, Germany.

Results were also presented at the World Psychiatric Associations Thematic Conference "Coercive Treatment in Psychiatry: A Comprehensive Review", held from 6<sup>th</sup> - 8<sup>th</sup> June 2007 in Dresden, Germany. In the session "Care for Mentally Disordered Prison Inmates in Europe", that was co-chaired by the leaders of this project, three papers were presented that summarised specific aspects of this project. Apart from a general overview of the study results, the situation in Poland and in the Netherlands was highlighted by the Polish and Dutch collaborators on this study.

Additionally, an overview of the study results was given by the study leader at the Meeting of the Working Party on Information on Lifestyle, Specific and Deprived Population Groups, held in Luxembourg, 19<sup>th</sup> April 2007.

In October 2007, a set of key indicators on the issue was sent to the European Health Indicators Project Group (ECHI) as a proposal for inclusion in the ECHI comprehensive indicator list ("long-list"). The indicators were proposed according to the general format of the ECHI long-list and included:

- **„Suicides“** and **„Suicides in prison/detention“**, to be added to ECHI-long-list indicator 2.2.5 (health status/mortality cause specific/mental, behavioural)
- **„Suicide attempts in prison/detention“**, to be added to ECHI-long-list indicator 2.3.5 (health status/morbidity disease specific/mental, behavioural)
- **„Health care staff in prisons/detention (by physicians, psychiatrists, psychologists, nurses)“**, to be added to ECHI-long-list indicator 4.2.2 (health care resources /manpower)
- **„Psychiatrist's training for involuntary/forensic/prison treatment“**, to be added to ECHI-long-list indicator 4.2.3 (health care resources /education)
- **„Inpatient or hospital episodes of prison inmates (by selected diagnoses including mental disorders)“**, to be added to ECHI-long-list indicator 4.3.1 (health care utilisation / inpatient care utilisation)
- **„Referrals of prison inmates to NHS-hospitals (by selected diagnoses including mental disorders)“** to be added to ECHI-long-list indicator 4.3.1 (health care utilisation / inpatient care utilisation)
- **„Expenditures on prison health care“**, to be added to ECHI-long-list indicator 4.4.3 (health expenditures and financing / expenditures on medical services).

The selection and decision process by the ECHI group is still ongoing during the finalisation of this report.

The dissemination activities will be continued. Due to the relevance for decision makers, programme administrators, researchers, NGOs and other stakeholders in the field, major results from the study will be published in international scientific journals as well as presented at symposia and scientific congresses.

**Communication with the European Commission and Report Writing**

Communication with the Directorate-General Health and Consumer Protection took place whenever required by e-mail or phone. The interim activity report, as well as a financial interim report, were submitted to the Directorate-General by June 2006. This final study document was forwarded to the Directorate-General Health and Consumer Protection at the end of the funding period.

### 3. Results

The following section presents the results from the survey which was conducted as a central part of this study. The section describes separately the results for each of the following topics:

- Structure of European Prison Systems
- Mental Health Care Capacities in Prison
- Mental State Screening and Assessment / Pathway to Care
- Psychopharmacological Treatment
- Involuntary Treatment in Prison
- Prison Release / Aftercare
- Prison Population / Psychiatric Prevalence in Prison
- Quality Standards for Prison Mental Health Care
- Ethics and Human Rights Aspects

By summarising and comparing the collected data in a standardised way, it provides an overview of the current situation of prison mental health care in the included countries.

The chapter relies almost completely on data from the study questionnaire which was filled in by the collaborating experts. When necessary, additional non-standardised information as contributed by the experts was also included. In a few cases, information from other sources was added.

## Structure of European Prison Systems

To analyse the current state of mental health care provision for prison inmates, basic information on the structure and the capacity of national prison systems is crucial. Without such estimates, the effectiveness of prison mental health care cannot be evaluated.

### Prison Capacities

Table 1 outlines the variety of the prison capacities in terms of places in all kind of prisons or remand prisons of the countries included in this study.

The most basic standardised indicator (prison places per 1,000 population) suggests a considerable variation throughout Europe<sup>1</sup>. With rates above 1.0 per 1,000 population, Eastern European countries show an overall tendency towards larger prison capacities. Slovenia is located at the lower end of the range and is an exception, whereas Lithuania reports the largest prison capacities among all included countries. On a much lower level compared to Eastern Europe, Scandinavian countries share common rates, too, which lay below 0.8 per 1,000 population. In Southern Europe the situation is more heterogeneous, with surprisingly low prison capacities in Cyprus and Greece.

Although not a very reliable indicator, the capacity of the largest national prison may demonstrate the degree of centralisation of a national penitentiary system. However, less populous countries necessarily operate a small number of penitentiaries that are likely to cover a large proportion of all prison places (e.g., Iceland, Luxembourg, Cyprus, see table 1). Nevertheless, many European countries still run large prison services providing 1,000 or more places. Although it may be easier to provide centralised health care services or medical wards to large penitentiaries, large or old prisons are more likely to pose a number of unfavourable mental health conditions for inmates.

In almost all countries included in this study, there were no significant changes of prison capacities over time throughout the last fifteen years (see figure 1 or table 2). Significant changes would probably suggest a need to adapt the capacities or even the structure of prison health care.

In general, the number of prison places may indicate a certain size of a penitentiary system and may thus provide basic background information. However, from a prison health care perspective, the occupancy figures for penal institutions would be a much stronger indicator in evaluating the quality of health care provision – even more so, when the actual occupancy may override the nominal prison capacities, as is the case in many countries (see table 27).

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<sup>1</sup> Although the experts collaborating in this study were asked to report the overall numbers of national prison and remand prison places, comparisons should be drawn cautiously due to the lack of international standardisation and varying prison systems. It could not be completely ruled out that some countries reported figures that included the capacities of detention centres for illegal immigrants, juvenile prisons, or similar institutions, whereas other countries may have excluded them.

Table 1: Prison Capacities in European Countries

Country, year	No. of prison services	Total no. of prison places	Prison places per 1000 population	Capacity of largest prison (number of places, name or location of prison )	Share of places in largest prison
Austria, 2005	27	8,360	1.02	1,258 (JA Wien-Josefstadt)	15 %
Belgium, 2005	33	8,147	0.81	694 (Prison Lantin in Liège)	8.6 %
Bulgaria, 2005	13	13,750	1.76	2,000 (Central Prison of Sofia)	14.6 %
Cyprus, 2005	1	340	0.44	340 (Cyprus Prison Dep.)	100 %
Czech Republic, 2005	35	18,784	1.8	1,196 (Pilsen Prison)	6.4 %
Denmark, 2005	57	4,149	0.72	429 (Vestre Fængsel)	10.3 %
England & Wales, 2005	93	69,394	1.11	1,406 (Liverpool)	2 %
Finland, 2005	35	3,379	0.65	330 (Lounais-Suomen)	9.8 %
France, 2005	188	48,603	0.78	3,830 (Prison de Fleury-Mérogis)	7.9 %
Germany, 2005	199	79,687	0.97	1,571 (JVA Tegel)	6.4 %
Greece, 2006	30	5,284	0.48	640 (Korydallos Prison)	11.5 %
Hungary, 2005	33	11,263	1.12	1,214 (Palhaima, National Prison)	10.8 %
Iceland, 2005	5	137	0.47	87 (Litla-Hraun Prison)	63.5 %
Ireland, 2004	14	3,341	0.81	475 (Midlands Prison)	14.2 %
Italy, 2005	207	42,771	0.73	1,387 (Poggioreale, Napoli)	3.2 %
Lithuania, 2005*	15	9,476	2.79	1,554 (Alytus Correctional Institution)	16.4 %
Luxembourg, 2005	2	776	1.72	679 (Centre Penitenciaire de Luxembourg)	87.5 %
The Netherlands, 2005*	66	17,757	1.08	998 (Penitentiair Instituut Flevoland)	5.6 %
Norway, 2005	46	3,273	0.71	354 (Oslo Prison)	10.8 %
Poland, 2005	156	71,435	1.87	1,470 (Wronki Prison)	2.1 %
Portugal, 2005	56	12,356	1.19	887 (Estabelecimento Prisional de Lisboa)	7.2 %
Slovenia, 2006	7	1,103	0.55	296 (Dob Prison)	26.8 %
Spain, 2005	77	45,811	1.43	unknown	unknown
Sweden, 2005*	86	6,707	0.73	257 (Kriminalvarden, Anstalten Kumla)	3.8 %

\* The Netherlands: This figure includes 20 cluster of prisons with in total 66 locations, prisons or jails (1,258 places for illegal immigrants are included, juvenile institutions are excluded; Lithuania: In 2007 a probation model was implemented that is expected to lower the number of prisoners considerably  
Sweden: Juvenile prisons, detention centres and jails (administered by police) were excluded; Denmark and some other countries may have excluded places for custody prior to deportation.  
All countries: population data origin used for calculating population based rates: Eurostat 2006





Table 2: Change of Prison Capacities in European Countries, Time series 1990 – 2005 (Prison Places per 1,000 Population)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
<b>Austria</b>	1.09	1.08	1.07	1.06	1.05	1.05	1.05	1.05	1.05	1.05	1.04	1.04	1.04	1.03	1.03	1.02
<b>Belgium</b>								0.72	0.72	0.75	0.73	0.72	0.76	0.78	0.78	0.81
<b>Bulgaria</b>	1.57	1.59	1.6	1.62	1.63	1.63	1.64	1.65	1.66	1.67	1.68	1.73	1.74	1.75	1.76	1.77
<b>Cyprus</b>	0.37	0.36	0.35	0.34	0.33	0.33	0.32	0.32	0.31	0.31	0.31	0.34	0.34	0.48	0.47	0.44
<b>Czech Republic</b>		1.46	1.46	1.61	1.74	1.76	1.81	1.83	1.87	1.91	1.97	1.97	1.73	1.51	1.8	1.83
<b>Denmark</b>	0.73	0.72	0.71	0.72	0.72	0.73	0.7	0.71	0.7	0.7	0.69	0.67	0.67	0.7	0.72	0.77
<b>England &amp; Wales</b>					0.84	0.87	0.91	0.97	1.05	1.06	1.08	1.08	1.08	1.11	1.13	1.16
<b>Finland</b>	0.81	0.81	0.78	0.8	0.76	0.75	0.72	0.71	0.65	0.64	0.61	0.61	0.63	0.63	0.64	0.65
<b>France</b>	0.57						0.76				0.79		0.78			0.78
<b>Germany</b>	0.75					0.87	0.87	0.88	0.9	0.92	0.93	0.95	0.95	0.95	0.96	0.97
<b>Greece</b>										0.41	0.43	0.44	0.48			
<b>Hungary</b>							1.02	1	1	0.99	0.98	1.05	1.1	1.11	1.12	1.12
<b>Iceland</b>	0.4	0.4	0.39	0.39	0.38	0.39	0.51	0.51	0.51	0.5	0.49	0.48	0.48	0.47	0.47	0.47
<b>Ireland</b>		0.61	0.62	0.62	0.62	0.59	0.61	0.66	0.71	1	0.98	0.91	0.9	0.84	0.83	0.81
<b>Italy</b>						0.72	0.74	0.78	0.77	0.75	0.75	0.75	0.73	0.73	0.73	0.73
<b>Lithuania</b>													2.86	2.77	2.79	2.77
<b>Luxembourg</b>	1.16	1.14	1.13	1.11	1.1	1.08	1.07	1.17	1.16	1.14	1.13	1.77	1.75	1.74	1.72	1.71
<b>The Netherlands</b>	0.52	0.51	0.51	0.53	0.62	0.66	0.78	0.81	0.83	0.84	0.8	0.8	0.89	1.01	1.11	1.09
<b>Norway</b>	0.56	0.6	0.58	0.62	0.62	0.62	0.63	0.66	0.65	0.66	0.65	0.65	0.65	0.65	0.67	0.68
<b>Poland</b>	1.77	1.71	1.75	1.73	1.75	1.76	1.75	1.73	1.73	1.68	1.8	1.83	1.85	1.87	1.86	1.87
<b>Portugal</b>							0.91		1.1		1.1	1.11	1.11	1.16	1.19	1.17
<b>Slovenia</b>								0.53	0.53	0.53	0.53	0.54	0.53	0.53	0.55	0.55
<b>Spain</b>										1.04	1.06		1.11	1.16	1.08	1.06
<b>Sweden</b>	0.63	0.64	0.62	0.65	0.73	0.73	0.71	0.67	0.63	0.63	0.64	0.66	0.68	0.7	0.73	0.74

### Administrative Responsibility for Health Care Provision in Prison

On a theoretical level, administrative responsibility may provide a criterion to categorise prison mental health care in terms of general approaches. These may include

- prison mental health care as a responsibility of general mental health care (model 1)
- provision of mental health care for prison inmates as an integral part of the detention or penitentiary system (model 2)
- provision of mental health care for prison inmates as part of forensic psychiatry (model 3).

Each model may entail specific consequences affecting financial, administrative, security or training aspects and may bear certain disadvantages. In reality, these approaches are not clearly distinct from one another. Responsibilities may overlap in a complex way. Usually, judicial authorities, prison administrations, and the department of health are forced to interact and to collaborate in providing health care for prisoners. So the decision as to which department or agency holds general responsibility for prison health care and how the actual service provision is regulated and coordinated may have a significant impact.

**Table 3: General Responsibility for Prison Health Care Provision (Including Prison Mental Health Care)**

<i>Ministry of Justice / Prison Administration</i>	<i>Ministry of Health / National Health Service (NHS)</i>	<i>Mixed or split responsibility (NHS/Ministry of Health and Prison Administration / Ministry of Justice)</i>
<i>Austria</i>	<i>Cyprus</i>	<i>Hungary</i>
<i>Belgium</i>	<i>England &amp; Wales</i>	<i>Luxembourg</i>
<i>Bulgaria</i>	<i>France</i>	<i>Slovenia</i>
<i>Denmark</i>	<i>Iceland</i>	<i>Italy*</i>
<i>Finland</i>	<i>Norway</i>	
<i>Germany</i>		
<i>Czech Republic</i>		
<i>Greece</i>		
<i>Ireland</i>		
<i>Lithuania</i>		
<i>The Netherlands</i>		
<i>Poland</i>		
<i>Portugal</i>		
<i>Spain*</i>		
<i>Sweden</i>		

\* *Italy: NHS only for drug addiction treatment*

*Spain: Prison administration is under the responsibility of the Ministry of Internal Affairs*

It may reduce bureaucracy if health care professionals in the prison sector work under the same authority as other prison staff. However, running a separate system of prison health care under juridical authority that is more or less divorced from the general health care system may entail a tendency to duplicate services and risk inefficacy or inequality. Budget restrictions may force prison administrations to give preferential treatment to safety aspects at the expense of health care requirements. On the other hand, the opposite approach of a general health care responsibility for prison health care may pose specific administrative obstacles to coordinating public health services with medical prison services.

A variety of prison health care models is preferred in Europe at the moment. All approaches cover prison mental health care as well, which in none of the countries included in these analyses is run

separately from general prison health care (see table 3). On a practical level, administrative models may differ. Where the Ministry of Justice is exclusively responsible for medical prison services, this responsibility usually covers only the health care staff or medical wards within a prison, while liaison physicians from the general health care system who may contribute to care for prisoners usually remain under the tutelage of the National Health Service. In the case of Cyprus, medical staff working exclusively in the national prison is nonetheless NHS-administrated.

### Organisational Models of Prison Mental Health Care

No matter how the general responsibility for medical prison services is regulated in detail, most countries included in this study involve general psychiatric services in the care for prisoners. The contribution of external psychiatric services to prison mental health care is most often substantial. This applies particularly for psychiatric inpatient care, but it may also cover outpatient care to a considerable degree.

However, currently there are no exact data available to quantify the contribution of external services to both sectors. Instead, one must rely on estimates provided by experts collaborating in this study. To this end, global categories were chosen to classify collaboration models (see table 4).

**Table 4: Organisation of Prison Mental Health Care**

<b>Internal</b> (exclusively by prison mental health care ser- vices)	<b>External</b> (exclusively by external mental health care or NHS services )	<b>Mixed</b> (by internal prison and ex- ternal services) <b>internal services</b> <b>dominating</b>	<b>Mixed</b> (by internal prison and external services) <b>external services</b> <b>dominating</b>
Belgium Lithuania	England & Wales* Cyprus Ireland* Norway	Bulgaria Czech Republic Finland Hungary Italy The Netherlands Poland* Portugal	Austria Denmark France Germany Greece* Iceland* Luxembourg Slovenia* Spain Sweden*

\* England & Wales: First-level care is provided in prison by staff employed by the NHS, inpatient treatment by general psychiatric services.

Greece: Due to a lack of data, it is unknown whether external or internal services dominate in the mixed care model.

Iceland: No medical prison wards are implemented.

Ireland: Mentally disordered prisoners are treated at Central Mental Hospital, which is a forensic psychiatric facility.

Poland: Apart from a few liaison contacts or emergency cases, mental health care is mostly internal.

Slovenia: Inpatient treatment is provided by general psychiatric services, outpatient treatment by general psychiatric services or by prison services.

Sweden: Outpatient treatment is provided in prison, inpatient treatment by general psychiatric services.

The terms “internal” or “external” (i.e., professionals from the NHS or the general mental health care system) refer to the respective system which professionals providing mental health care for prisoners may belong to or come from. The actual location of care, e.g., if prisoners are cared for on the prison premises (e.g., in medical prison wards) or outside the prison (e.g., in forensic hospitals, general psychiatric hospitals, or outpatient services) is considered secondary in this regard, as this may vary or depend on the severity of cases, the availability of beds, or other criteria. This aspect is outlined in table 5.

Table 4 suggests prison mental health care in Europe as provided by general psychiatry to a considerable degree. The majority of the included countries adopts an approach that mixes external with internal prison health services in varying proportions. Forensic psychiatry plays a role, too, although to a much lesser degree. England and Wales, Cyprus and Norway represent a cluster of countries preferring a clearly NHS-supported system of prison mental health care. Although categorised similarly to the aforementioned countries in table 4, Ireland favours a combined model of forensic and prison health care provision - most probably for pragmatic reasons, since all Irish mentally disordered offenders (whether or not they are forensic cases) are placed and treated in a centralised secured hospital. Belgium and Lithuania are protagonists of an internal prison mental health care model. To a certain extent, Italy and Poland might be added to this category, too. Apart from a few liaison contacts or emergency cases, most of Poland's prison mental health care is provided internally within the prison system.

The inclusion of general psychiatric services may be organised either by sending psychiatrists or other mental health care staff from the NHS to a prison ("come structure") or by referring prisoners to external services ("go structure"). Any such classification suffers from a lack of exact data that would allow one to quantify the actual numbers of liaison contacts of psychiatrists or referrals of prisoners to mental hospitals. So the overview in table 5 was based on estimations by the experts included in this study. The dominating "mixed" category in table 5 suggests that in most countries, it is most probably regional conditions or resources that determine routine practices.

**Table 5: Integration of External Mental Health Care Services into Prison Health Care (estimated)**

<b>"Go structure" (referrals to external services)</b>	<b>"Come structure" (visits of external staff in prison)</b>	<b>Mixed (come structure and go structure)</b>	<b>Not applicable (no external service usage)</b>
Denmark	none	Austria	Belgium
Italy		Bulgaria	Lithuania
Spain		Czech Republic	
		Cyprus	
		England & Wales	
		Finland	
		France	
		Germany	
		Greece	
		Hungary	
		Iceland	
		Ireland	
		Luxembourg	
		The Netherlands	
		Norway	
		Poland	
		Portugal	
		Slovenia	
		Sweden	

### Legal Activities Regarding Prison Mental Health Care

In most countries, prison health care is the subject of ongoing legal change. Together with these changes, split responsibilities for prison health care (see table 3) add to rather complex legal frameworks that encompass a range of law books, legal instruments or codes. Additionally, each passing of

new prison laws or the adaptation of old regulations may potentially affect health conditions in prison, even if they do not directly aim at prison health or regulate prison health care.

To demonstrate the most recent developments in this area, table 6 lists selected legal activities from the included countries, as they were reported by the participating experts. This list is incomplete and legal categories or terms are not standardised. This selection does not suggest a distinct cross-national pattern for adapting the legal frameworks for prison mental health care to requirements of the routine practice. An analysis of the impact of specific national laws is beyond the objective of this report and must be the subject of detailed studies on a national level.

**Table 6: Recent Legal Activities to Improve Prison Mental Health Care (selected)**

Country	Year	Activity
Belgium	2005	<i>Legal Position of Detainees Act</i>
Cyprus	2004	<i>Implementation of a multidisciplinary team for prison health care</i>
Czech Republic	1997	<i>inclusion of NGOs into the care for detained substance abusers</i>
Denmark	2000	<i>Passing of "Enforcement of Sentences Act", stressing the equity of prison health care and general health care (including mental health care)</i>
England & Wales	2002	<i>National Health Service Reform and Health Care Professions Act (responsibility of prison health care transferred to NHS)</i>
France	1994	<i>General hospitals responsible for prison health care</i>
Finland	2006	<i>Passing of "New Prison Sentence Act" restructuring prison health services; since 1997 risk and needs assessment of prison inmates (OASYS) is implemented</i>
Hungary	2003/2005	<i>Regulation on the co-operation of Ministries of Justice and Health; regulation of Ministry of Health about quality assurance</i>
Ireland	2006	<i>Criminal Law (Insanity) Act 2006 clarifies admission and discharge to Central Mental Hospital</i>
Italy	2000	<i>Implementation of internal prison health care provision</i>
Lithuania	1995-2005	<i>Adaptation of the Law on Mental Health Care (equality of health care for prisoners); concept of drug abuse prevention and control in penal institutions; Implementation of suicide prevention program for 2003-2005</i>
Luxembourg	2002	<i>Co-operation with two external health services for providing health care to prisoners</i>
The Netherlands	1998-2006	<i>Implementation of "Penitenciaire Maatregel" (possibility of appeal against medical treatment); implementation of reducing recidivism program; restructuring of prison system is ongoing</i>
Poland	2003	<i>Ordinance of the Minister of Justice on the matter of detailed rules, extent and forms of prison medical units providing medical and psychiatric services to persons deprived of their liberty</i>
Portugal	1991/1996	<i>Implementation of two psychiatric clinics in prisons (1991); implementation of free drug sectors and therapeutic communities inside prisons (1996)</i>
Slovenia	unknown	<i>Implementation of prison health care provision by NHS</i>
Sweden	1997	<i>Responsibility for supervising health care in the prison system changed to The National Board of Health and Welfare</i>

*List is incomplete. No major legal activities were reported from Austria, Germany, Greece, Iceland, Norway or Spain.*

## Mental Health Care Capacities in Prison

### Psychiatric Prison Beds

It is particularly difficult to define what may be considered a psychiatric prison bed. Due to the heterogeneous models of prison health care that most often mix small medical teams in penal institutions

**Table 7: Psychiatric Beds in Medical Prison Wards**

Country, year	Medical prison beds (total number)	Psychiatric prison beds (total number)	Psychiatric prison beds per 1,000 prison places	Psychiatric prison beds per 1,000 population
Austria, 2005	332	25	3	0.003
Belgium, 2001	45	337	41.5	0.030
Bulgaria, 2005	180	30	2.2	0.004
Cyprus, 2005	0	0	0	0
Czech Republic, 2005	286	58	3.1	0.006
Denmark, 2005*	36	127	30.6	0.020
England & Wales 2005	0	0	0	0
Finland, 2005	68	55	16.3	0.011
France, 2005	240	0	0	0
Germany, 2005*	unknown	unknown	unknown	unknown
Greece, 2002	60	160	30.3	0.015
Hungary, 2005	450	94	8.3	0.009
Iceland, 2005	0	0	0	0
Ireland, 2005	0	0	0	0
Italy, 2005	973	76	1.8	0.001
Lithuania, 2005	111	25	2.6	0.007
Luxembourg, 2005	11	18	23.2	0.040
The Netherlands, 2005	56	269	15.1	0.017
Norway, 2005	0	0	0	0
Poland, 2005	1,287	222	3.1	0.007
Portugal, 2004	196	27	2.2	0.003
Slovenia, 2005	0	0	0	0
Spain, 2004*	2,414	unknown	unknown	unknown
Sweden, 2005*	33	55	8.2	0.006

Please note: The definition of medical or psychiatric prison beds may be inconsistent across boundaries. No prison beds may indicate a completely external provision hospital care for mentally disordered prisoners.

\* Austria: The 25 prison beds are almost exclusively reserved for mentally ill offenders (NGRI "not guilty for reason of insanity", and for mentally ill remand prisoners who presumably will be exculpated during court trial. Prisoners with acute mental illness can only be treated in the regional psychiatric hospitals or - depending on availability of beds - in the acute ward of Austria's central institution for mentally ill offenders NGRI). Therefore, the Austrian prison system does not dispose of psychiatric wards, exclusively (or at least primarily) designated for acutely or chronically mentally ill inmates.

Denmark: Psychiatric prison beds are for treating prisoners with non-psychotic mental disorders only.

Germany: Due to Federal State responsibilities and the lack of a national register, nationwide figures are not available.

Spain: For security reasons, most details of the Spanish prison system are protected and thus not available. 292 beds for prisoners are additionally available in general hospitals.

Sweden: No medical staff available at medical prison wards during nights or weekends.

with liaison physicians or contracted health services from the outside, beds in medical prison wards are often substantially more poorly staffed than beds in general hospital wards – although such more poorly staffed medical prison beds are constantly available and are officially counted as full medical prison beds. This is even more so the case when these beds are designated for mentally ill prison inmates, if such a distinction is made at all. So any officially provided number of beds in medical or psychiatric prison wards is probably less expressive than less ambiguous indicators such as “hospital beds” or “psychiatric beds” in general health care or mental health care systems are, which are internationally used to describe overall health care resources.

**Table 8: Medical or Therapeutic Prison Staff (total number in full time equivalents; in brackets: staff per 1,000 prison places)**

Country, year	Physicians in prison services*	Psychiatrists in prison services	Psychologists in prison services	Nurses in prison services
Austria, 2004	22.6 (2.7)	10.6 (1.3)	49.4 (5.9)	49.4 (5.9)
Belgium, 2006	unknown**	32 (3.4)	147 (15.8)	122 (13.1)
Bulgaria, 2005	50 (3.6)	13 (1)	37 (2.7)	99 (7.2)
Cyprus, 2006 **	2 (5.9)	1 (2.9)	2 (5.9)	7 (20.6)
Czech Republic, 2005	75 (3.9)	3 (0.2)	107 (5.7)	312 (16.6)
Denmark, 2005**	26 (6.3)	12 (2.9)	14 (3.8)	84 (20.3)
England & Wales, 2005**	0	0	0	0
Finland, 2005	20 (5.9)	4 (1.2)	3 (0.9)	115 (34)
France	unknown	unknown	unknown	unknown
Germany	unknown	unknown	unknown	unknown
Greece, 2006 **	unknown	1 (0.2)	unknown	unknown
Hungary, 2005	93 (8.3)	14 (1.2)	12 (1.1)	470 (41.7)
Iceland, 2006 **	1.85 (13.5)	0.75 (5.5)	2 (14.6)	1.25 (9.1)
Ireland, 2006	10 (3)	3 (0.9)	15 (4.5)	100 (29.9)
Italy, 2005	1,238.8 (29)	94 (2.2)	182.4 (10.7)	960.4 (56)
Lithuania, 2005	83.5 (8.8)	10 (1.1)	19 (2)	180.8 (19.1)
Luxembourg, 2005	5.5 (1.2)	2.5 (0.5)	1 (0.2)	23.4 (5.1)
the Netherlands, 2006 **	141 (7.9)	unknown	unknown	387 (21.8)
Norway	0	0	0	0
Poland, 2005 **	646 (9.0)	59 (0.8)	320 (4.6)	827 (11.6)
Portugal, 2004	42 (3.4)	7 (0.6)	29 (2.3)	97 (7.8)
Slovenia, 2005	0	0	8 (7.3)	13 (11.8)
Spain, 2004	444 (7.2)	6	unknown	502 (8.5)
Sweden, 2005	unknown	2.9 (0.4)**	16.85 (2.5)	140 (20.9)

\* Number of physicians includes psychiatrists as given in third column

\*\* Belgium: Due to contracting conditions, the number of physicians can not be expressed in full-time equivalents.

Cyprus: Medical staff is supervised by the Mental Health Service but placed at the prison.

Denmark: Number of psychiatrists is estimated.

England & Wales: Most prisons are staffed with medical officers, however all medical prison staff is employed by the NHS.

Greece: Four part-time psychiatrists (unknown workload) to be added to the only full-time psychiatrist at Korydallos Prison.

Iceland: Psychologists under the responsibility of the prison and probation administration are only available on a regular basis in the largest prison.

The Netherlands: Figures are the number of employed persons, full-time equivalents are not available.

Poland: Number of psychologists includes those working in medical prison wards and in penitentiary departments.

Nevertheless, for this study we have tried to collect the number of beds in medical prison wards in the included countries that are officially designated for the inpatient treatment of mentally disordered prisoners (see table 7). Due to the absence of an international definition for psychiatric prison beds, there is no standardisation of national figures, so that these must be interpreted against the background of the prevailing national prison mental health care model (see tables 4 and 5). A high number of psychiatric prison beds must not necessarily be associated with a good standard of inpatient mental

health care for prisoners. Similarly, a low psychiatric prison bed rate (as in the case of Ireland, Iceland, Norway and Slovenia) must not suggest a poor provision mental health care for prison inmates when the respective care model is based predominantly on referrals of mentally disordered prisoners to mental health care services outside the prison system. The number of these referrals contributes substantially to the wide variation among the psychiatric prison bed rates specified here (“psychiatric prison beds per 1,000 population”, “psychiatric prison beds per 1,000 prison places”). The availability of statistics on the referrals of prisoners to external psychiatric hospitals or outpatient services is shown elsewhere (see table 31).

### Mental Health Care Staff in Prison

Similar problems arise when trying to collect the number of psychiatric staff permanently available at a prison. The number of mental health care professionals at a prison differs according to the general model of prison mental health care favoured by the respective country.

However, a basic psychological, psychiatric or nursing expertise should be permanently available on the prison premises, even if referrals to external mental health care services are immediate and frequent. Easy access to professional psychological prison staff is essential for a variety of purposes, e.g., to assess the urgency of referrals or emergency cases, to provide general psychological counselling or care in cases of psychological distress due to prison conditions. Unfortunately, no international guidelines are available that recommend appropriate staff numbers or ratios required for good practice.

**Table 9: Specific Training for Medical Prison Staff (in addition to regular job trainings, as a prerequisite for employment in medical prison services)**

<i>additional training or qualification legally required</i>	<i>Additional training or qualification not legally required</i>
<i>Denmark*</i>	<i>Austria</i>
<i>Germany*</i>	<i>Belgium*</i>
<i>Hungary*</i>	<i>Bulgaria</i>
<i>Poland*</i>	<i>Cyprus</i>
<i>Spain*</i>	<i>Czech Republic</i>
	<i>England &amp; Wales</i>
	<i>Finland</i>
	<i>France</i>
	<i>Greece</i>
	<i>Iceland</i>
	<i>Ireland</i>
	<i>Italy</i>
	<i>Lithuania</i>
	<i>Luxembourg</i>
	<i>The Netherlands*</i>
	<i>Norway</i>
	<i>Portugal</i>
	<i>Slovenia</i>
	<i>Sweden</i>

\* *Belgium: Training programme provided by prison administration and covering issues such as the prison as workplace, treatment of sexual abusers, mental state assessment, risk assessment etc.). However, this training is not legally required.*

*Denmark: Additional training is required on juridical aspects and regulation standards, not on medical or psychiatric aspects.*

*Germany: In some Federal States, nurses in the prison system must qualify as prison officers.*

*Hungary: Obligatory course regarding the Law Enforcement System*

*The Netherlands: Usually, additional training is required for medical doctors and nurses, a legal basis is being prepared*

*Poland: For upper or middle grade positions, an additional qualification (officer) and a certain length of employment in the prison services is required.*

*Spain: Medical prison staff has to pass a practical training in prison and a specific examination*



According to the results of the data collection in this study, the number of full-time physicians, nurses, psychiatrists, or psychologists working in a prison varies remarkably across the included countries (see table 8). Standardised estimates range from 0.2 to 5.5 psychiatrists and 0.2 to 15.8 psychologists per 1,000 prison places. Similar to the rates of psychiatric prison beds, staff rates must be interpreted by taking into account the general model of prison mental health care implemented in the respective country (see tables 4, 5 and 7). Thus, the large number of medical staff working in Italian penitentiaries, which ranks high above the average, is to be seen against the background of the specific Italian policy to provide medical care within the prison system. A doubling in the number of prisoners from 1989 to 2005 may have forced an increase in the number of medical staff in Italian prisons.

### Training of Mental Health Care Staff in Prison

The specific conditions of mentally disordered offenders (e.g., increased psychiatric co-morbidity, high rates of dissocial personality disorders, violent or aggressive behaviour) require a specific expertise and a specific training on the part of mental health care staff responsible for the care of prisoners. This applies to all professionals involved in the regular mental health care for prisoners, no matter where this care may take place. Specific training may address, e.g., specific psychological problems of prison inmates, rehabilitation strategies after release, secondary crime or medical prevention, security issues, legal regulations for prison health care provision or other aspects. However, only in a minority of countries assessed here is a specific qualification in addition to a regular job training required of mental health care professionals caring for prisoners (see table 9). Moreover, in most cases this applies merely to mental health care staff within the penal system, and not to those working in the NHS. As a consequence, offenders referred to general mental health care services are often likely to be included in routine psychiatric treatment procedures or are cared for by regular teams that may lack experience in how to deal with the specific needs of prison clientele.

**Table 10: Prison Health Care Funding (Mental Health Care included)**

<i>National Health Service</i>	<i>Ministry of Justice/Prison Administration</i>	<i>Mixed or split funding</i>	<i>Other</i>
<i>Cyprus</i>	<i>Austria</i>	<i>Czech Republic<sup>a</sup></i>	<i>France (social welfare)</i>
<i>England &amp; Wales</i>	<i>Belgium</i>	<i>Denmark<sup>b</sup></i>	
<i>Iceland</i>	<i>Bulgaria</i>	<i>Hungary<sup>b</sup></i>	
<i>Norway</i>	<i>Finland</i>	<i>Ireland<sup>b</sup></i>	
	<i>Germany</i>	<i>Sweden<sup>b</sup></i>	
	<i>Greece</i>		
	<i>Italy</i>		
	<i>Lithuania</i>		
	<i>Luxembourg</i>		
	<i>The Netherlands</i>		
	<i>Poland</i>		
	<i>Portugal</i>		
	<i>Slovenia</i>		
	<i>Spain<sup>c</sup></i>		

<sup>a</sup> Ministry of Justice and health insurance of prisoners

<sup>b</sup> National Health Service and Prison Administration

<sup>c</sup> Prison Administration (Ministry of Internal Affairs)

Table 11: Annual Prison Health Care Budget (in €)

Country, year	Total prison budget (€) * (in brackets: per prison place)	Total budget for prison health care (in brackets: per prison place)	Proportion of prison health care budget (of total prison budget)	Proportion of prison health care budget (of general domestic product GDP <sup>a</sup> )
Austria, 2003/5	291.9 Mio (34 923)	32 Mio (3,828)	11 %	0.014 %
Belgium, 2000	261.6 Mio (30 104)	19.3 Mio (2,224)	7.4 %	0.007 %
Bulgaria, 2005	45 Mio (3 272)	0.15 Mio (11)	0.3 %	0.00025 %
Cyprus, 2006	14.9 Mio (43 824)	unknown	unknown	unknown
Czech Republic, 2005**	247.8 Mio (13 192)	unknown	unknown	unknown
Denmark, 2005	298.8 Mio (72 028)	10.8 Mio (2,592)	3.6 %	0.007 %
England & Wales	unknown	unknown	unknown	unknown
Finland, 2005	177.7 Mio (52 590)	12 Mio (3,551)	6.8 %	0.009 %
France, 2005	1,654 Mio (34 031)	45 Mio (926)	2.7 %	0.003 %
Germany	unknown	unknown	unknown	unknown
Greece	unknown	unknown	unknown	unknown
Hungary, 2005	153.7 Mio (13 648)	7.8 Mio (691)	5.1 %	0.006 %
Iceland, 2006	9.1 Mio (66 108)	0.6 Mio (4,405)	6.7 %	0.007 %
Ireland, 2004	261.2 Mio (77 668)	unknown	unknown	unknown
Italy, 2004	2,549.8 Mio (59 616)	129.1 Mio (3,017)	5 %	0.009 %
Lithuania, 2006	45.8 Mio (4 829)	unknown	unknown	unknown
Luxembourg, 2006	34.2 Mio (44 134)	4.4 Mio (5,684)	12.9 %	0.17 %
The Netherlands, 2006	1,095 Mio (61 665)	20 Mio (1,143)	1.8 %	0.005 %
Norway, 2005	242.9 Mio (7 7026)	**10.3 Mio (3,266)	4.2 %	0.006 %
Poland, 2005	427.4 Mio (5 983)	21.2 Mio (296)	5 %	0.005 %
Portugal, 2004	207.1 Mio (16 757)	unknown	unknown	unknown
Slovenia, 2005	26.5 Mio (24 025)	1.1 Mio (965)	4 %	0.003 %
Spain	unknown	unknown	unknown	unknown
Sweden, 2005	629.7 Mio (93 888)	17.9 Mio (2,676)	2.9 %	unknown

<sup>a</sup> Source for gross domestic product: International Monetary Fund, World Economic Outlook Database, December 2005

\* For operating all prison services (running cost), \*\* Czech Republic: expenditures, income is not subtracted \*\*\* Norway: includes only costs for primary health services

## Prison Health Care Budgets

The quality of prison health care is necessarily linked to the financial budgets provided for this purpose. However, while annual prison budgets are available in most countries, funds for the expenditures for medical services in prison are provided to a much lesser degree. When specified, official prison health care budgets must be interpreted cautiously. Most often, they include only running costs for infrastructure or for staff that is directly employed by the prison administration or by the Ministry of Justice. In the case of split responsibilities or shared funding models, substantial contributions from the National Health Service budgets mask the actual health care expenditures for prisoners, although in most cases, NHS-contributions remain unspecified. In most countries included in this evaluation, health insurance payments play no significant role in financing prison health care. Table 10 shows the national funding mechanisms for prison mental health care, and table 11 shows the prison health care budgets that were collected during this study.

Prison health care funding mechanisms as outlined in table 10 include mental health care funding as well. Again, the various models of prison health care (see table 4 and 5) must be taken into account when comparing prison health care budgets across boundaries. Not surprisingly, the prison health care budgets vary substantially. None of the included countries specified separate budgets for mental health care for prisoners. All expenditures for mental health care purposes are included in the overall health care budgets in unknown proportions. All figures as listed in table 11 are not controlled for purchasing power parities, which do vary across the included countries. So the percentage of the total prison budget spent for health care, or the proportion of prison health care compared to the gross national product may serve as a rough, but more or less standardised, indicator for international comparison.

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*International Monetary Fund (2005)* *World Economic Outlook Database, December 2005*

## Mental State Screening and Assessment / Pathway to Care

### Screening of Mental Health Status at Prison Entry

An essential prerequisite to providing adequate mental health care for prison inmates is state of the art screening or the assessment procedures implemented in all prison services. Immediately after prison entry, every new prisoner should be screened in order to assess his mental state. Among a number of purposes, a mandatory early screening would enable mental disorders that were acquired before the imprisonment to be distinguished from adjustment disorders due to prison conditions or from any other serious mental disorder that may arise during the prison term.

The degree of standardisation of screening or assessment procedures, the applied diagnostic methods, and the profession or training of staff members eligible to perform screening are criteria for the quality of implemented entry assessment or screening procedures.

However, to the information provided by the experts collaborating in this study reveals that even on a national level common standards hardly exist with regard to the quality of mental health screenings in European prisons. Even within countries, routine practices may differ from region to region, which may be due to the lack of adequately trained staff, scarce financial resources, or other causes. Apart from these deficits in routine practice, legal standards for regulating the mental state assessments or screenings at prison entry or during prison terms vary as well.

Figure 2 gives an overview of the professional status of persons entitled to conduct a mental health screening at prison entry. When using this legally defined professional status of staff members as a quality indicator, among all included countries, Cyprus, Greece and Slovenia have in common that an initial screening may be done by non-medical staff. In these countries, a new prisoner will probably be referred to a physician or a psychiatrist for a more thorough mental state assessment only if initial findings are precarious.

In Denmark, Finland, France, Luxembourg, the Netherlands, Norway and Sweden, the staff member must at least be a nurse in order to perform an initial mental health screening, which may be supplemented by a more thorough assessment by a physician or a psychiatrist when needed. It is unclear, whether nurses must be specifically trained in psychiatric care. At least in the case of Sweden, such training is not required. Moreover, neither Dutch or Norwegian laws stipulate even a mental state screening by nurses, although such procedures are widely implemented into routine practice and may probably cover all new prison entries. Finnish laws define as a threshold for an obligatory mental state screening at entry a minimum term of two years.

In Austria, Belgium, Bulgaria, the Czech Republic, England & Wales, Germany, Hungary, Iceland, Italy, Poland, Portugal and Spain, general practitioners are entitled to screen the mental state of new inmates, most often as part of a general medical examination at prison entry. In Ireland, Spain and probably some other of the aforementioned countries, all receptions would be accompanied by a routine assessment by a physician and, if positive for mental health pathology, further assessment by a psychiatrist or psychologist would be arranged. In Iceland, where legal regulations call for an examination by a general practitioner, too, the actual mental state screening is often done by a nurse. Depending on the psychiatric expertise or the experience of GPs, quality standards of mental state assessments may vary.

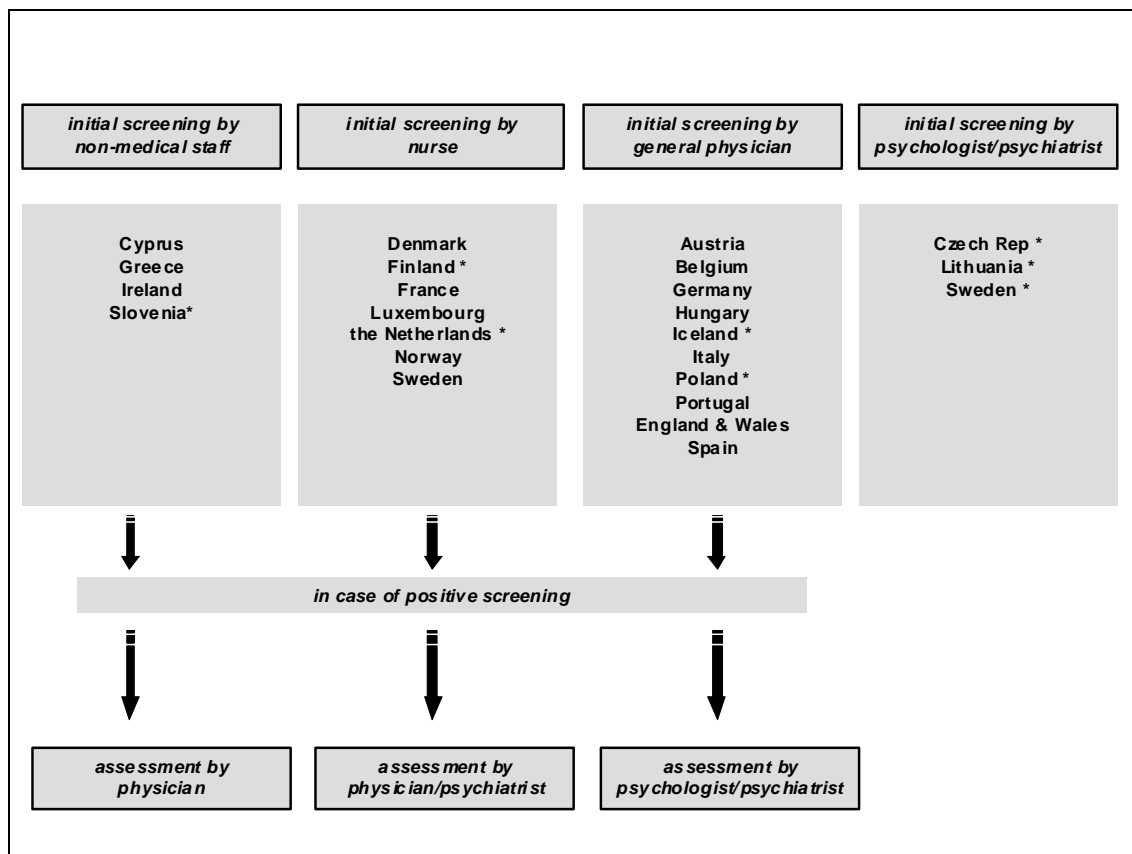
In Sweden, legal regulations require a psychiatric assessment by a psychologist or psychiatrist for all prisoners sentenced to term of four years or longer. In Lithuania, a full mental health assessment by a psychologist or a psychiatrist is stipulated for all new entries, too. Fulfilment of this legal obligation is hampered by a shortage of trained psychologists or psychiatrists, however.

All in all, rather than being the rule, a mental state screening at prison entry by psychologists or psychiatrists that fulfils quality standards seems to be a rare event across Europe. In many countries, inadequately trained staff is appointed to do a mental state screening at prison entry. Professionals

without sufficient skills are unlikely to detect either the most prevalent mental disorders among new prison entries or the considerable proportion of malingering or lying among new prisoners with psychopathic behaviour or symptoms. Thus professionals responsible for mental state screening in prisons should be specifically trained to recognise the behaviour or needs of mentally disordered offenders. At the moment, legal standards and routine practices in Europe seem to be far removed from that quality level.

However, the high rate of cases identified in Cyprus, where qualified mental health care teams are implemented in the prison system shows that a weak legal regulation may be balanced by routine practices of high standard.

**Figure 2: Mental State Screening and Assessment Routines at Prison Entry**  
(eligible staff requirement according to legal regulations)



\* Czech Republic: Psychological assessment at entry is required for all prisoners sentenced to more than 3 months.

Finland: for all prisoners sentenced to a term of more than 2 years

Iceland: Although it is the responsibility of a GP, screening is frequently done by nurse.

Lithuania: if a psychologist is available

The Netherlands: not legally required but routine practice

Norway: not legally required but routine practice

Poland: General physicians, psychiatrists or psychologists are authorised to do a screening.

Slovenia: All prison staff members (including non-medical staff) may do a mental state screening.

Sweden: for all prisoners sentenced to a term of more than 4 years

## Mental Health Screening during Imprisonment

Most research studies on this issue agree that mental disorders, particularly substance abuse, personality disorders, or chronic psychotic disorders are found more frequently in prisoners than in general population samples. The restriction of freedom, the prison setting in general, or specific environmental factors in prison are potential mental health hazards. Particularly the early phases of imprisonment must be recognised as periods of high vulnerability.

Despite this research evidence, none of the countries included in this evaluation legally requires an obligatory mental health re-screening by qualified staff during imprisonment (see table 12). Routine practices are not likely to amend this serious legal omission, so that regularly updated mental state screenings by adequately trained professionals are far from being standard procedure in European prisons. This may be different when prisoners are referred to general psychiatric or forensic hospitals for psychiatric treatment, which happens to a considerable but unfortunately unknown degree (see table 31). In such a case, they are included in the regular hospital routines and re-assessed or diagnosed according to their psychopathological needs.

In the prison setting, Danish prisoners are monthly re-screened by non-medical staff, although a health professional may attend the screening session if the inmate agrees to it. Clinical cases are visited daily by a nurse, physician, or psychiatrist. In Luxembourg, mentally ill prisoners are re-assessed once a week during acute phases. In the case of continuing treatment, a re-assessment eight or twelve weeks later is scheduled.

A variety of routines like the aforementioned may be implemented across Europe, which suggests that there is a rather high risk that prisoners who acquire a mental disorder during imprisonment will remain undetected. This adds to the already considerable amount of prevalence overlooked at prison entry.

**Table 12 Regular Mental State Re-screening in Prison**

<i>Obligatory</i>	<i>Not obligatory</i>
	<i>Austria</i>
	<i>Belgium</i>
	<i>Bulgaria</i>
	<i>Cyprus</i>
	<i>Czech Republic</i>
	<i>Denmark</i>
	<i>England &amp; Wales</i>
	<i>Finland</i>
	<i>France</i>
	<i>Germany</i>
	<i>Greece</i>
	<i>Hungary</i>
	<i>Iceland</i>
	<i>Ireland</i>
	<i>Italy</i>
	<i>Lithuania</i>
	<i>Luxembourg</i>
	<i>The Netherlands</i>
	<i>Norway</i>
	<i>Poland</i>
	<i>Portugal</i>
	<i>Slovenia</i>
	<i>Spain</i>
	<i>Sweden</i>

## Acute Psychiatric Treatment for Prison Inmates

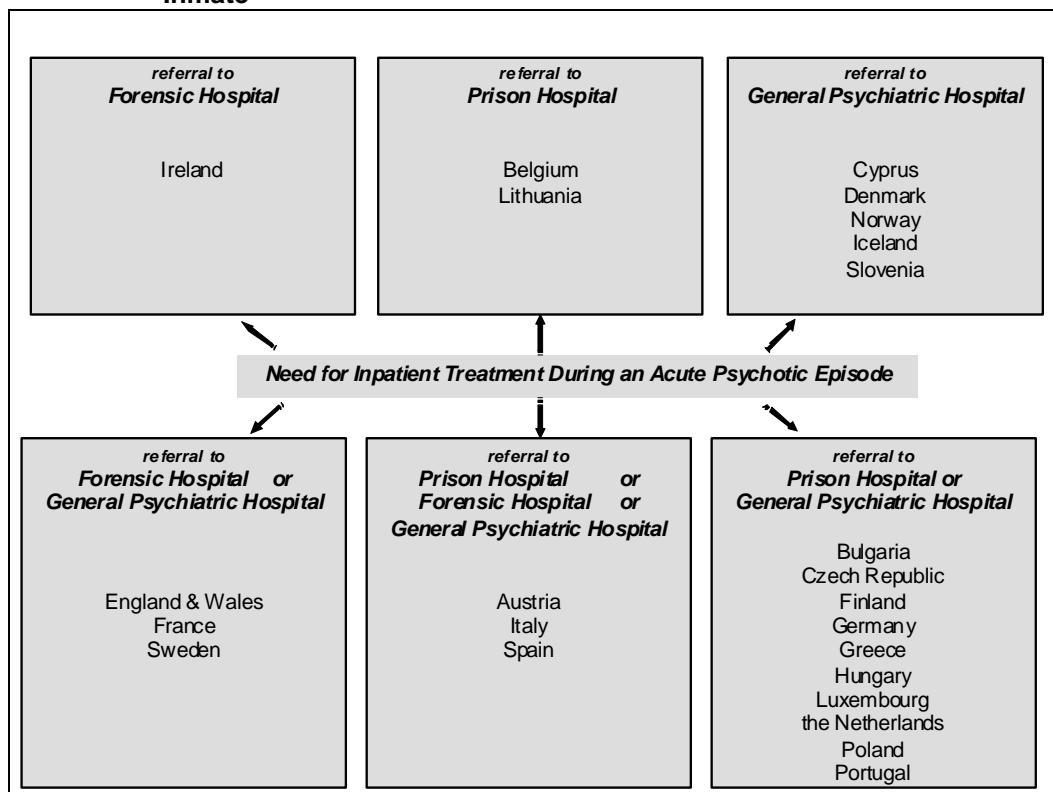
Among prison populations, research studies found that between 2% to 4% inmates suffered from schizophrenia or other psychotic disorders (Andersen 2004, Fazel 2002). Due to this two- to four-fold higher prevalence than in general population samples, the treatment of acute psychotic episodes is crucial for prison health care. The severity of psychotic disorders usually requires inpatient treatment in an adequate service with staff that is trained and experienced in caring for psychotic patients. In general, pathways to adequate care for a prisoner suffering from a psychotic episode include:

- psychiatric inpatient treatment in a prison hospital or medical prison ward,
- referral to a forensic psychiatric hospital,
- referral to a general psychiatric hospital or department.

Combinations of these alternatives are likely across Europe, depending on the availability of services or other regional circumstances. No matter which pathway to care is preferred in a national prison system, it should enable and ensure that prisoners receive equal care as patients in the National Health System. However, the extent to which this is achieved by the countries included in this evaluation is unknown.

Figure 3 outlines the respective models of care adopted by the various countries. The most frequent model of care is the combined treatment of prisoners suffering from psychotic disorders either in a medical prison ward or in a general psychiatric inpatient service (e.g. in Bulgaria, the Czech Republic, Finland, Germany, Greece, Hungary, Luxembourg, Poland, Portugal). Belgium and Lithuania are the only countries where psychotic prison inmates are treated in principle within the prison system, e.g., in medical prison wards or hospitals. Some other countries rely on services from all potentially eligible sectors (forensic hospitals, prison hospitals or general psychiatric hospitals), which is the case in Austria, Italy, the Netherlands and Spain. In Ireland, inpatient treatment for psychotic prisoners is exclusively provided by forensic hospitals. In Cyprus, Denmark, Norway, Iceland and Slovenia, a referral of prisoners suffering from psychotic symptoms to psychiatric hospitals of the National Health System is the usual option.

**Figure 3: Pathways to Inpatient Care in Case of an Acute Psychotic Episode of a Prison Inmate**



## Equivalent Care for Mentally Disordered Prisoners

Since it is impossible to deduct the actual quality of care provided for psychotic prisoners from the various pathways to inpatient facilities available (as outlined in figure 3), the experts collaborating in this study were asked to estimate the equivalence of treatment standards for mentally disordered prisoners compared to those for non-convicted patients suffering from the same disorders in their country. As indicators were chosen

- a possible delay for referrals of mentally disordered prisoners to medical prison wards,
- a possible delay for referrals of mentally disordered prisoners to general psychiatric hospitals.

The latter indicator offers the opportunity to identify a possible discrimination or neglect of mentally disordered prisoners by comparing their average waiting time to that of non-convicted mentally ill persons in need of an inpatient bed. Replies by the collaborating experts must be seen as a subjective estimation. Additionally, even within a country the situation may vary from region to region. However, the answers show that in most European countries immediate referrals to medical prison wards or prison hospitals are problematical (see table 13).

**Table 13 Waiting Times for Referrals of Mentally Disordered Inmates to Medical Prison Wards or Prison Hospitals**

<i>Immediate referral As needed</i>	<i>Delayed referrals may happen</i>	<i>Not applicable (treatment external)</i>	<i>Unknown</i>
<i>Austria</i>	<i>Belgium *</i>	<i>Cyprus</i>	<i>Spain</i>
<i>Bulgaria</i>	<i>Czech Republic</i>	<i>Denmark</i>	
<i>Finland *</i>	<i>Germany</i>	<i>England &amp; Wales</i>	
<i>Greece</i>	<i>Hungary *</i>	<i>France</i>	
<i>Luxembourg</i>	<i>Italy</i>	<i>Iceland</i>	
	<i>Lithuania *</i>	<i>Ireland</i>	
	<i>The Netherlands</i>	<i>Norway</i>	
	<i>Poland *</i>	<i>Spain</i>	
	<i>Portugal *</i>		
	<i>Slovenia</i>		
	<i>Sweden</i>		

\* *Belgium: Delays are not officially registered, priority will be given to the most urgent cases.*

*Finland: There is even less delay, compared to referrals to general psychiatric services.*

*Hungary: Delays are not frequent, and if so are mostly due to shortages of beds.*

*Lithuania: Transfer to prison hospital once a week, in acute cases an immediate transfer is organised.*

*Poland: usually only short delays (shorter than in general hospitals)*

*Portugal: Usually only a few days' delay due to shortage of beds, in this case prisoners will stay in emergency rooms.*

Due to security or other reasons, the referral of a mentally disordered prisoner to a general psychiatric hospital may be difficult. This is even more the case since the closure of psychiatric hospitals in Europe has considerably limited the availability of psychiatric beds in closed wards, which in most cases would be the natural place to admit a mentally ill prisoner. Surprisingly, most countries did not report longer waiting times for admission to general psychiatric hospitals for mentally disordered prisoners than those for non-convicted patients (see table 14). Delayed referrals in Austria, Denmark, England & Wales, Italy and The Netherlands were attributed to a shortage of security beds or security staff and an overall stigma attached to patients from prisons.

## Security Aspects in Case of Referrals

When advocating the principle of equivalent care or de-stigmatisation, the referral of mentally disordered prisoners to services outside the prison system may be favoured. However, this raises a number of security issues. From the perspective of security, treatment in medical prison wards would



be a priority, particularly when taking into account that countries preferring the concept of NHS-treatment of prisoners report probable longer waiting times for referrals from prison (e.g., Denmark or England & Wales, see table 14). Table 15 gives an overview of how referrals of prisoners to services outside the prison systems are usually safeguarded.

**Table 14 Equivalent Referrals of Mentally Disordered Inmates to General Psychiatric Hospitals**

<b>Waiting time similar to that for non-incarcerated patients</b>	<b>Waiting time longer than for non-incarcerated patients</b>	<b>Not applicable (no referrals)</b>	<b>Unknown</b>
Bulgaria	Austria	Belgium	Czech Republic
Cyprus	Denmark*	Ireland	
Finland	England & Wales*	Lithuania	
France	Italy	Spain	
Germany	The Netherlands*		
Greece			
Hungary			
Iceland *			
Poland			
Portugal			
Luxembourg			
Norway			
Slovenia			
Sweden			

\* Denmark: Due to shortage of beds (at closed wards), particularly remand prisoners may wait longer.

Iceland: Usually there are no differences, but in fact only few referrals are made.

The Netherlands: mainly for security reasons

England & Wales: Due to a shortage of psychiatric beds, particularly of secure beds, waits can be for weeks or months.

**Table 15 Security Measures for Referring Mentally Disordered Prisoners to General Psychiatric Services**

<b>Security provided by prison guards or police</b>	<b>No specific security measures by prison guards or police</b>	<b>No referrals</b>
Austria	Bulgaria	Belgium
Cyprus	Denmark	Ireland
Czech Republic	England & Wales*	Lithuania
Finland	France	
Germany	The Netherlands*	
Greece	Norway*	
Hungary		
Iceland		
Italy		
Luxembourg		
Poland		
Portugal		
Slovenia		
Spain		
Sweden		

\* The Netherlands: Psychiatric hospitals are responsible for providing adequate security measures, but in somatic medical hospitals prison services or police provide security measures.

Norway: Hospitals are responsible for providing adequate security measures.

England & Wales: Most referrals are to forensic units, where safety is the concept.

### Specific Treatment Programmes for Mentally Disordered Prisoners

The high prevalence of drug or alcohol misuse, suicidal behaviour, and sexual offenses in prison requires adequate treatment for these problems or disorders. The actual provision of programmes that address these problems may reflect the awareness that is given to these issues. As shown in table 16, European prisons particularly lack treatment programmes for sex offender and programmes for suicide prevention. When available, the capacities of such programmes are widely unknown. Even when specific programmes are provided, they most probably do not cover all prisoners in need of such treatments or therapies. Additionally, the underlying concepts differ, since in some countries, attendance is voluntary, whereas in others there may be an open or hidden obligation for prisoners to participate (e.g., England & Wales, Germany).

**Table 16 Provision of Treatment Programmes for Specific Mental Health Problems in Prison**

<b>Country</b>	<b>Sex offender treatment programmes</b>	<b>Alcohol/drug addiction treatment programmes</b>	<b>Suicide prevention programmes</b>
<i>Austria</i>	<i>available</i>	<i>available</i>	<i>available</i>
<i>Belgium</i>	<i>available</i>	<i>available</i>	<i>available</i>
<i>Bulgaria*</i>	<i>available</i>	<i>available</i>	<i>available</i>
<i>Cyprus</i>	<i>none</i>	<i>none</i>	<i>none</i>
<i>Czech Republic*</i>	<i>available</i>	<i>available</i>	<i>none</i>
<i>Denmark*</i>	<i>available</i>	<i>available</i>	<i>available</i>
<i>England &amp; Wales*</i>	<i>available</i>	<i>available</i>	<i>none</i>
<i>Finland*</i>	<i>available</i>	<i>available</i>	<i>none</i>
<i>France</i>	<i>none</i>	<i>none</i>	<i>none</i>
<i>Germany*</i>	<i>available</i>	<i>none</i>	<i>none</i>
<i>Greece*</i>	<i>none</i>	<i>available</i>	<i>none</i>
<i>Hungary*</i>	<i>none</i>	<i>available</i>	<i>none</i>
<i>Iceland*</i>	<i>none</i>	<i>none</i>	<i>none</i>
<i>Ireland</i>	<i>available</i>	<i>available</i>	<i>unknown</i>
<i>Italy</i>	<i>none</i>	<i>available</i>	<i>none</i>
<i>Lithuania*</i>	<i>available</i>	<i>available</i>	<i>available</i>
<i>Luxembourg*</i>	<i>available</i>	<i>available</i>	<i>available</i>
<i>The Netherlands*</i>	<i>available</i>	<i>available</i>	<i>available</i>
<i>Norway*</i>	<i>available</i>	<i>available</i>	<i>available</i>
<i>Poland*</i>	<i>available</i>	<i>available</i>	<i>none</i>
<i>Portugal*</i>	<i>none</i>	<i>available</i>	<i>none</i>
<i>Slovenia*</i>	<i>available</i>	<i>available</i>	<i>available</i>
<i>Spain</i>	<i>available</i>	<i>available</i>	<i>available</i>
<i>Sweden*</i>	<i>available</i>	<i>available</i>	<i>none</i>

\* **Austria:** Specific treatment programmes are not stipulated by the law. Intensive treatment programmes are offered only for responsible mentally disordered offenders (§ 21/2 StGB), primarily for those treated in one special institution (Justizanstalt Wien-Mittersteig). Treatment is also possible to a certain degree (usually limited by the availability of qualified staff) in several prisons for sex offenders and extremely violent offenders. Additionally, some prisons have so-called "drug-free zones". **Bulgaria:** sex-offender programmes: 2.2 places per 1,000 prison places, alcohol or drug addiction programmes: 7.3 places per 1,000 prison places, suicide prevention programmes: 2.9 places per 1,000 prison places. **Czech Republic:** sex-offender programmes: 4.3 places per 1,000 prison places (80 in total), alcohol or drug addiction programmes: 10.5 places per 1,000 prison places (197 in total). **England & Wales:** Specific programmes are offered to all sex-offenders, severe offenders are unlikely to receive probation without having engaged in a treatment programme **Finland:** sex-offender programmes: 24 participants in 2005, alcohol or drug addiction programmes: 2303 participants in 2005, prisoners have the right to attend the programmes but may not be forced to. **Germany:** Participation is mandatory for sexual offenders sentenced to a term longer than 2 years. **Greece:** Participation in an alcohol or drug addiction programme is voluntary. **Hungary:** alcohol or drug addiction programmes: 18,5 places per 1,000 prison places (208 in total) participation is voluntary **Iceland:** Treatment programs are in preparation. **Lithuania:** Although alcohol or drug addiction programmes are legally stipulated, they are not implemented, or used episodically. A prevention programme against the sexual abuse of children started in 2006, a suicide prevention programme also. **Luxembourg:** Patients meeting the criteria or presenting symptoms will be selected and offered specific treatment or care. **The Netherlands:** Inclusion criteria are motivation, long sentence, and the prisoner's readiness for group treatment. **Norway:** Programmes are not mandatory but are available in most large prisons.. **Poland:** alcohol or drug addiction programmes: 15 places per 1,000 prison places (1,070 in total). **Portugal:** alcohol or drug addiction programmes: 17.6 places per 1,000 prison places (217 in total). **Slovenia:** Different availability depending on prison service. **Sweden:** sex-offender programmes: 42 places per 1,000 prison places (283 in total), alcohol or drug addiction programmes: 192 places per 1,000 prison places (1,290 in total).

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## Involuntary Treatment Regimes in Prison

The issue of treating prison inmates against their will in case of an acute psychiatric crisis or for other medical reasons is a delicate one. It may be argued that a prisoner's consent to any medical intervention in a custodial setting per se is impossible or invalid, as prisoners are generally deprived of their liberty. This basic philosophical dilemma will probably never be solved, but human rights principles lend the right to refuse treatment also to prisoners even if this decision would cause them serious harm.

In general psychiatry or any other non-custodial setting, it is hotly debated in which cases it may be justified to treat a mentally disordered patient involuntarily and how to judicially regulate this matter in an appropriate way. Across Europe, a variety of legal frameworks are in effect to balance the conflicting principles with regard to this problem (Salize & Dressing 2004, Dressing & Salize 2004). However, it is unclear to which extent these regulations may apply for persons who become mentally disordered while being incarcerated, or whose mental disorder worsens during their prison term.

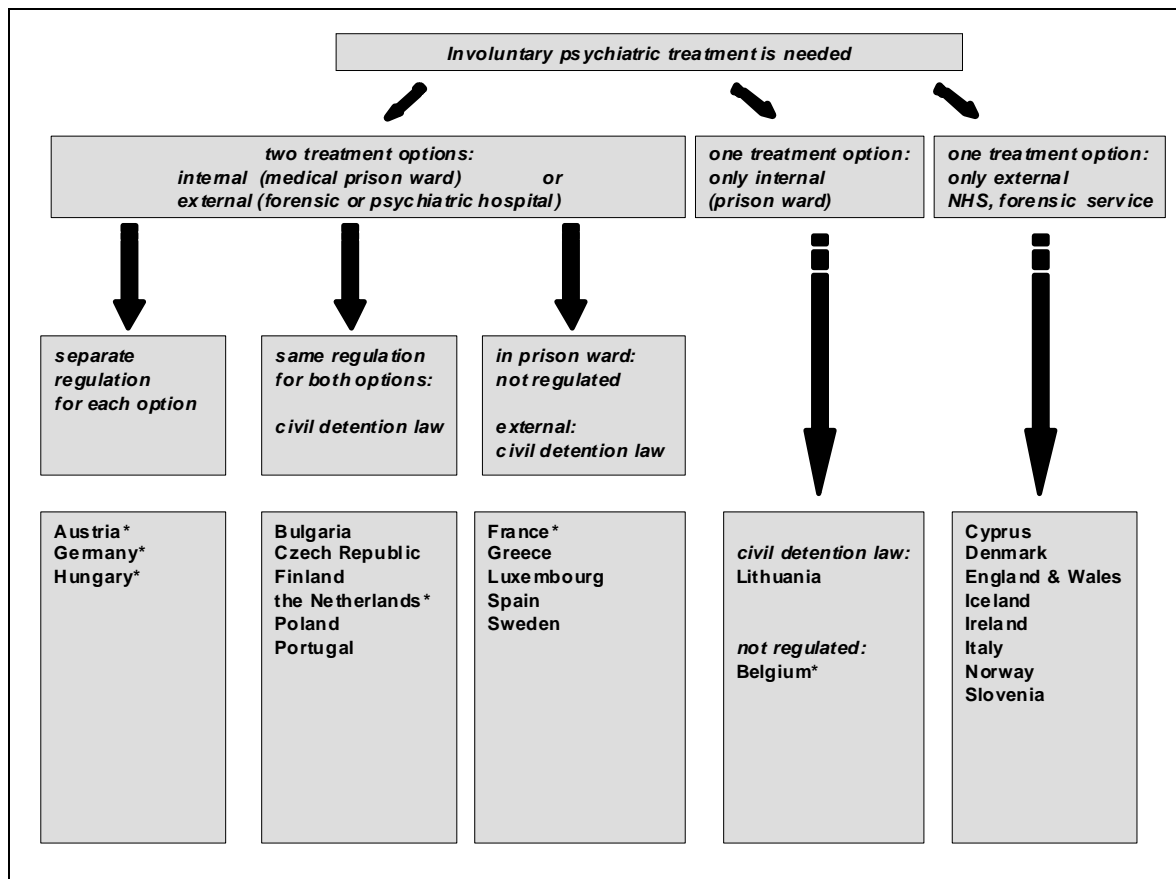
Regulating the involuntary psychiatric treatment of prison inmates is more complex than it is in general psychiatry, as most countries prefer a mixed model of prison mental health care in which medical prison services are combined with NHS-based or general psychiatric services (see table 5). Depending on the actual treatment setting, judicial competences for coerced psychiatric treatment of a prisoner may change during the course or even conflict with each other.

The majority of countries included in this study seem to share a common approach of applying civil detention laws to mentally disordered prisoners if they are compulsory admitted to or treated involuntarily in general psychiatric services (as a part of their prison term). As shown in figure 4, there is a group of countries (including Bulgaria, the Czech Republic, Finland, the Netherlands, Poland and Portugal) where civil detention laws apply for any coerced psychiatric treatment of a prisoner, no matter whether the patient is treated in a prison ward or within the National Health System. Other countries that, according to their general prison health care approach (see table 4), in principle have the option to treat a mentally disordered prisoner either inside the prison system or in general psychiatric services regulate involuntary treatment outside the prison walls (where civil detention laws apply), while involuntary psychiatric treatment in medical prison wards, or even in prison cells, remains unregulated. In these countries (including France, Greece, Luxembourg, Spain and Sweden), under civil detention regimes immediate referral to forensic or general psychiatric services is the usual procedure in case the lacking consent of a prisoner who is in urgent need of treatment would mandate compulsory measures. However, even in emergency cases it is at least theoretically possible that referrals to services outside the prison walls may be delayed, in which case compulsory measures would not be legally backed up.

Such a juridical gap is most evident in Belgium, which relies completely on a prison-based system of mental health care for inmates. The Belgian prison or mental health laws are completely devoid of passages regulating the involuntary psychiatric care of prison inmates. Lithuania, which has adopted a similar prison-based mental health care approach, treats mentally disordered inmates internally under civil detention rules.

Austria, Germany and Hungary, which also apply civil detention regimes to prisoners referred involuntarily to forensic or general psychiatric services, have passed specific laws regulating compulsory treatment in prison. In the case of Germany, these laws may create even higher thresholds for compulsory treatment inside prison walls. In Hungary, where civil detention laws and court controlling mechanisms for involuntary treatment measures are in principle in effect for prison inmates, too, routine practise suffers from a somewhat contradictory prison law that withdraws from prisoners any right to refuse treatment.

Figure 4 Legal Regulation of Involuntary Psychiatric Treatment of Prison Inmates



\* Austria: Permission of the Ministry of Justice is required for compulsory treatment inside prison.

Belgium: No rules for compulsory treatment in prison settings are specified, except that „when provided it must be done in a psychiatric ward“

France: No consent is required in emergency cases.

Germany: Specific prison laws apply, however; they are rather similar to civil detention laws.

Hungary: According to prison law, a prisoner has no right to refuse medical treatment.

The Netherlands: Involuntary Treatment is provided almost exclusively by the Forensic Observation and Treatment Unit.

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## Psychopharmacological Treatment for Prison Inmates

Focusing on mental health care for prisoners necessarily includes the description of current psychopharmacological practises in prison as an essential part of psychiatric treatment. For this purpose, the patterns of psychotropic drug prescription in the national prison systems were assessed. Unfortunately, only a small minority of countries operate national registers for recording the prescription or intake of psychopharmacological or other drugs in the national prison services, which would provide basic data for evaluating pharmacological drug treatment practise over time (see table 17). It is unknown, to which degree regional or local registers are implemented throughout Europe, although it is most probable that the amount or the cost of medication prescribed to prison inmates is recorded at least on a service level.

It would be a simple organisational problem to standardise and collect the available data on a national level and bridge this serious and crucial gap in the national reporting systems. As long as this is not the case, any international evaluation will be forced to rely on selected research data, estimates, assumptions, or expert opinions to assess the dimension of the issue in question, as was done in this study.

**Table 17 Systematic Recording of Psychopharmacological Drug Prescription in Prison (National Register)**

<i>Nationwide recording routines implemented</i>	<i>Nationwide recording routines not implemented</i>
<i>Cyprus</i>	<i>Austria</i>
<i>Luxembourg</i>	<i>Bulgaria</i>
<i>Sweden</i>	<i>Czech Republic</i>
<i>Belgium*</i>	<i>Denmark</i>
	<i>England &amp; Wales</i>
	<i>Finland</i>
	<i>France</i>
	<i>Germany</i>
	<i>Greece</i>
	<i>Iceland</i>
	<i>Ireland</i>
	<i>Italy</i>
	<i>Lithuania</i>
	<i>The Netherlands</i>
	<i>Norway</i>
	<i>Poland*</i>
	<i>Portugal</i>
	<i>Slovenia</i>
	<i>Spain</i>

\*Belgium: A nationwide electronic database for pharmacological drug use in prison is implemented, completeness is unknown  
Poland: Only expenditures for drug prescription in prison are recorded.

## Prescription of Psychopharmacological Drugs in Prison

Based on estimates by the collaborating experts, large proportions of inmates of the European prison systems are to be considered to regularly take some kind of psychopharmacological drug, although neither the exact extent of prescription nor of consumption in most countries is known.

It is an issue of more detailed research, to what extent intake patterns would be justified by the actual psychiatric prevalence in prisons or whether prescription practises follow international guidelines. Considering the poor mental state assessment routines in the assessed prison systems (see the respective chapter), a high amount of psychopharmacological drug prescription paradoxically could mask unmet drug treatment needs of mentally disordered prisoners, if psychotropic drugs are being extensively dispatched to prisoners merely to ensure their mentally well-being or for security purposes (e.g., psychopharmacological restraint).

**Table 18 Proportion of psychopharmacological drug-users among prisoners (estimated)**

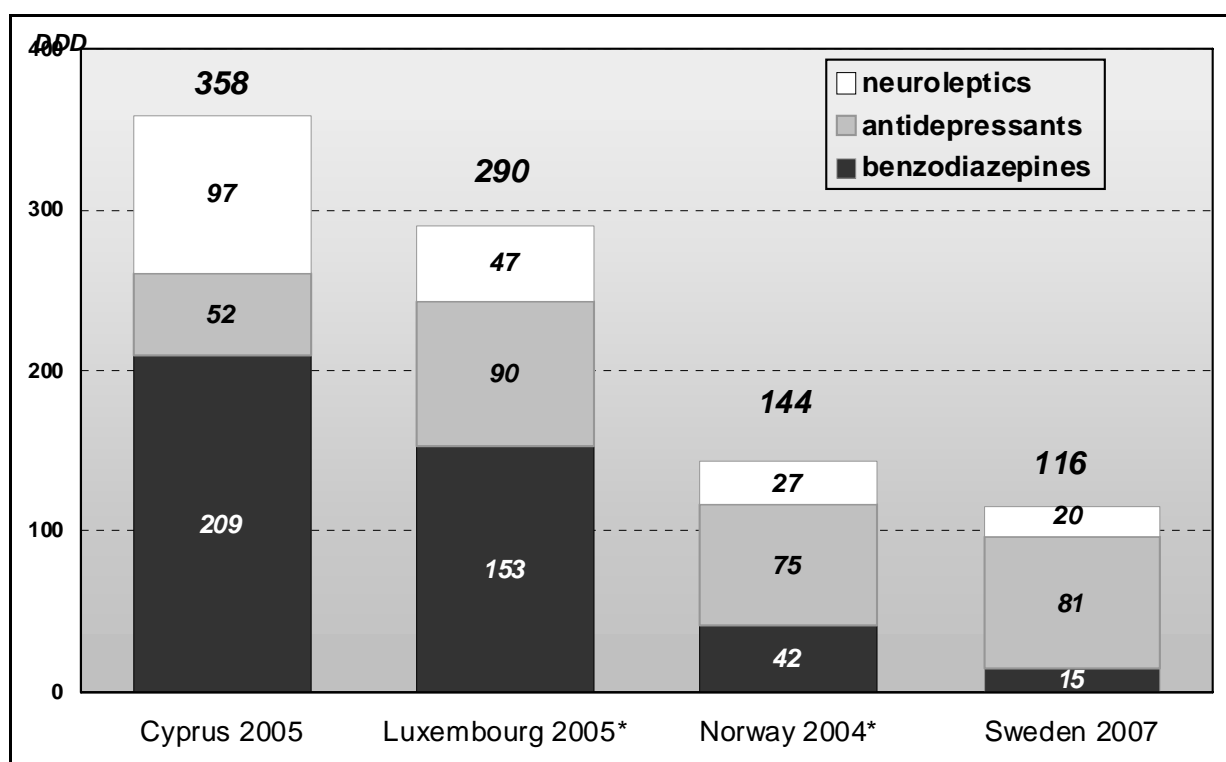
<i>Less than 30 %</i>	<i>Between 30 and 50 %</i>	<i>More than 50 %</i>	<i>Unknown</i>
<i>Cyprus</i>	<i>England &amp; Wales</i>	<i>Finland</i>	<i>Austria</i>
<i>France</i>	<i>Italy</i>		<i>Belgium</i>
<i>Greece</i>	<i>Lithuania</i>		<i>Bulgaria</i>
<i>Hungary</i>	<i>Luxembourg</i>		<i>Czech Republic</i>
<i>Ireland</i>	<i>Norway</i>		<i>Denmark</i>
<i>Sweden</i>	<i>Slovenia</i>		<i>Germany</i>
			<i>Iceland</i>
			<i>The Netherlands</i>
			<i>Poland</i>
			<i>Portugal</i>
			<i>Spain</i>

Unfortunately, the actual extent of psychopharmacologic drug prescription for prisoners could be quantified for only four countries included in this study. The data were transformed into defined daily doses (DDDs), the internationally agreed upon standard measure of pharmacological drug intake (see figure 5).

Understandably, more detailed medication data can be more easily provided for small countries with only a few penal facilities, such as Cyprus (one prison) or Luxembourg (two prisons). However, as shown in figure 5, Sweden (86 prisons) demonstrates that it is possible to collect nationwide medication data for much larger countries, too. Norway (46 prisons) was able to provide nationwide DDDs prescribed in prison without running an official register. The meagre data base does not allow any valid international comparison. So it remains unknown whether or not the variation of DDD-data as shown in figure 5 indicates a “natural” prison range.

However, it is possible to compare the annual per capita consumption of psychopharmacological drugs in the prisons of Luxembourg, Sweden and Norway to the per capita consumption of psychopharmacological drugs in the total population of these countries, as provided by OECD Health Data Base (2006). The results are shown in table 19. Although OECD categories for drug prescription (nervous system, ATC-Code N) do not completely match those used in this study, the comparison suggests an at least two- to fourfold increase in psychopharmacological drug consumption by prisoners compared to that by general population samples. Most likely, these ratios underestimate to a considerable degree, as OECD population samples cover all age groups (including ca. 27 % below five years of age, CIA World Fact Book 2006), whereas the prison samples as defined in this study refer only to adults.

**Figure 5** Amount of Prescribed Psychopharmacological Drugs in Prison, Selected European Countries (DDDs per Inmate and Year)



\* Luxembourg: Apart from the other countries using DDDs, figures from Luxembourg relate to the number of pills of the respective drug (according to C. Brauner, Prison Pharmacie Centre Pénitentiaire de Luxembourg)

Norway: DDDs for all psychopharmacologic drugs are higher (see table below)

**Table 19** Psychopharmacological Drug Prescription in Prison and in Total Population of Selected European Countries (per Capita and Year)

Country	DDDs per capita / year total population	DDDs per capita / year prison population
Belgium	34	
Czech Republic	44	
Denmark	88	
Finland	79	
Germany	31	
Greece	64	
Iceland	104	
Luxembourg	69	290
Norway*	71	186
Portugal	66	
Sweden	87	216

Data origin for total population estimates (referring to 2004): OECD Health Data 2006

\* Norway: Prison population drug use according to: Kjelsberg E & Hartvig P (2005)



Some additional countries were able to rank the subtypes of psychopharmacological drugs most frequently prescribed in prison, which in most cases are benzodiazepines (see table 20). Considering the potential of benzodiazepines to calm down and reduce anxiety or aggression, these rankings may support the need for further analyses of appropriate psychopharmacological drug prescription policies in European prisons. The potential “misuse” of benzodiazepine prescription for other than strictly therapeutic or medical purposes should be analysed.

**Table 20 Ranking of the most frequently Prescribed Psychopharmacological Drugs in Prison (Estimation by Collaborating Experts)**

<b><i>Benzodiazepines most frequently prescribed</i></b>	<b><i>Antidepressants most frequently prescribed</i></b>	<b><i>Neuroleptics most frequently prescribed</i></b>	<b><i>unknown</i></b>
Cyprus*	Norway*	Italy	Austria
Germany	Sweden*		Belgium
Greece			Bulgaria
Luxembourg*			Czech Republic
Slovenia			Denmark
			England & Wales
			France
			Finland
			Hungary
			Iceland
			Ireland
			Lithuania
			The Netherlands
			Poland
			Portugal
			Spain

\* Sweden: Prescription routines may vary regionally for various reasons.

Norway, Cyprus, Luxembourg. Ranking was done on the basis of exact data

**Table 21 Prescription of Second-Generation Neuroleptics in Prison Settings (Estimation by Collaborating Experts)**

<b><i>In proportions equal or similar to those in general psychiatry</i></b>	<b><i>In lesser proportions than in general psychiatry</i></b>	<b><i>Unknown</i></b>
Cyprus	Greece	Austria
Denmark	Hungary*	Belgium
England & Wales	Lithuania*	Czech Republic
Finland		Germany
France		Iceland
Ireland		The Netherlands
Italy		
Luxembourg		
Norway		
Poland		
Portugal		
Slovenia		
Spain		
Sweden		

\* Hungary: Prescription of atypical neuroleptics in 40-50 % of the cases; in general psychiatry there is a better marketing policy and a large number of pharmaceutical studies (which are prohibited in prison) so that the number of prescriptions is 70-80 %.

Lithuania: Limited prescription of atypical neuroleptics due to budget reasons

A key indicator for evaluating whether or not mental health care standards in prisons are equivalent to those in general psychiatry may be policies regarding so-called second-generation, or atypical neuroleptics for prison inmates suffering from psychotic or related disorders. Since they are considerably more expensive than first-generation neuroleptics, the prescription of atypical neuroleptics might be more strongly restricted in prison settings than it is the case in general psychiatry. However, no major differences were identified when the collaborating experts compared the prescription routines in prison settings to those in the national health care system of their country (see table 21).

In prison settings, the intake of psychopharmacological drugs is associated with particular risks of non-compliance, causing relapse or a potential misuse (hoarding psychoactive drugs for dealing or even more harmful other purposes, e.g., suicidal behaviour). Supervision of psychopharmacological drug intake is likely to reduce these risks. Table 22 suggests a broad awareness of the potential danger. All included countries have implemented supervision routines for drug intake either in all inmates for whom any kind of medication has been prescribed or at least for specific cases where risks are increased.

**Table 22 Supervision of Therapeutic Drug Intake in Prison Settings (Estimation by Collaborating Experts)**

<i>In all inmates for whom any kind of medication has been prescribed</i>	<i>In specific cases (e.g., mentally disordered or suicidal inmates)</i>
<i>Cyprus</i>	<i>Austria*</i>
<i>Denmark</i>	<i>Belgium</i>
<i>Iceland</i>	<i>Bulgaria</i>
<i>Lithuania</i>	<i>Czech Republic</i>
<i>Poland</i>	<i>England &amp; Wales</i>
<i>Sweden</i>	<i>Finland</i>
	<i>France</i>
	<i>Germany</i>
	<i>Greece</i>
	<i>Hungary</i>
	<i>Ireland</i>
	<i>Italy</i>
	<i>Luxembourg</i>
	<i>The Netherlands</i>
	<i>Norway</i>
	<i>Portugal</i>
	<i>Slovenia</i>
	<i>Spain</i>

\* Austria: Supervision in cases of opiate substitution (methadone programmes) and in other selected cases (for various reasons)

## References

- OECD Health Data 2006 <http://www.oecd.org/health/healthdata>.  
 CIA World Fact Book 2006 <https://www.cia.gov/library/publications/the-world-factbook/>.  
 Braunert C. (2007) Prison Pharmacie Centre Pénitentiaire de Luxembourg, oral communication  
 Kjelsberg E & Hartvig P. (2005) Too much or too little? Prescription drug use in a nationwide prison sample. *International Journal of Prisoner Health*, 1, pp, 75-87.

## Prison Release, Psychiatric After-care

Since psychiatric after-care is essential for each mentally ill person who is discharged from an institutional setting, one would expect the organisation of disorder-specific after-care measures to be an integral aspect of planning the release of prison inmates who have been diagnosed with a mental disorder during their term. Not only this would safeguard the principle of equivalent health care standards for prisoners, even more it would enhance public safety, since a prisoner with an untreated mental disorder bears a significantly increased risk of re-offending after discharge.

**Table 23** Mental State Assessment Prior to Release from Prison

<b>Country</b>	<b>Mental state assessment procedures prior to release</b>
<i>Austria</i>	<i>not obligatory, but routinely done for those diagnosed as mentally ill</i>
<i>Belgium</i>	<i>obligatory upon conditional release of sex offenders and routinely done upon conditional release for persons detained for five years or longer</i>
<i>Bulgaria</i>	<i>obligatory for those diagnosed as mentally ill</i>
<i>Cyprus</i>	<i>no routine assessment</i>
<i>Czech Republic</i>	<i>no routine assessment</i>
<i>Denmark</i>	<i>obligatory upon conditional release of inmates sentenced to security detention</i>
<i>England &amp; Wales</i>	<i>obligatory medical examination (includes mental state screening)</i>
<i>Finland</i>	<i>obligatory assessment according to a stipulated release plan*</i>
<i>France</i>	<i>no routine assessment</i>
<i>Germany</i>	<i>no routine assessment</i>
<i>Greece</i>	<i>no routine assessment</i>
<i>Hungary</i>	<i>obligatory for those diagnosed as mentally ill</i>
<i>Iceland</i>	<i>no routine assessment</i>
<i>Ireland</i>	<i>no routine assessment</i>
<i>Italy</i>	<i>no routine assessment</i>
<i>Lithuania</i>	<i>obligatory in case of conditional release</i>
<i>Luxembourg</i>	<i>not obligatory but routinely done for those diagnosed as mentally ill</i>
<i>the Netherlands</i>	<i>no routine assessment</i>
<i>Norway</i>	<i>not obligatory, but done routinely for prisoners with severe case files</i>
<i>Poland</i>	<i>obligatory for those diagnosed as mentally ill</i>
<i>Portugal</i>	<i>no routine assessment</i>
<i>Slovenia</i>	<i>no routine assessment</i>
<i>Spain</i>	<i>unknown</i>
<i>Sweden</i>	<i>no routine assessment</i>

\* Finland: Only for persons sentenced for two or more years, according to the 2006 law on imprisonment

Due to limited research done in this field, it is unknown whether mentally ill persons discharged from detention or correctional facilities would benefit from specific after-care services that address the specific needs of this clientele, or whether integrating them into routine outpatient mental care would be similarly effective. The only study to date that has compared the outcome of specialised forensic

outpatient services with that of routine psychiatric after-care as provided by community services found no differences in the terms of re-offenders or those readmitted to institutional care (Coid et al. 2007). Many more studies on this issue are required in future.

To support and encourage further research, the following tables provide an overview of the current organisational standards of psychiatric after-care and release-planning routines in European prison systems.

As table 23 shows, there is a large cluster of countries that have not implemented procedures for the mental state screening or assessment of prisoners prior to their release from prison. Although in some countries appropriate cases may be assessed, these practises are not likely to provide solid psychopathological information for any adequate release planning, including referrals to psychiatric after-care services. So it is not too surprising that specialised aftercare services or programmes for released prisoners suffering from mental disorders are available in only four countries included in this study (see table 24). Specific re-entry programs for released prisoners that address mental health problems are available in Austria, the Czech Republic, and Ireland, and in some regions of Sweden. Such programmes are not available in any of the other countries.

This absence is hardly a consequence of scarce research evidence on the effectiveness of such programs or services, but must be taken as an indicator of the rather limited awareness of this sensitive issue, one which obviously is shared by many health or prison administrations or societies in general throughout Europe.

**Table 24 Provision of After-care Services or Programmes Specifically Implemented for Mentally Disordered Persons Released from Prison**

<i>No services or programmes provided</i>	<i>Specific services or programmes available</i>
<i>Belgium</i>	<i>Austria (6 residences, 8 outpatient clinics)*</i>
<i>Bulgaria</i>	<i>Czech Republic (NGO directed drug addicts programs)</i>
<i>Cyprus</i>	<i>Ireland (community forensic mental health services)</i>
<i>Denmark</i>	<i>Sweden (outpatient units of probation services)</i>
<i>England &amp; Wales</i>	
<i>Finland</i>	
<i>France</i>	
<i>Germany</i>	
<i>Greece</i>	
<i>Hungary</i>	
<i>Iceland</i>	
<i>Italy</i>	
<i>Lithuania</i>	
<i>Luxembourg</i>	
<i>The Netherlands</i>	
<i>Norway</i>	
<i>Poland</i>	
<i>Portugal</i>	
<i>Slovenia</i>	
<i>Spain</i>	

\* Primarily for mentally ill offenders (NGRI) who are discharged conditionally

More seriously, referrals to community mental health care services are infrequent (see table 25), a practise that cannot be explained by scarce capacities in community care, even if the scarcity of such facilities may justify the reluctance to admit prisoners to specialised after-care services. And where referrals have been implemented or stipulated, the frequency is not recorded. Thus, even in

countries where after-care programmes are available, there is currently no way to quantify the actual deficiencies.

**Table 25 Referral Mechanisms of Mentally Disordered Prisoners to Mental Health Care Services upon Release**

<b>Country</b>	<b>Referral procedures upon release</b>
<i>Austria*</i>	<i>no automatic referral</i>
<i>Belgium</i>	<i>no automatic referral</i>
<i>Bulgaria*</i>	<i>automatic referral to probation officer</i>
<i>Cyprus</i>	<i>no automatic referral</i>
<i>Czech Republic</i>	<i>no automatic referral</i>
<i>Denmark</i>	<i>no automatic referral</i>
<i>England &amp; Wales</i>	<i>automatic referral to psychiatric outpatient service and GP</i>
<i>Finland</i>	<i>no automatic referral</i>
<i>France</i>	<i>no automatic referral</i>
<i>Germany</i>	<i>no automatic referral</i>
<i>Greece</i>	<i>no automatic referral</i>
<i>Hungary</i>	<i>no automatic referral</i>
<i>Iceland</i>	<i>no automatic referral</i>
<i>Ireland</i>	<i>automatic referral to psychiatric outpatient service</i>
<i>Italy*</i>	<i>automatic referral stipulated by law</i>
<i>Lithuania</i>	<i>no automatic referral</i>
<i>Luxembourg</i>	<i>no automatic referral</i>
<i>The Netherlands</i>	<i>no automatic referral</i>
<i>Norway*</i>	<i>no automatic referral</i>
<i>Poland*</i>	<i>automatic referral to psychiatric outpatient service</i>
<i>Portugal</i>	<i>automatic referral to psychiatric outpatient service</i>
<i>Slovenia*</i>	<i>automatic referral to psychiatric outpatient service</i>
<i>Spain*</i>	<i>no automatic referral</i>
<i>Sweden</i>	<i>no automatic referral</i>

\* *Austria: Automatic referral only in case of conditional release*

*Bulgaria: Does not necessarily include referral to a psychiatric service*

*Italy: Rarely applied in routine practise*

*Norway: Referral may be made in cases of serious mental disorder.*

*Poland: Depending on a prisoner's mental condition at release, different scenarios are possible: If the sentence was served and the former prisoner poses no threat to himself or others because of his mental illness, he is free not to show up in psychiatric outpatient service despite his referral; if he is a threat to self or others, he will be transferred to a mental hospital and treated against his own will if the criteria stipulated by the Mental Health Act are met. Note that in Poland, civil detention is understood to be a preventive measure and is applied to offenders who are found to be of not sound mind tempore criminis and therefore need to be isolated from the community and treated.*

*Slovenia: Routinely done only in selected prisons*

*Spain: Referral may be done in cases of serious mental disorder.*

Approximately half of the included countries require the written consent of the prisoner in order to reporting the mental health state or other psychopathologic data to health services in case of a referral (see table 26). Confidentiality or data protection should never represent an obstacle to the provision of adequate health care, although it remains a sensitive and open question how to balance the right of released prisoners to confidentiality against their right to psychiatric after-care and public safety concerns.

Table 26 Consent for Transferring Mental State Information

Country	Required for reporting to health services	Required for reporting to probation officer
Austria	no	no
Belgium	yes	no
Bulgaria	unknown	no
Cyprus	no	no
Czech Republic	no	no
Denmark	yes	yes
England & Wales	no	yes
Finland	yes	yes
France	no	unknown
Germany	yes	yes
Greece	unknown	unknown
Hungary	yes	yes
Iceland	yes	yes
Ireland*	yes	yes
Italy	no	unknown
Lithuania	no	no
Luxembourg	no	unknown
The Netherlands	yes	unknown
Norway*	yes	yes
Poland	no	yes
Portugal	no	no
Slovenia	unknown	unknown
Spain	unknown	unknown
Sweden	yes	unknown

\* Ireland and Norway: In case of on-going care, consent is presumed for the first doctor-doctor transfer of information; thereafter, all further communication requires prior written consent.

## References

Coid JW, Hickey N, Yang M (2007) Comparison of outcomes following after-care from forensic and general adult psychiatric services. *British Journal of Psychiatry*, 190, pp. 509-514.

## Prison Populations / Psychiatric Prevalence in Prisons

### Prison Occupancy

The number of persons detained in penal institutions usually differs from the official number of prison places that in many countries is used as a standard measure for various administrative purposes such as allocation of funds etc.

The steady interplay of prison entries and releases, seasonal imbalances or other causes contribute to “natural” fluctuations in the actual prison occupancy. In some cases, these fluctuations considerably exceed official prison capacities. As a consequence, instead of the number of prison places, the prison population is a much more preferable estimate for many purposes, including the evaluation of prison health care.

However, even official prison population data suffer from the lack of international standardisation and may include or exclude to an unknown degree specific subgroups such as remand prisoners, persons in custody prior to deportation, or others. The following data may not completely be free of such biases, although the effort was made to harmonise definitions and categories when the data were collected. As shown in the cross-sectional overview in table 27, the actual prison occupancy across the included countries varies remarkably.

**Table 27: Percentage of occupied prison places (census data, most recent year available)**

<b>Country, year</b>	<b>Prison occupancy</b>
<i>Austria, 2005</i>	102.8 %
<i>Belgium, 2005</i>	112.3 %
<i>Bulgaria, 2005</i>	76.4 %
<i>Cyprus, 2005</i>	178 %
<i>Czech Republic, 2005</i>	101 %
<i>Denmark, 2005*</i>	102.8 %
<i>England &amp; Wales, 2005</i>	115 %
<i>Finland, 2005</i>	114.9 %
<i>France, 2005</i>	121.8 %
<i>Germany, 2004</i>	98.7 %
<i>Greece, 2002</i>	198 %
<i>Hungary, 2005</i>	139.6 %
<i>Iceland, 2005</i>	86.1 %
<i>Ireland, 2004</i>	95.8 %
<i>Italy, 2005</i>	139.2 %
<i>Lithuania, 2005</i>	85.9 %
<i>Luxembourg, 2005</i>	94.7 %
<i>The Netherlands, 2005</i>	99.1 %
<i>Norway, 2005</i>	96 %
<i>Poland, 2005</i>	115.9 %
<i>Portugal, 2005</i>	106.1 %
<i>Slovenia, 2005</i>	103.2 %
<i>Spain, 2005</i>	132.5 %
<i>Sweden, 2005</i>	98 %

*Algorithm for occupied prison places at given census day: (number of prison inmates\* / official prison places) \*100*

*Census day: either December 31 or March 31 of respective year. Data origin available*

*\* Denmark. Annual averages of prisoners were taken rather than census day data.*

According to these data, among all countries included, the highest degree of prison overcrowding exists in Greece, where each prison cell is occupied by twice as many inmates as it was designed for. Cyprus follows closely. Prison populations in Hungary and Italy exceed the official capacity by approx. 40%. Generally, any overcrowding of these proportions is likely to be associated with unfavourable mental health conditions for the inmates, although any such correlation needs to be analysed further.

Assuming that the given frequencies were not biased by covering only parts of the actual prison population, a number of countries have vacant prison capacities available, which is indicated by a rate of occupancy below 100% (see table 23). Among these countries is Lithuania, whose prison capacities rank high above those of all other countries included in this study (see tables 1 and 2).

### **Time series**

Being a most basic indicator, the number of persons imprisoned during the last 15 years was available for the majority of countries included in this study. To compare changes over time and across the included countries, population-based rates were calculated on the basis of these time series. Results are given in figures 6a to 6d, which were grouped according to the general population size of the included countries. However, heterogeneous rates across similarly populated countries suggest no global association of the size of the general population and the number of imprisoned persons. Within countries, the prison population rate may take a more complex course. Against an overall tendency of slightly rising rates during the last fifteen years in a majority of countries, some periods of decreasing rates can be detected (e.g., in Lithuania, the Czech Republic, Hungary). Country-specific factors that might affect this rate need to be analysed further on a national level.



Table 28: Prisoners per 1,000 Population

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
<b>Austria</b>											0.82	0.87	0.8	1.01	1.1	1.05
<b>Belgium</b>	0.59	0.62	0.71	0.74	0.75	0.75	0.82	0.8	0.8	0.77	0.85	0.83	0.83	0.9	0.89	0.89
<b>Bulgaria</b>											1.22	1.32	1.37	1.41	1.42	1.35
<b>Cyprus</b>											0.41	0.36	0.43	0.5	0.62	0.64
<b>Czech Republic</b>	0.79	1.23	1.35	1.6	1.81	1.89	2.02	2.09	2.14	2.24	2.1	1.89	1.59	1.69	1.8	1.84
<b>Denmark*</b>	0.73	0.72	0.71	0.72	0.72	0.73	0.7	0.71	0.7	0.7	0.69	0.68	0.67	0.7	0.72	0.77
<b>England &amp; Wales</b>	0.76	0.79	0.71	0.78	0.82	0.86	0.97	1.07	1.1	1.06	1.05	1.12	1.18	1.22	1.23	1.25
<b>Finland*</b>	0.69	0.69	0.7	0.68	0.64	0.64	0.58	0.55	0.54	0.52	0.56	0.6	0.67	0.67	0.68	0.74
<b>France</b>	0.8	0.84	0.86	0.85	0.89	0.91	0.93	0.9	0.91	0.88	0.85	0.79	0.79	0.9	0.96	0.95
<b>Germany</b>	0.56	0.58	0.61	0.74	0.74	0.75	0.79	0.83	0.85	0.84	0.86	0.85	0.86	0.96	0.96	
<b>Greece</b>										0.91	0.9	0.97	0.95			
<b>Hungary</b>	1.19	1.43	1.46	1.27	1.23	1.2	1.72	1.3	1.4	1.47	1.52	1.69	1.71	1.63	1.64	1.56
<b>Iceland</b>	0.38	0.38	0.35	0.38	0.38	0.4	0.47	0.44	0.38	0.33	0.28	0.39	0.37	0.39	0.4	0.4
<b>Ireland*</b>		0.61	0.62	0.61	0.61	0.59	0.61	0.66	0.71	0.77	0.78	0.81	0.81	0.8	0.79	
<b>Italy</b>	0.46	0.63	0.84	0.88	0.9	0.84	0.86	0.89	0.86	0.93	0.95	0.97	0.98	0.95	0.97	1.02
<b>Lithuania</b>	2.43	2.59	2.83	2.94	3.34	3.57	3.43	3.55	3.89	4.01	3.04	3.32	3.19	2.33	2.36	2.38
<b>Luxembourg</b>	1.01	0.95	1.04	1.06	1.13	1.11	1.03	1.06	0.92	0.9	0.92	0.78	0.96	1.11	1.4	1.62
<b>The Netherlands</b>	0.46	0.49	0.5	0.53	0.57	0.67	0.77	0.76	0.75	0.75	0.74	0.78	0.81	0.86	1.01	1.06
<b>Norway*</b>	0.56	0.6	0.58	0.62	0.62	0.6	0.6	0.58	0.56	0.57	0.57	0.61	0.63	0.65	0.66	0.68
<b>Poland</b>	1.32	1.54	1.6	1.6	1.63	1.58	1.44	1.49	1.41	1.47	1.83	2.08	2.1	2.07	2.1	2.17
<b>Portugal</b>											1.25	1.28	1.33	1.31	1.26	1.24
<b>Slovenia*</b>								0.38	0.41	0.48	0.57	0.6	0.58	0.56	0.57	0.57
<b>Spain</b>	0.85	0.94	1.05	1.16	1.23	1.15	1.12	1.10	1.13	1.14	1.13	1.15	1.23	1.31	1.39	1.41
<b>Sweden*</b>												0.61	0.65	0.70	0.74	0.73

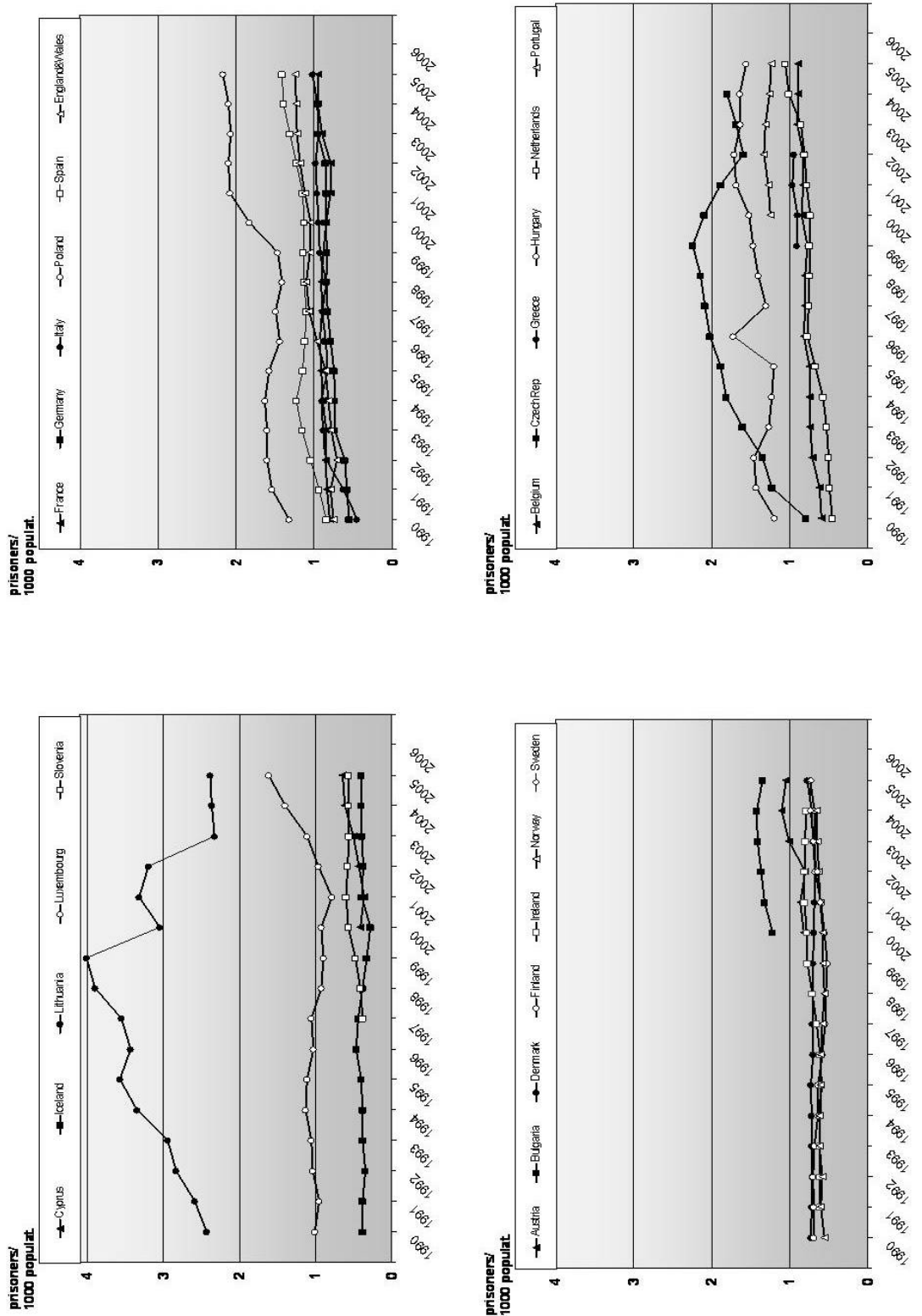
Census data at end of year, data origins available, data origin used to calculate population-based rates: Eurostat 2006

\* Denmark: 1990-2003, average number per year was taken, not census data

Finland: 1990-1994, average number per year was taken, not census data

Ireland, Norway, Slovenia, Sweden: average number per year was taken, not census data

Figure 6a – 6d : Prisoners per 1,000 Population



## Data Collection on Mental Ill Health in Prisons

Despite a reported increase of mental health problems among prisoners in Europe and worldwide, official data on the frequency of psychiatric cases or the diagnoses in prisons are scarce. Most European countries included in this study do not run psychiatric prison registers or have available routine information on the frequency of mental disorders among their prison population (see table 29).

This is a most serious omission, which is not moderated by the fact that similarly sensitive fields (e.g., forensic psychiatry) suffer from the same shortcoming. Without basic morbidity data, the extent and burden of mental disorders in prisons will remain unclear and any analyses focussing on the appropriateness of prison mental health care will be blocked.

**Table 29: Availability of Official Information on the Frequency of Mentally Disordered Prison Inmates**

<i>Data not recorded</i>	<i>Data available</i>	<i>Unknown</i>
<i>Belgium</i>	<i>Bulgaria</i>	<i>Austria</i>
<i>Czech Republic</i>	<i>Cyprus</i>	<i>Denmark</i>
<i>Finland</i>	<i>England &amp; Wales*</i>	<i>France</i>
<i>Germany</i>	<i>Hungary*</i>	<i>Ireland</i>
<i>Greece</i>	<i>Lithuania</i>	<i>Portugal</i>
<i>Iceland</i>	<i>Luxembourg</i>	
<i>Italy</i>	<i>Poland*</i>	
<i>The Netherlands</i>		
<i>Norway</i>		
<i>Slovenia</i>		
<i>Spain</i>		
<i>Sweden</i>		

\* *Research data*

## Diagnostic Patterns of Mental Disorders in Prisons

Given the almost completely lack of routine morbidity data, research findings may provide more detailed information on mental disorders in prisons. However, samples in prison studies are usually small, selected or not representative. Selected research findings, which are in part unpublished and provided by the panel of experts collaborating in this study, suggest a significantly increased psychiatric prevalence among imprisoned persons in Europe, and which is considerably higher than that found in general population samples (see table 30).

The heterogeneity of the total psychiatric morbidity, as well as of diagnostic sub-categories as shown in table 30, is due to selection biases, varying diagnostic procedures, different study designs and other reasons. The combination of these rates and proportions in a common table suffers from a lack of standardisation and is done only to demonstrate the varying, although generally high, psychiatric morbidity. However, apart from methodological factors, different concepts of prison mental health care, organisational features or the respective health system or national policies may also contribute considerably to a varying psychiatric prevalence. The specific interplay of forensic psychiatry, general psychiatry, and prison mental health care most probably plays a significant role. There is an urgent need for international research to analyse the variety of the factors likely to influence the mental ill health patterns in European prisoners.

**Table 30: Diagnostic Breakdown for Mentally Disordered Prisoners in selected Countries,** (percentage of mental disorders in assessed prison samples, psychiatric co-morbidity or double diagnoses possible, published or unpublished research data)

Country, year	ICD-10 Diagnostic Groups (%)							Any (%)	Sample size
	F1	F2	F3	F4	F5	F6	F7		
Austria, 2004	59	3	5	2					100
Belgium, 2005	28.7		2.3					31	439
Cyprus, 2005	29.6	8.4	8	9.1	1.8	41	6.5		
Denmark, 1996	44	7	10	16		17		64	228
England & Wales, 1991	38	5		26		11			1,169
Finland, 1995	50	3		16		17		56	903
Finland, 2000								21	187
France, 2004		8	7	12		34			
France, 2004*	26.5	23.9	39.2	44.5				40	799
France, 2006	14	12.1	21.4	21.2				27.4	800
Germany, 2006	71.2	7.9	17.3	27.3	.	53.2		88.2	139
Greece*	1.1	2.6	5.5	3.6		16			495
Greece, 2006	53.8	11.2	27.5	37.5		27.5	15	78.8	80
Ireland, 2005	69.7	7.6	12.6	6.8				21.4*	232
Ireland, 2006	79.6	2.7	8.5	13.8				26.7	438
Lithuania 2005*	2.2	0.1	0.2	1.8	0.5	13.4		21.4	8,137
The Netherlands, 1997	18		16	13		32		54	135
Poland, 2003*	7.7	0.4	0.7	0.9		3.7	0.3		1,305
Sweden, 2005	60								

\* Austria: Research data from an unselected sample (n = 100; personality disorders not recorded, unpublished report, 2004)

Belgium: Feron et al 2005

Denmark: Andersen et al 1996

Finland 1995: Joukamaa 1995

Finland 2000: Gamman & Linaker 2000

France 2004a: Prieto & Faure 2004

France 2004b: Cemka-Eval 2006

France 2006: Falissard et al 2006

Germany: von Schönfeld et al. 2006

Greece: Unknown year: research data from 495 male prisoners at Korydallos prison (representing 5.33% of all male prisoners)

Greece 2006 Fotiadou et al. 2006

Ireland 2005: Remand prisoners, any psychiatric disorder, excluding substance use, Linehan et al. 2005

Ireland 2006: Any psychiatric disorder, excluding substance use, Duffy et al. 2006

Lithuania: Census data provided by Prison department, the actual frequency of mentally disordered prisoners is probably higher

The Netherlands, Vaartjes, K., 2006. Jaarverslag monitoring (B)IBA. Den Haag: Dienst Justitiële Inrichtingen

Poland: Ksel 2003.

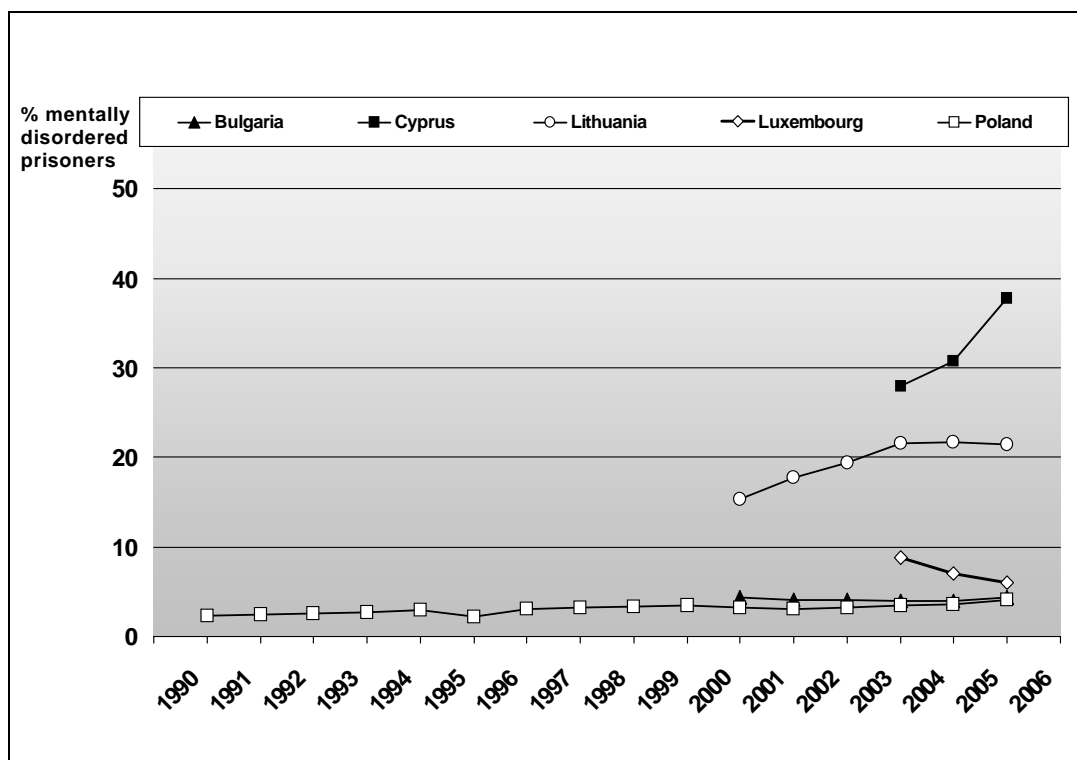
Sweden: Data origin Kriminalvårdens Officiella Statistik 2005

England & Wales: Gunn, Maden & Swinton 1991

During this study, time series on the psychiatric morbidity in the respective national prison population could be collected only from Bulgaria, Cyprus, Lithuania and Poland (see figure 7). When considering the weak diagnostic and health reporting procedures implemented in the various national prison systems (see above), this is hardly surprising. Moreover, it underscores the fact that the Ministries of Health or Justice in Europe know virtually nothing about the mental state of their detained population. According to the provided information, Bulgaria and Poland (the latter being the only country able to provide time series for a period longer than a decade) show an evenly spread pattern of mental ill health prevalence in prison without any significant changes in recent years. However, figures from Poland do not represent accumulated diagnostic data, but merely the averages of cases admitted to psychiatric prison wards per year added to the number of prisoners treated in therapeutic prison departments for non-psychotic or addiction disorders. The steep increase of mental disorders

in Cyprus (see figure 7) is probably due to the recent implementation of a mental health care team in the sole penitentiary of Cyprus, which most probably has significantly improved the detection rate. These few examples show that any information on psychiatric prevalence in prisons must carefully controlled for biases. Any interpretation or cross-boundary comparison would need much more background information than is currently available. Defining and standardising basic indicators would be one of the major initial steps towards developing and implementing an appropriate information system.

**Figure 7: Changes in Psychiatric Prevalence in Prisons over Time** (percentages of mentally disordered prisoners of total prison population, estimated or research data)



\* Luxembourg: Estimated number according to the Penitentiary Médico-Psychological Service (SMPP)

Poland: Frequencies represent annual averages of episodes in psychiatric prison wards plus the number of prisoners admitted to therapeutic prison departments

## Referrals to Mental Health Services outside Prisons

Not surprisingly, information on the utilisation of external mental care services (NHS, general psychiatry, forensic psychiatry) by prisoners is even poorer than the data on mental health care staff in prisons. Obviously, only very few countries systematically record referrals of prisoners to inpatient or outpatient services of the general mental health care system. The same applies to liaison contacts or visits of external mental health care staff in prisons. For the vast majority of countries, it is impossible to quantify either the contribution of general psychiatry to prison mental health care or the burden of prison mental health care carried elsewhere. Even the data provided seem selected and not representative of the number of actual referrals (see table 31), when considering the high psychiatric morbidity among prisoners and the most probably decisive contribution of the various National Health Systems to treating this prevalence.

Apart from a number of administration, responsibility or budget problems which may arise when the actual share of general mental health care services is unknown, the lack of referral data seriously affects the implementation of specific programmes, quality assurance or the security measures that are essential for treating prison inmates in general mental health care settings.

**Table 31: Annual Referrals of Mentally Disordered Prison Inmates to external Mental Health Care Services** (during imprisonment, most recent year available)

<b>Country, year</b>	<b>Number of recorded referrals to general psychiatric hospitals</b>	<b>Number of recorded referrals to psychiatric outpatient services</b>	<b>Number of recorded liaison contacts of external mental health care staff</b>
<i>Austria, 2004*</i>	323	244	
<i>Belgium, 2006</i>	0 (no referrals)	0 (no referrals)	
<i>Cyprus, 2005</i>	1	7	3
<i>Hungary, 2005</i>	418	10 506	
<i>Luxembourg, 2005</i>	less than 5*		
<i>Poland, 2005</i>		615	
<i>Sweden, 2005</i>	786		
<i>Lithuania, 2005</i>	0 (no referrals)	0 (no referrals)	

\* Empty cells: No information. Complete data unavailable for: Bulgaria, Czech Republic, Denmark, England & Wales, Finland, France, Germany, Greece, Iceland, Ireland, Italy, The Netherlands, Norway, Portugal, Slovenia, Spain.  
Austria: Data of “Projektgruppe 2003/2004”, however, referrals are not officially recorded  
Luxembourg: Estimated by multidisciplinary teams (SMPP); inmates have to pay for external outpatient consultations and police escort, thus these kinds of contacts are rare  
The Netherlands: Figures only available for (B)IBA’s

### Psychiatric Care in Medical Prison Wards

Internationally, the rate of admission to inpatient treatment is the most common indicator for the quality of mental health care systems. No similar indicator describing inpatient psychiatric treatment in medical prison wards has been established yet. As a consequence, data on admissions to medical prison wards due to mental disorders are available only for a minority of the countries participating in this study (see tables 32 and 33). Currently, such an indicator would be less convincing since its adequate interpretation is affected by a variety of factors, including:

- the standards of inpatient treatment for mentally disordered prisoners in medical prison wards, which may range from a mere observation of patients by poorly trained staff (e.g., nurses or guards) to a full-scale psychiatric inpatient treatment including 24-hour attendance of psychiatrists,
- lack of a clear definition for a “psychiatric prison bed”,
- varying involvement of external mental health care services in prison mental health care,
- lack of information on the types or severity of mental disorders treated in medical prison wards.

Any cross-boundary comparison of data on admissions to medical prison wards due to mental disorders would be seriously affected by these biases. For this reason, data on medical prison ward admissions as assessed during this study have not been subsequently transformed into prison population-based rates.

The same applies for the mean length of stay, another major indicator in assessing the quality of inpatient mental health care. All information on the duration of psychiatric episodes in medical prison wards collected during this study (see table 33) was from selected samples that were referred to medical prison wards. Prison inmates referred to general psychiatric or other hospitals for psychiatric treatment are not covered. The selection criteria are unknown but are probably psychopathological reasons (e.g., severity of cases).

Due to this selection, it is not informative whether the mean length of stay of psychiatric episodes in medical prison wards may exceed or lie below the national average in general psychiatry. Again, these

fundamental problems underline the need to define and implement internationally substantial indicators for prison mental health care.

**Table 32: Availability of Information on the Frequency of Psychiatric Inpatient Episodes in Medical Prison Wards**

<i>Data not recorded</i>	<i>Data available</i>	<i>Data unknown</i>	<i>Not applicable (no psychiatric inpatient treatment in prison)</i>
Belgium	Bulgaria	Austria	Cyprus
Greece	Czech Republic	Denmark	England & Wales
Ireland	Finland	France	Norway
Luxembourg	Hungary	Germany	
The Netherlands	Lithuania	Iceland	
Italy	Poland	Sweden	
	Portugal*		
	Slovenia*		

\* Slovenia: Data available only in selected prisons

Portugal: Data available only for 2005

**Table 33: Mean Length of Stay of Psychiatric Inpatient Episodes in Medical Prison Wards**

<i>Country, year</i>	<i>Total number of psychiatric inpatient stays in prison wards</i>	<i>Mean length of inpatient stay (in days)</i>
Bulgaria, 2005	60	40
Czech Rep, 2005	553	unknown
Finland, 2005	455	35
Hungary, 2005	879	15
Lithuania, 2005	411	23
Poland, 2005	605	51
Portugal, 2005*	114	61

\* Portugal: Data are from the mental health department of the Lisbon prison hospital, not from all Portuguese prisons

## Prison Suicides

Being the most adverse event that may occur during a prison term, prison suicides are usually recorded in a better way than other events or mental disorders on the part of prisoners in general. As a consequence, prison suicides are currently to be seen as the most feasible and informative indirect indicator of the mental ill health of prison inmates.

International surveys suggest that suicide rates in prisons or other correctional facilities significantly exceed those in the general population and are increasing over time (Matschnig et al. 2006). Remand or pre-trial, as well long-term prisoners share the highest risk for suicidal behaviour. Additional factors associated with an increased risk for suicidal behaviour include isolation or single cell use, a previous history of suicide attempts and mental disorder or substance abuse. (Frühwald et al. 2003). Although there are several international data bases recording prison suicides (e.g., SPACE (Council of Europe 2007)), inconsistencies in case definitions or recording procedures may contribute to con-

tradictory rates that are reported for the same country. Table 34 shows the numbers of prison suicides per 1,000 prison inmates for the most recent year available, as they were collected for this study. The rates vary considerably across Europe. However, there are no significantly discernible patterns.

Generally, small prison populations support high rates, since minor changes in the total number of suicides per year may increase the per capita rates significantly. For example, this was the case in Iceland, where throughout the 1990s no suicide in state penitentiaries was recorded. Only 1998 marked a clear exemption, when three prisoners took their life during this year. These events increased the suicide rate per 1,000 prison inmates to a towering 29.1, which is not representative for the overall trend. Prison suicides in Luxembourg or Iceland tend to fluctuate in a similarly strong way, due to the small prison populations. The more heavily populated European countries show more stable trends over time (see table 35 and figures 8a – 8d).

**Table 34: Annual Prison Suicides per 1,000 Prisoners (most recent year available)**

<b>Country</b>	<b>year</b>	<b>suicides per 1,000 prisoners</b>
<i>Austria</i>	<i>2004</i>	<i>0.78</i>
<i>Belgium</i>	<i>2005</i>	<i>1.18</i>
<i>Bulgaria</i>	<i>2005</i>	<i>0.48</i>
<i>Cyprus</i>	<i>2003</i>	<i>0.0</i>
<i>Czech Republic</i>	<i>2004</i>	<i>0.87</i>
<i>Denmark</i>	<i>2005</i>	<i>1.93</i>
<i>England &amp; Wales</i>	<i>2005</i>	<i>1.8</i>
<i>Finland</i>	<i>2005</i>	<i>1.03</i>
<i>France</i>	<i>2004</i>	<i>1.7</i>
<i>Germany</i>	<i>2003</i>	<i>1.28</i>
<i>Greece*</i>	<i>2002</i>	<i>0.1</i>
<i>Hungary</i>	<i>2005</i>	<i>0.25</i>
<i>Iceland</i>	<i>2005</i>	<i>8.47</i>
<i>Ireland</i>	<i>2004</i>	<i>1.25</i>
<i>Italy</i>	<i>2005</i>	<i>0.96</i>
<i>Lithuania</i>	<i>2005</i>	<i>1.35</i>
<i>Luxembourg</i>	<i>2005</i>	<i>2.72</i>
<i>The Netherlands</i>	<i>2005</i>	<i>1.16</i>
<i>Norway</i>	<i>2004</i>	<i>1.65</i>
<i>Poland</i>	<i>2005</i>	<i>0.39</i>
<i>Portugal</i>	<i>2004</i>	<i>1.6</i>
<i>Slovenia</i>	<i>2005</i>	<i>1.76</i>
<i>Spain*</i>	<i>2004</i>	<i>0.82</i>
<i>Sweden</i>	<i>2005</i>	<i>1.06</i>

\* Data source: SPACE (Council of Europe 2007)



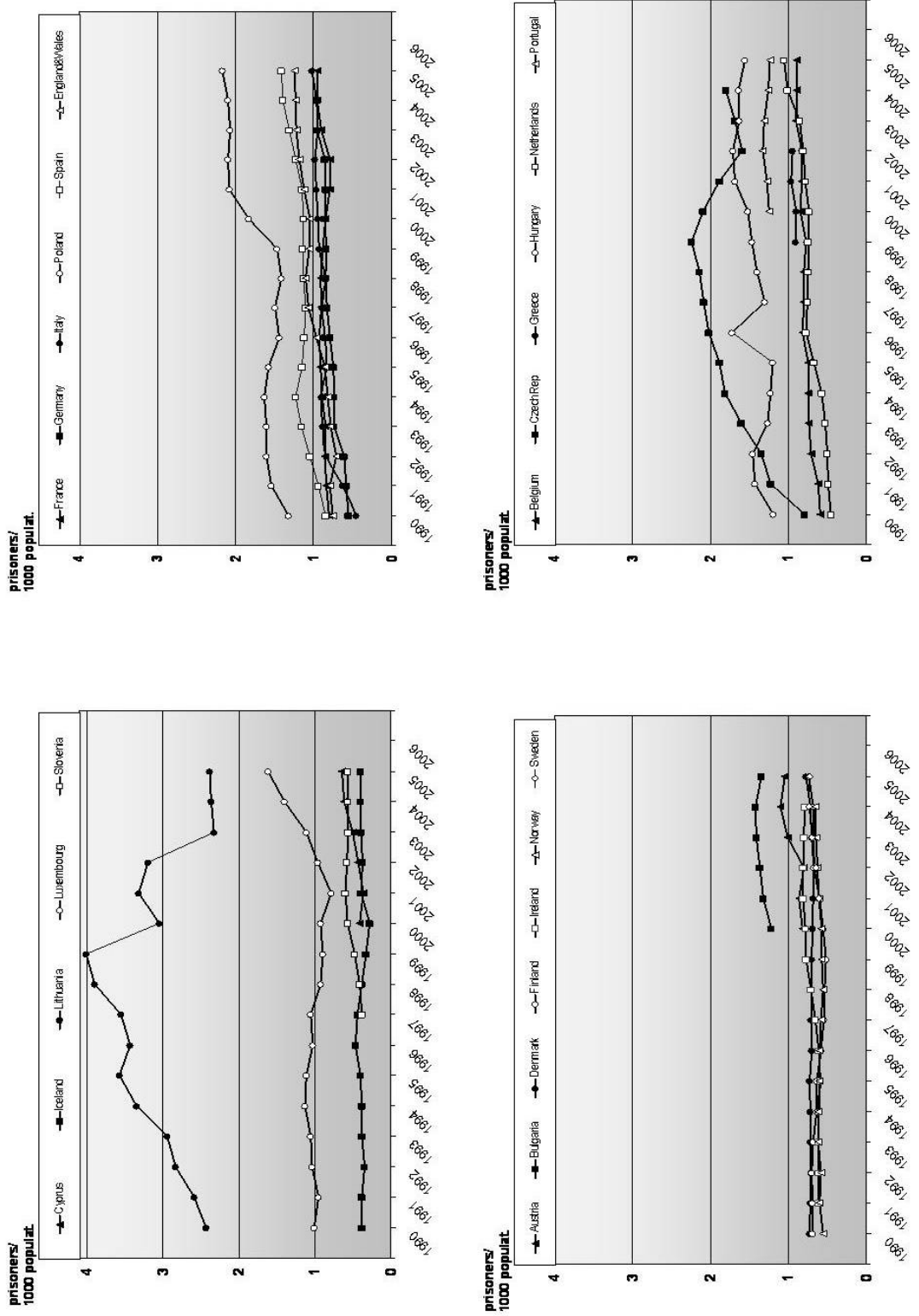
Table 35: Annual Prison Suicides per 1,000 Prisoners (time series)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
<b>Austria</b>											2.13	1.72	1.54	1.23	0.78	
<b>Belgium</b>	1.02	2.9	1.68	2.14	1.73	1.85	2.18	2.94	3.55	2.03	1.84	2.46	2.21	1.07	0.86	1.18
<b>Bulgaria</b>											0.4	0.29	0.28	0.45	0.36	0.48
<b>Cyprus</b>	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Czech Republic</b>	0.85	0.86	0.72	0.91	0.64	0.36	0.62	0.74	0.41	0.22	0.42	0.26	0.8	0.64	0.87	0.32
<b>Denmark</b>						1.05	2.17	1.88	1.34	2.14	1.36	2.74	0.83	1.32	1.79	1.93
<b>England &amp; Wales</b>				1.66	1.74	1.66	1.74	1.6	1.78	1.95	1.93	1.5	1.84	1.81	1.8	
<b>Finland</b>									3.25	3	1.04	1.93	1.73	0.87	1.41	1.03
<b>France</b>			1.9	2.01	1.92	1.98	2.51		2.17	2.36	2.35	2.17	2.61	2.17	1.7	
<b>Germany</b>					1.54	1.70		1.46				1.40	1.00	1.01	1.02	
<b>Greece*</b>										0.51	0.91	0.47	0.10			
<b>Hungary*</b>									0.49	0.60	0.32	0.64	0.06	0.55	0.36	0.25
<b>Iceland</b>	0	0	0	0	0	0	0	0	29.1	0	0	0	0	0	8.7	8.47
<b>Ireland</b>		1.87	1.37	0.46	1.38	0.47	2.28	1.24	0.38	2.09	0.68	0.32	1.26	0.63	1.25	
<b>Italy</b>	0.88	0.82	0.99	1.21	0.98	1.05	0.92	1.09	1.04	1	1.04	1.25	0.93	1.05	0.93	0.96
<b>Lithuania</b>									0.65	1.20	0.84	1.12	0.81	1.94	0.49	1.35
<b>Luxembourg</b>	2.6	5.49	7.41	2.4	2.22	0	0	6.82	2.57	5.21	12.53	0	4.67	0	1.58	2.72
<b>The Netherlands</b>	0.73	0.55	0.93	1	0.34	1.36	1.34	0.85	0.85	1.01	0.77	0.89	0.77	0.93	1.28	1.16
<b>Norway</b>	0	1.57	1.61	0.75	0.37	2.3	1.54	1.18	0.81	0.4	0.39	1.45	0.71	2.38	1.65	1.60
<b>Poland</b>	0.54	0.49	0.41	0.28	0.35	0.29	0.31	0.68	0.7	0.56	0.65	0.59	0.46	0.47	0.37	0.39
<b>Portugal</b>													0.87	1.1	1.6	
<b>Slovenia</b>								2.62	4.94	1.05	3.54	3.33	3.48	2.68	0	1.76
<b>Spain*</b>									0.22	0.57	0.40	0.43	0.47	0.66	0.82	
<b>Sweden</b>												0.74	1.39	1.29	1.05	1.06

*Census data at end of year, data origin available for each country*  
 \* Data source: SPACG

**Please note:** Prison suicide rates calculated on the basis of census prison population data (as most often done here) suffer from a certain weakness. Cross-sectional prison population figures will miss numerous prison entries and discharges throughout a given year, which are not included in the calculation of rates. A sound indicator for prison suicides would incorporate all prison inmates during a given year, weighted by the total days of their terms. However, such detailed data are hardly available.

Figure 6a – 6d : Prisoners per 1,000 Population



## Personality Disorders

According to research findings, personality disorders are very common in prison populations, although – as outlined above – routine screening or assessment procedures are unlikely to detect the actual prevalence. Coid (1998) reported that nearly all members of a prison sample he had assessed did fulfil the criteria for at least one subtype of personality disorder. Fazel and Danesh's (2002) systematic review of 62 prison surveys showed that 47% of approx. 23,000 prisoners were suffering from antisocial personality disorder. In female prison samples, borderline personality disorder was detected in up to 25% (Jordan et al. 1996). Other personality disorder subtypes are also likely to exceed the prevalence to be found in the general population.

In a prison context or from the perspective of criminal offending, psychopathic personality disorder is particularly important. While in general population samples the prevalence of psychopathic personality disorder is about one percent, it will rise to up to 25% among patients in forensic facilities or among prisoners (Hare 1996). However, cultural differences may account for a certain heterogeneity, as some European studies report lower rates (between 3% - 7%) in prison populations (Cooke 1996, Ulrich 2003).

**Table 36: Estimated Prevalence of Borderline Personality Disorder, Dissocial Personality Disorder and Psychopathic Personality Disorder in Prisons (Expert Assessment)**

<i>Dissocial personality disorder is frequent</i>	<i>Psychopathic personality disorder is frequent</i>	<i>Borderline personality disorder is frequent</i>	<i>Frequency is generally underestimated</i>	<i>Unknown</i>
<i>Austria</i>	<i>Austria</i>	<i>Austria</i>	<i>Austria</i>	<i>Denmark</i>
<i>Belgium</i>	<i>Belgium</i>	<i>Belgium</i>		
<i>Bulgaria</i>	<i>Bulgaria</i>	<i>Bulgaria</i>		
<i>Cyprus</i>				
<i>Czech Republic</i>	<i>Czech Republic</i>	<i>Czech Republic</i>	<i>Czech Republic</i>	
<i>England &amp; Wales</i>				
<i>Finland</i>				
<i>France</i>	<i>France</i>	<i>France</i>		
<i>Germany</i>		<i>Germany</i>		
<i>Greece</i>	<i>Greece</i>	<i>Greece</i>	<i>Greece</i>	
<i>Hungary</i>	<i>Hungary</i>	<i>Hungary</i>		
<i>Iceland</i>				<i>Iceland*</i>
<i>Ireland</i>	<i>Ireland</i>	<i>Ireland</i>	<i>Ireland</i>	
<i>Italy</i>	<i>Italy</i>	<i>Italy</i>	<i>Italy</i>	
<i>Lithuania</i>	<i>Lithuania</i>	<i>Lithuania</i>		
<i>Luxembourg</i>	<i>Luxembourg</i>	<i>Luxembourg</i>	<i>Luxembourg</i>	
<i>The Netherlands</i>				
<i>Norway</i>	<i>Norway</i>	<i>Norway</i>		
<i>Poland</i>	<i>Poland</i>	<i>Poland</i>	<i>Poland</i>	
<i>Portugal</i>	<i>Portugal</i>	<i>Portugal</i>	<i>Portugal</i>	
<i>Slovenia</i>	<i>Slovenia</i>	<i>Slovenia</i>	<i>Slovenia</i>	
	<i>Sweden</i>	<i>Sweden</i>		

\* *Iceland: Unknown for psychopathic and borderline personality disorder; over- or underestimation is unknown, too*

Nevertheless, prisoners suffering from psychopathic personality disorder are highly problematic for any routine practise in European prisons – whether or not the disorder is identified. The issue becomes additionally aggravated if the view is taken that persons with psychopathic personality disorder should primarily be considered as criminally not responsible since they to suffer from a mental illness and therefore should be exempted from punishment. Although not being finally confirmed, this

view is supported by increasing neurobiological evidence that in persons with psychopathic personality disorder their cognition, emotional reactivity and impulsiveness are affected by neurobiological dysfunctions that make these persons organically incapable of appropriately regulating their behaviour (Sapolsky 2004).

Despite the ongoing and open debate, in the light of these findings, it is of particular interest which status would be given to offenders with psychopathic (or any other) personality disorder during court trial procedures against them in European countries and where they would be subsequently placed or detained.

Due to the lacking prevalence data, and the fact that patient-based data collection is beyond the scope of this study, the effort was made to evaluate the problem dimension by collecting the opinions and views of the collaborating experts. All experts estimated whether the most important subtypes of personality disorder would frequently be found in the respective national prison system, whether the prison prevalence of these disorders would generally be underestimated, and where an offender suffering from a personality disorder most likely would be admitted to after court trial. Tables 36 and 37 show the results.

This rough estimation demonstrates that in all included countries it obviously is routine to classify offenders with a personality disorder - whether or not this disorder has been properly diagnosed - as being criminally responsible and send them to prison, without adequately considering alternatives. Most often there seems to be denial of an illness status for borderline and personality disorders. As a consequence, personality disorders add substantially to the prevalence of mental ill health in European prisons.

**Table 37 Most Likely Placement of a Criminal Offender Suffering from Borderline Personality Disorder, Dissocial Personality Disorder and Psychopathic Personality Disorder (Expert Assessment)**

<i>Prison placement</i>	<i>Other options</i>
<i>Austria*</i>	<i>Bulgaria</i>
<i>Belgium</i>	<i>Hungary*</i>
<i>Cyprus</i>	
<i>Czech Republic</i>	
<i>Denmark</i>	
<i>England &amp; Wales</i>	
<i>Finland</i>	
<i>France</i>	
<i>Germany</i>	
<i>Greece</i>	
<i>Iceland</i>	
<i>Ireland</i>	
<i>Italy</i>	
<i>Lithuania</i>	
<i>Luxembourg</i>	
<i>The Netherlands</i>	
<i>Norway</i>	
<i>Poland</i>	
<i>Portugal</i>	
<i>Slovenia</i>	
<i>Sweden</i>	

\* *Austria: Placement in forensic facilities in case of criminal commitment as non-responsible or responsible mentally ill offender*

*Hungary: Placement in a medical-educational group is possible*

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## Quality Standards for Prison Mental Health Care

Many documents stress the right of prison inmates to proper health care standards. Article 39 of the European Prison Rules states that “Prison authorities shall safeguard the health of all prisoners in their care.” (Committee of Ministers 2006). This includes the responsibility to provide conditions in keeping with the constitution and, if necessary, individual treatment of disorders which also may be a result of detention conditions. Further guiding principles are provided by the Recommendations of the Committee of Ministers of the Council of Europe No. R (98) 7 (Committee of Ministers 1998) concerning the ethical and organisational aspects of health care in prisons.

These stress that medical practise in the community and in the prison context should be guided by the same ethical principles and that the respect for the fundamental rights of prisoners entails the provision to prisoners of preventive treatment and health care equivalent to that provided to the community in general.

**Table 38: Overall Quality Standard of Prison Mental Health Care (Expert Assessment)**

<i>Equivalent to general mental health care in the respective country</i>	<i>Not equivalent to general mental health care in the respective country</i>
<i>Cyprus</i>	<i>Austria</i>
<i>Denmark</i>	<i>Belgium</i>
<i>Finland</i>	<i>Bulgaria</i>
<i>France</i>	<i>Czech Republic</i>
<i>Luxembourg</i>	<i>England &amp; Wales</i>
<i>Norway</i>	<i>Germany</i>
<i>Poland</i>	<i>Greece</i>
<i>Slovenia</i>	<i>Hungary</i>
<i>Sweden</i>	<i>Iceland</i>
	<i>Ireland</i>
	<i>Italy</i>
	<i>Lithuania</i>
	<i>The Netherlands</i>
	<i>Portugal</i>
	<i>Spain</i>

Given the above shown strong evidence of poor standards of mental health care in European prisons and penitentiaries, the experts collaborating in this study were asked to give an overall verdict on how far the standards of mental health care in prisons is to be considered equivalent to general mental health care standards in their countries. Despite the subjective and non-standardised character of such an evaluation, table 38 shows a considerable gap between the standards of prison and general mental health care in almost two thirds of the included countries.

**Table 39: Most Crucial Shortages of Prison Mental Health Care (Expert Assessment)\***

<b>Country</b>	<b>Most crucial shortages</b>
<i>Austria</i>	<i>lack of beds for sufficient inpatient treatment within the prison system, shortages of therapeutic treatment (except for psychopharmacologic care)</i>
<i>Belgium</i>	<i>lack of mental health professionals, professionals are occupied with assessing inmates for juridical decisions on the expense of treatment</i>
<i>Bulgaria</i>	<i>shortages of psychotherapeutic programmes; serious problems with adequate mental state assessment, particularly in the case of personality disorders, depression and mental illnesses in general; no influence of professional association; severe under-funding; weak recording routines (no data analysis possible for policy making)</i>
<i>Cyprus</i>	<i>lack of therapeutic or research programmes due to lack of staff and infrastructure</i>
<i>Czech Republic</i>	<i>lack of adequately trained staff due to low prestige and wages, shortages of psychotherapeutic programmes, inadequate mental state assessment and care</i>
<i>Denmark</i>	<i>shortages of capacity in Herstedvester Institution, long waiting times of prisoners to be admitted to general psychiatry</i>
<i>England &amp; Wales</i>	<i>insufficient and inadequate psychiatric services to diagnose illness; long referral delays due to shortage of psychiatric beds in NHS; absence of treatment for minor mental disorders; wholly inadequate aftercare system</i>
<i>Finland</i>	<i>shortages in substance use treatment programmes, particularly for prisoners with short sentences; shortages also in assessment and treatment</i>
<i>France</i>	<i>no answer</i>
<i>Germany</i>	<i>shortages of treatment, staffing, organisation and infrastructure</i>
<i>Greece</i>	<i>major shortages regarding personnel and special care facilities, there is only one prison hospital which is more a primary care facility than a regular hospital</i>
<i>Hungary</i>	<i>approximately 80% of mentally ill prisoners suffer from personality disorders; violation of human rights principles (no refusal of treatment), a lack of psychiatric treatment alternatives and atypical neuroleptics; no comprehensive quality control; there are well trained psychiatrists, but poor working conditions</i>
<i>Iceland</i>	<i>no medical wards, access to psychiatric and psychological services and treatment programmes should be improved</i>
<i>Ireland</i>	<i>relative shortage of all services, particularly of dedicated mental health nurses, access to community mental health facilities and psychotherapeutic services should be improved</i>
<i>Italy</i>	<i>psychotherapy is uncommon, alcohol is allowed in many prisons, aftercare is lacking</i>
<i>Lithuania</i>	<i>serious shortage of mental health care for mentally ill prisoners; no vocational training or occupational programmes; very poor psychotherapeutic treatment</i>
<i>Luxembourg</i>	<i>no crucial shortages, maybe a lack of a forensic unit in the CHNP (national psychiatric hospital), however, there are approx. fewer than five prisoners in need of such a service</i>
<i>The Netherlands</i>	<i>insufficient collaboration with general mental health care (offered care does not meet the specific needs of mentally disordered detainees), judicial process and measures could aim more at effective solutions regarding care and recidivism reduction, implementation of treatment programmes, e.g., for sex offenders (in development), better community aftercare (recent developments in civil and penal law are in progress)</i>
<i>Norway</i>	<i>availability of illegal drugs inside prison; lack of mandatory assessment with adequate screening instruments; lack of mental health aftercare services;</i>

Poland	<i>shortages in vocational therapy and occupational programmes, lower wages for medical prison staff than for personnel in general health services, lack of adequate cooperation between judicial system and health care system</i>
Portugal	<i>psychosocial interventions are scarce (e.g., occupational programmes), problems to implement psychotherapy due to shortage of competent staff,</i>
Slovenia	<i>lack of specific treatment programmes, group psychotherapy</i>
Spain	<i>shortages of specialized staff, poor reporting standards, lack of knowledge of the real prevalence of mentally ill people within the Spanish penitentiaries; necessity to designate a system of alternative placement and treatment options for mentally ill persons in prison; lack of regulation for the use of coercive measures for therapeutic reasons in all penitentiary centres; necessity to organise a currently non-existing continuous specific training for prison staff responsible for assessing and treating mentally disordered inmates; necessity to implement specific services for the treatment of detainees, prisoners and sentenced mentally ill persons</i>
Sweden	<i>access to professional staff trained in treating addiction disorders; occupational programmes</i>

*\* For details please see the country-specific chapters attached to this report.*

Table 39 shows the most crucial shortages that are currently to be identified, as reported by the experts. The most frequently mentioned problem areas may be summarized as follows:

- lacking respectively an insufficient number of places in (psycho)therapeutic treatment programmes,
- insufficient number of beds for psychiatric inpatient treatment,
- lack of appropriately trained staff,
- insufficient mental state screening routines,
- lacking aftercare,
- under-funding,
- insufficient cooperation with national health systems.

To safeguard quality standards and human right principles in prisons, external evaluation is crucial. The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (Principle 29), as well as the Standard Minimum Rules for the Treatment of Prisoners (Rule 55), demand regular inspections of all prisons and places of detention, which should be conducted by organisations independent from the respective prison administration (Office of the High Commissioner 1977, 1988).

The Council of Europe has entitled at least two institutions to visit detention facilities of its Member States and report on prison conditions. These include:

- The Commissioner for Human Rights (CHR), an independent institution mandated to promote the awareness of and respect for human rights in the 47 Member States of the Council of Europe.
- The Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), which includes independent and impartial experts from a variety of backgrounds (e.g., lawyers, medical doctors and experts in prison or police matters).

Both are entitled to visit all places in which persons are deprived of their liberty by a public authority, including prisons and juvenile detention centres, police stations, immigration holding centres, psychiatric hospitals, and homes for elderly or disabled persons. Table 40 lists the most recent CHR or CPT visits to the countries included in this study.



**Table 40: Evaluation of Human Rights Standards in National Prison Systems (by the Commissioner for Human Rights CHR or the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment CPT)**

Country	Year of most recent visit	Visiting institution of the Council of Europe*	Recommendations for prison mental health care
Austria	2007 / 2004	CHR / CPT	yes
Belgium	2005	CPT	yes
Bulgaria	2004 / 2006	CHR / CPT	yes
Cyprus	2005 / 2004	CHR / CPT	yes
Czech Republic	2006 / 2006	CHR / CPT	yes
Denmark	2006 / 2002	CHR / CPT	yes
England & Wales	2004 / 2005	CHR / CPT	yes
Finland	2005 / 2003	CHR / CPT	yes
France	2005 / 2006	CHR / CPT	unknown
Germany	2006 / 2005	CHR / CPT	yes
Greece	2005 / 2005	CHR / CPT	yes
Hungary	2005 / 2005	CHR / CPT	yes
Iceland	2005 / 2004	CHR / CPT	yes
Ireland	2006	CPT	yes
Italy	2005 / 2006	CHR / CPT	yes
Lithuania	2006 / 2004	CHR / CPT	yes
Luxembourg	2004 / 2003	CHR / CPT	yes
The Netherlands	2005	CPT	yes
Norway	2005 / 2005	CHR / CPT	yes
Poland	2006 / 2004	CHR / CPT	yes
Portugal	2003 / 2003	CHR / CPT	yes
Slovenia	2005 / 2006	CHR / CPT	yes
Spain	2005 / 2005	CHR / CPT	yes
Sweden	2004 / 2003	CHR / CPT	yes

Apart from these official visits, regular national assessments of the quality standards of prison health care are hardly implemented. Only eight countries reported additional routines (see table 41). However, in all countries NGOs or other independent organisations (e.g., ombudsmen) are granted unrestricted access to prisons or other detention facilities (this is unknown for Spain and France, however). In some countries (e.g., Austria, Greece, Hungary, visits by NGOs require prior submission of a written request to the Ministry of Justice), whereas other countries (e.g., Czech Republic) report no NGO focussing on prison mental health care.

National Psychiatric Societies or Associations are bodies with decisive potential for improving the mental health care standards in prisons. Regrettably, in many countries psychiatric societies obviously do not consider prison mental health care to be a field of major interest, as an overview of recent activities may show (see table 42). Please note that this overview lacks standardisation of what may be considered to be a relevant activity and in some cases may be biased by the limited information available to the collaborating experts.

Table 41: Regular Assessment of Quality Standards for Prison Mental Health Care (apart from CHR or CHP Visits)

No regular quality standard assessment	Regular quality standard assessment is implemented	Unknown
Belgium	Austria*	Greece
Cyprus	Bulgaria*	Slovenia
Czech Rep	England & Wales*	
Denmark	Finland*	
France	The Netherlands*	
Germany	Norway*	
Hungary	Portugal*	
Iceland	Spain*	
Ireland	Sweden*	
Italy		
Lithuania		
Luxembourg		
Poland		

\* **Austria:** Unannounced visits at least once a year by "Vollzugskommissionen" **Bulgaria:** Assessments by the Medical Department of the National Prisons Directorate with representatives of the Ministry of Justice. **England & Wales:** Overall assessment by Independent Monitoring Board and HM Chief Inspector of Prisons. **Finland:** Assessment by Criminal Sanctions Agency and Parliament Ombudsman. **The Netherlands:** Every prison has a Supervisory Committee which meets monthly, additional assessments by the Inspection Committee of Health Care, the Council for Execution of Penal Law and Juvenile Protection, and Inspection for Execution of Sanctions. **Norway:** Inspections of prison health services at intervals by The Norwegian Board of Health. **Poland:** Visits by Commissioner for Civil Rights Protection, which are not regularly, limited to selected penitentiaries, and concerning human rights in general. **Portugal:** Prison inspections by the Audit and Inspection Service and the Ministry of Justice. **Spain:** Periodical inspection for Parliament Ombudsman (Annual Report to Parliament). **Sweden:** Once in ten years assessment of health care by The National Board for Health and Welfare

Table 42 Relevant Activities of National Psychiatric Societies or Associations regarding Mental Health Care Provision in Prison (Expert Assessment)

No relevant activity	recent activities for improving mental health care provision in prison
Bulgaria	Austria*
Czech Republic	Belgium*
Denmark	Cyprus*
Greece	England & Wales*
Finland*	France
Iceland	Germany*
Ireland	Hungary*
Lithuania	Italy*
Luxembourg	The Netherlands*
Portugal	Norway*
Slovenia	Poland*
	Spain*
	Sweden*

\* **Austria:** Activities by the Austrian Psychiatric Society and – to a rather limited extent - the Ministry of Justice. **Belgium:** Activities by the Dutch and the French speaking Psychiatric Societies. **Cyprus:** Specific seminars on mental health for offenders. **England & Wales:** The Royal College of Psychiatrists issues guidance on the availability of mental health care services in prisons and advises government departments and special committees. **Finland:** Long-term study on health, working capacity and healthcare needs of prisoners is conducted, however not by the National Psychiatric Association. **Germany:** Specialisation in forensic psychiatry (DGPPN). **Hungary:** activities by the forensic section of the Hungarian Psychiatric Association. **Italy:** Consensus Conference of Mental Health in Prison by Italian Society of Psychiatry. **The Netherlands:** Forensic section of the Netherlands Association of Psychiatrists. **Norway:** activities by The Norwegian Psychiatric Association, The Ethical Committee of the Norwegian Medical Association and The Norwegian Psychological Association. **Poland:** Professional training courses organised by the Health Care Bureau of the Central Executive of the Prison Services and the Forensic Psychiatry Section of the Polish Psychiatric Association. **Spain:** Spanish Association of Neuropsychiatry. **Sweden:** Activities by Swedish Society for Prison Medicine and a Government coordinator.

A diminished awareness of the needs of mentally ill offenders in correctional services or the hazards they pose may also be reflected by an overall neglect of this topic in psychiatric training courses or medical school curricula. Even in Belgium, Bulgaria, Hungary, Italy, or the Netherlands, where prison mental health care may be addressed during psychiatric training courses, these courses are neither available nation-wide nor are they mandatory (see table 43)

**Table 43: Inclusion of Prison Mental Health Care Provision into Regular Psychiatric Training Courses of Medical Schools or Universities**

<i>No inclusion</i>	<i>Inclusion of prison mental health care topics into regular psychiatric training</i>
<i>Austria</i>	<i>Belgium*</i>
<i>Cyprus*</i>	<i>Bulgaria*</i>
<i>Czech Republic</i>	<i>Hungary*</i>
<i>Denmark</i>	<i>Italy*</i>
<i>England &amp; Wales</i>	<i>The Netherlands*</i>
<i>Finland</i>	
<i>France</i>	
<i>Germany</i>	
<i>Greece</i>	
<i>Iceland</i>	
<i>Ireland</i>	
<i>Lithuania</i>	
<i>Luxembourg</i>	
<i>Norway</i>	
<i>Poland*</i>	
<i>Portugal</i>	
<i>Slovenia</i>	
<i>Spain</i>	
<i>Sweden</i>	

\* *Belgium: Only trainees spending an optional year of training in the prison system receive theoretical and practical education on prison mental health care issues.*

*Bulgaria: Some training courses for clinical psychologists and social workers are available.*

*Cyprus: No medical school or university is established in Cyprus; recommendations for specific training courses are made.*

*Hungary: Psychiatric prison wards are also accredited for post-graduate training of forensic psychiatry.*

*Italy: Some universities provide practical training courses, but they are not mandatory.*

*Netherlands: Regular curriculum includes 8-16 hours of forensic psychiatry, trainee psychiatrists can choose to work in a prison.*

*Poland: Professional training courses organised by the Health Care Bureau of the Central Executive of the Prison Services and the Forensic Psychiatry Section of the Polish Psychiatric Association are available.*

## References

- Committee of Ministers (1998) Recommendation No. R (98) 7 Concerning the Ethical and Organisational Aspects of Health Care in Prison (Apr. 8, 1998)*
- Committee of Ministers (2006) Recommendation Rec (2006)2 of the Committee of Ministers to Member States on the European Prison Rules.*
- Office of the High Commissioner for Human Rights (1977) Standard Minimum Rules for the Treatment of Prisoners, Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977.*
- Office of the High Commissioner for Human Rights (1988) Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, Adopted by General Assembly resolution 43/173 of 9 December 1988*

## Ethics and Human Rights Aspects

Many prison conditions bear potential hazards of violating human rights. The European Prison Rules (Committee of Ministers 2006) include several recommendations that shall safeguard human rights standards of prisoners or ethical principles during imprisonment, e.g., the right of prisoners to “ample opportunity to make requests or complaints to the director of the prison or to any other competent authority” (Principle 70.1). Prisoners “are entitled to seek legal advice about complaints and appeals procedures and to legal assistance when the interests of justice require” (Principle 70.7).

Table 44 lists the availability of institutions or independent bodies to whom prisoners may direct any complaints. According to the information collected during this study, prisoners in Bulgaria, France, Greece, Hungary, Ireland and Italy lack the opportunity to complain to an independent organisation.

**Table 44 Availability of Independent Ombudsman or Grievance Committees for Complaining about Insufficient Prison Mental Health Care**

<b>Country</b>	<b>Organisation or committee</b>
<i>Austria</i>	<i>“Vollzugskammer”, “Vollzugskommissionen”, Ombudsmen, Human Rights Commission, CPT</i>
<i>Belgium</i>	<i>Commissie van Toezicht”, “Penitentiaire Gezondheidsraad”, CPT</i>
<i>Bulgaria</i>	<i>not available</i>
<i>Cyprus</i>	<i>Ombudsman Office, Commissioner for Human Rights, Committee for Supervision of Mental Health</i>
<i>Czech Republic</i>	<i>Czech Helsinki Committee</i>
<i>Denmark</i>	<i>National Board of Patient’s Complaints of the Danish Public Health Authorities</i>
<i>England &amp; Wales</i>	<i>Prisons and Probation Ombudsman; Independent Monitoring Board</i>
<i>Finland</i>	<i>district administrative court, Office for Medico-Legal Affairs, parliament Ombudsman</i>
<i>France</i>	<i>not available</i>
<i>Germany</i>	<i>“Vollzugsbeirat”</i>
<i>Greece</i>	<i>not available</i>
<i>Hungary</i>	<i>not available</i>
<i>Iceland</i>	<i>Parliamentary Ombudsman, the Medical Director of Health</i>
<i>Ireland</i>	<i>not available</i>
<i>Italy</i>	<i>not available</i>
<i>Lithuania</i>	<i>The Seimas Ombudsmen’s office of the Republic of Lithuania</i>
<i>Luxembourg</i>	<i>National Ombudsman</i>
<i>The Netherlands</i>	<i>National Council for Execution of Penal Law and Juvenile Protection; National Inspection Committee for Health Care; Lawyer</i>
<i>Norway</i>	<i>The Norwegian Parliamentary Ombudsman, The Norwegian Association for Penal Reform, Mental Health Norway</i>
<i>Poland</i>	<i>Ombudsman (16 deputies, one in each Province)</i>
<i>Portugal</i>	<i>Justice Ombudsman</i>
<i>Slovenia</i>	<i>Human Rights Ombudsman, CPT</i>
<i>Spain</i>	<i>Parliament Ombudsman</i>
<i>Sweden</i>	<i>National Board of Health and Welfare; Medical responsibility board; The Parliamentary Ombudsmen</i>

One particular aspect of complaints are disciplinary measures which are coercive by nature. Mentally disordered prisoners are more likely to become the subject of disciplinary measures due to misbehaviour that may be caused by the disorder. It is well known that specific coercive measures (e.g., solitary confinement) are likely to aggravate mental disorders. Thus it is crucial to assess the psychological status of a prisoner prior to implementing such measures in order to avoid any additional harm.

In Austria, Belgium, Greece, Italy, Norway, Spain and Sweden, any prisoner known to suffer from a mental disorder will be assessed prior to implementation of disciplinary measures. Regulations or routines in Bulgaria, England & Wales, Germany, Greece, Hungary, Italy, Poland and Slovenia go one step further in that psychological assessments will be conducted in all cases requiring punitive or disciplinary measures. In the remaining countries, a psychological assessment is not stipulated (see table 45).

**Table 45: Mandatory Assessment of Psychological Status of Prisoners Prior to Punishing, Disciplinary or Coercive Measures**

<b>Psychological assessment stipulated</b>	<b>Psychological assessment stipulated only for mentally disordered prisoners</b>	<b>Psychological assessment not stipulated</b>
Bulgaria	Austria*	Cyprus
England & Wales	Belgium*	Czech Republic
Germany	Greece	Denmark
Greece	Italy	Finland*
Hungary	Norway	France
Italy	Sweden*	Iceland
Poland*	Spain*	Ireland
Slovenia*		Lithuania
		Luxembourg
		The Netherlands*
		Portugal

\* Austria: In case of infringement by a mentally disordered prisoner, the psychiatrist or psychologist has to conduct and record an assessment before the director decides about a possible punishment.

Belgium: If prisoners stay at a psychiatric unit, the attending psychiatrist is involved before the application of the punitive measure. In all other cases the psychiatrist is not involved in the decision-making process but must follow the secluded prisoner during the punishment.

Finland: If the prisoner seems to be mentally ill, he would be transferred to psychiatric care. Otherwise he will be treated like other prisoners.

Poland: Misbehaviour due to a mental disorder will not be punished.

The Netherlands: In practices, the psychologist advises about the most suitable measure regarding the prisoner's behaviour.

Slovenia: There is no isolation punishment for depressed and suicidal inmates.

Spain: In case of infringement by a mentally disordered prisoner, a psychiatrist or psychologist has to conduct and record an assessment before the Disciplinary Committee decides about a possible punishment.

Sweden: In case of seclusion if the reason for seclusion is risk of self harm or suicide

Somewhat surprisingly, there are a few countries where disciplinary or coercive measures during imprisonment must not mandatorily be recorded (see table 46). Such records or files are an essential tool for assessing the appropriateness of such measures, particularly in the case of mentally disordered prisoners.

Although epidemiological research studies in prison settings would be most welcome, in order to increase evidence on mental disorders or mental health care in the prison context, clinical research on prisoners is a different matter. The European Prison Rules (Committee of Ministers 2006) clearly state that prisoners shall not be subjected to any experiments without their consent (Principle 48.1) and that experiments involving prisoners that may result in physical injury, mental distress or other damage to health shall be prohibited (Principle 48.2).

Accordingly, more than half of the countries involved in this study generally have prohibited biological or pharmacological research on prison inmates. In case such research studies in principle are allowed, they are subject to specific conditions that have to be fulfilled. These include particularly obtaining the informed consent of prisoners participating in such studies, the permission of the responsible authorities, and the approval by ethics committees (see table 47).

**Table 46: Mandatory Recording of Punishing, Disciplinary or Coercive Measures**

<b>Recording mandatory</b>	<b>Recording not mandatory</b>	<b>Unknown</b>
Austria	Czech Republic	Luxembourg
Belgium	Hungary	
Bulgaria	Iceland	
Cyprus	Ireland	
Denmark	Portugal	
England & Wales		
Finland*		
France		
Germany		
Greece		
Italy		
Lithuania		
The Netherlands		
Norway		
Poland		
Slovenia		
Spain		
Sweden		

\* Finland: Only if the prisoner is in psychiatric care

**Table 47: Regulations on Biological or Pharmacological Research on Prison Inmates**

<b>Research in principle permitted</b>	<b>Research generally prohibited</b>	<b>Unknown</b>
Denmark <sup>a</sup>	Austria	Cyprus
Finland <sup>b</sup>	Belgium	
Germany <sup>a</sup>	Bulgaria	
Iceland <sup>a</sup>	Czech Republic	
Ireland <sup>a</sup>	England & Wales	
The Netherlands <sup>b</sup>	France	
Norway <sup>a</sup>	Greece	
Portugal <sup>c</sup>	Hungary	
Slovenia	Italy	
Spain	Lithuania	
Sweden <sup>a</sup>	Luxembourg	
	Poland	

<sup>a</sup> Only with the permission of the responsible authority, the informed consent of the prisoner, and the permission of an ethics committee

<sup>b</sup> Only with the permission of the responsible authority and the informed consent of the prisoner

<sup>c</sup> Only with the informed consent of the prisoner

## 4. Summary and Conclusion

The number or proportion of inmates with mental problems or mental disorders in prisons and penitentiaries worldwide is largely unknown. Despite the scarcity of research evidence, the prevalence is estimated to be much higher than that in general population samples.

Prisons are not primarily considered to be therapeutic facilities. They are places where sentences are executed for offenders who have passed a court trial that had sent them to custody, or - in case of remand prisons – where persons suspected of having committed a crime are waiting for their trial. Detention itself may cause mental health problems to a certain degree. However, from a health care perspective, it does not matter much whether the prevalence of mental disorders in prison is dominated by persons entering prison with already prevailing mental health problems or by inmates who acquired a mental disorder during their prison term due to unfavourable prison conditions or for whatever other reasons.

No matter what the cause may be or when the disorder has started, prison inmates suffering from mental disorders need to be treated.

Whether and how this treatment is applied across Europe, is the major research question addressed by this study. However, the question of the conceptual misplacement of mentally disordered prisoners is *not* covered here. From a global perspective, it is almost impossible to determine how many incarcerated persons with mental disorders have been wrongly placed in a national prison system or should better be exempted from sanctioning or punishment due to their being criminally not responsible. This needs to be carefully analysed by taking into account the national legal frameworks and criteria applicable for mentally ill offenders to be referred to forensic psychiatric services. A previous study funded within the framework of the DG Health and Consumer Protection of the European Commission has outlined the complexity of this field (Salize & Dressing 2005).

The criteria for deciding whether or not a certain model of prison mental health care is adequate stretch over a wide field. The decisive problem areas are described in detail in the results section of this report. This concluding chapter summarises, in a descriptive manner, the major findings, draws conclusions and identifies the most urgent fields of action. Thus, this chapter may be used as an executive summary, in which the most important points and findings are highlighted by bullet-points.

### Availability of Data on Prison Mental Health Care

A major focus of this report is on the availability of basic information or data in the field. Overall, the shortage of evidence in the field of psychiatric prevalence and mental health care in prisons is nothing less than dramatic. Even the most rudimentary health reporting standards for mental health care in prison are lacking almost everywhere in Europe.

- None of the included countries provides regular national statistics on the frequency of mental disorders of prisoners or on the availability or frequency of psychiatric treatments.

Without these most crucial indicators, it is almost impossible to evaluate the effectiveness or appropriateness of the various models of mental health care provision for prison inmates in Europe – at least when trying to apply the standards of contemporary mental health services research. However, not only these basic indicators, but all other fields and areas covered by this study also suffer from serious information shortages. Thus, most of the following conclusions and verdicts on models, concepts, or

the quality of care are based on descriptions, expert opinions, or other information rather than on exact figures, as are usually used to describe and classify general mental health care across Europe (e.g., psychiatric bed rates, mean length of stay etc.).

The reasons for this serious lack of information are manifold. Among them, a traditional neglect of the prison sector may rank high. But whatever the causes may be, it is hard to reject the impression that European societies or the authorities responsible for mental health care in prisons do not exactly want to know, as irresponsible and short-sighted as such an attitude would be. Though any neglect of the prison sector will be primarily at the expense of the persons concerned, and their suffering, it will also at the expense of society as a whole.

- The price society has to pay for saving on prison mental health care is an increased number of relapses and an increased rate of re-offending by released prisoners – and thus a loss of public safety, an increased strain on national health budgets, and increased expenditures by the criminal justice system.

### **Structure and Organisation of Prison Mental Health Care**

The overall framework in which the mental health problems of prisoners have to be managed shows considerable variation throughout Europe. Prison places per 1,000 population currently range from 2.79 (Lithuania) to 0.44 (Cyprus). The variety reveals that there is no common European model for dealing with offenders or persons who have violated social norms.

Prison health care and prison mental health care is organised in most European countries by the Ministry of Justice or the Prison Administration. A minority of countries prefers a shared or mixed responsibility of the Ministry of Justice and the Health Department or by the Ministry of Health alone. Given the rather different health expertise, experience or infrastructure of these Ministries or Departments, this variety indicates different basic concepts or philosophies of prison mental health care across Europe. The respective advantages or disadvantages are hard to assess and are probably associated with a variety of additional national conditions. However, at least theoretically, vesting responsibility in a Ministry of Health is likely to provide better opportunities to emphasise the principle of equivalent care inside and outside of prison walls, whereas a prison health care system directed by the Ministry of Justice perhaps has more expertise in managing the safety aspects associated with prison mental health care.

On an administrative level, none of the countries participating in this study differentiates between the provision of somatic care and the provision of mental health care in prison. It is doubtful whether this indicates that a separation of the mental health care system from the somatic health care system, which has dominated outside the prison walls in Europe for a long time, has been successfully overcome within them in the form of prison health care, or whether prison mental health care just does not carry sufficient weight to warrant its operation a separate discipline or department.

On an organizational level, two basic models of mental health care in prisons prevail in Europe, which do not necessarily correspond to the administrative responsibility as described above. Some countries rely completely on an internal concept of mental health care that foresees the provision of care exclusively on the prison premises by prison staff (e.g., Belgium or Lithuania). Other countries favour a completely external system of mental health care provision by NHS-services (e.g., Cyprus, England and Wales, France, Iceland, Norway), whereas a larger group of countries include NHS-based general mental health care services in the system of prison mental health care. The latter concept is applied with great variation even within countries. Along with deficient health care reporting on the collaboration between prison and NHS-services, this heterogeneity is a major obstacle to quantifying and evaluating the NHS-integration into prison mental health care. The effectiveness of the various regional or national approaches is unknown.

- Missing structure or outcome data currently prevents the identification of a favourable concept of prison mental health care across Europe.



## Mental Health Care Capacity in Prisons

Due to the unknown degree of NHS-integration into prison mental health care, quality markers for good clinical practise as used in general psychiatry (e.g., staff/patient ratio, bed rates etc.) fail to work in the prison context. Psychiatric prison bed rates or the number of mental health care staff in prison - if available at all - are not very expressive and lack validity in terms of describing the amount and quality of care. Any indicator for such purposes must cover the external contribution to the care of mentally ill prisoners (such as referrals to general psychiatric hospitals or outpatient services, liaison contacts of NHS-psychiatrists or psychiatrists in prisons etc.). However, such indicators have yet to be defined.

- Conventional indicators for mental health care fail to work in the prison context due to a largely varying involvement of NHS-services into prison mental health care.

Similarly deficient is the professional training of mental health care staff, as far as specific aspects of the care for mentally ill prisoners are concerned. Neither is there any sufficient provision of such training, nor have any training standards been defined.

- Specific requirements regarding the care of mentally disordered prisoners are not sufficiently covered by the professional training of prison mental health care staff. European standards do not exist.

## Mental State Screening and Assessment

A major reason for the lack of data on the prevalence of mental disorders in prisons is the deficient implementation of state-of-the-art procedures for psychiatric screening and assessment in prison services. Neither at prison entry, nor during the prison term or prior to release are such screenings exhaustive – if any are conducted at all. Legal standards for regulating mental state assessments in prison vary remarkably. In many countries, the appointment of inadequately trained staff to perform such screenings increases considerably the risk that mental disorders or psychiatric needs of the inmates will remain undetected.

- Regular mental state screenings of prisoners that fulfil quality standards are rare across Europe.

Immediately after prison entry, every new prisoner should be screened in order to assess his mental state. Apart from being essential for any appropriate provision of mental health care, mandatory early (and subsequently repeated) screenings would enable mental disorders that were acquired before the imprisonment to be distinguished from adjustment disorders or any other mental illness that may arise during the prison term – a distinction which is crucial, since it indicates the responsibility of the prison administration to tackle unfavourable prison conditions that are likely to increase the incidence of mental health problems of prisoners during their term.

- Inadequate diagnostic procedures prevent the implementation of adequate primary, secondary or tertiary prevention programmes for the mental disorders most prevalent in prisons.

Deficient mental state assessments prior to release hinder an appropriate release planning and psychiatric after-care. As a consequence, referrals of released prisoners with mental disorders to community services or specialised after-care services are scarce.

- Due to inadequate release planning, psychiatric after-care for mentally disordered persons released from prison is deficient. This increases the risk of relapsing and re-offending.

## Treatment of Mentally Disordered Prisoners

Along with depression and psychotic disorders, drug or alcohol misuse, suicidal behaviour, and personality disorders probably pose the greatest challenges to prison mental health care. Whereas serious cases that require inpatient treatment in many countries are referred to general psychiatric or forensic hospitals, drug or alcohol misuse, suicidal behaviour, and personality disorders usually require treatment programmes that are provided on the prison premises.

The available information suggests that prisoners referred to general psychiatric hospitals or similar NHS or forensic services more or less are treated according to the local standards that are applied to non-convicted patients, too. However, it is unknown whether all prisoners in need of inpatient mental health care are referred to external services at all or if so, in time. Without such information, it is impossible to assess the effectiveness of any of the numerous models of collaboration between prison services and forensic or general psychiatric services.

The availability of treatment programmes for specific mental disorders in prisons is more difficult. As shown in this report, European prisons particularly lack treatment programmes for sex offenders and for suicide prevention. And the capacities of such programmes that are available are widely unknown; however, they most probably fall far short of covering all prisoners in need. Personality disorders seem to be particularly underserved.

- Treatment programmes for specific mental disorders in prison are not sufficiently provided.

Psychopharmacologic drug treatment in prison would be a basic indicator and the one most easy to implement, as prescriptions or expenditures for pharmacologic drugs are recorded anyway, either on a prison service level or on a prison administration level. But on a national level this data is scarcely collected and made available. However,

- the available information supports the hypothesis that psychopharmacologic drug use by prisoners may significantly exceed that of the general population.

Whether an excess prescription would be clinically justified must be analysed. If not, this would hint at a certain risk of misuse of psychopharmacologic drugs, e.g., for suicidal behaviour, drug dealing or as a pharmaceutical restraint.

## Prevalence of Mental Disorders in Prison

Given the poor mental state assessment standards in European prison systems, it is not surprising that routine morbidity data on the prevalence of mental disorders in prisons is almost completely lacking. Going back to epidemiological research findings on psychiatric prevalence in prisons would be affected by poor research activities in this field, small or selected study samples, varying diagnostic procedures and other factors likely to bias the findings. Thus, study results on psychiatric morbidity in prison samples should be generalised very cautiously. This leads to the discouraging conclusion that

- prison or health administrations throughout Europe know neither how many nor what kind of mental disorders are prevalent in the national prison systems.

This impedes any serious health care planning. At least prison suicides are annually recorded and reported by a majority of countries, probably due to certain public awareness of this most adverse prison event.

- The annual number of prison suicides is the only feasible indirect indicator for mental health problems in prisons available at the moment.

## Quality Standards and Quality Assurance, Further Action to be Taken

All countries included in this study have adopted the European Prison Rules (Council of Europe 2006) that define standards and provide a natural guideline for quality assessments in prison settings. Some, but not all problem areas outlined in this report are covered. Additionally, prisons and detention centres of all countries are regularly visited by the Commissioner for Human Rights (CHR) and the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).

Since they are standardised and acknowledged on a European level, the European Prison Rules provide an umbrella concept for improving the quality standards of all forms of detention and imprisonment, including prison mental health care. However, as this study shows,

- effective quality assurance measures for prison mental health care must be tailored to the specific problem area and require a deeper analysis

than that conducted during CHR or CPT-visits. The fields and problems addressed by this study may be seen as a guideline for improving mental health care for European prisoners.

As a basic prerequisite for any action taken, more awareness of the deficiencies and problems must be raised by responsible authorities and decision makers, both on a national and on a European level. The definition of common (European) indicators would be most crucial for the visibility and a further evaluation of the dimension of the problem.

Currently, the very few rudimentary prison mental health data that are available on a national level are not standardised.

As a proposal for a homogenised approach, table 48 lists a set of basic indicators for prison mental health care in Europe. For standardisation, the set of indicators was defined according to the structure of the long-list of the European Health Indicators Project Group (ECHI). The appropriate ECHI categories are given in the second column of table 48. Any such set should be discussed, agreed upon and approved and implemented into European as well as into national reporting systems. Annual updates of this data from as many countries as possible would be a significant step forward.

**Tab. 48 Basic Set of Prison Mental Health Indicators (Proposal)**

<b><i>Prison Mental Health Indicator</i></b>	<b><i>Corresponding ECHI-long-list indicator</i></b>
• <i>Suicides in prison/detention</i>	<i>2.2.5 (health status / mortality cause specific / mental, behavioural)</i>
• <i>Suicide attempts in prison / detention</i>	<i>2.3.5 (health status/morbidity disease specific / mental, behavioural)</i>
• <i>Health care staff in prison/detention (by physicians, psychiatrists, psychologists, nurses)</i>	<i>4.2.2 (health care resources / manpower)</i>
• <i>Psychiatrist's training for involuntary/forensic/prison treatment</i>	<i>4.2.3 (health care resources / education)</i>
• <i>Inpatient or hospital episodes of prison inmates (by selected diagnoses inc. mental disorders)</i>	<i>4.3.1 (health care utilisation / inpatient care utilisation)</i>
• <i>Referrals of prison inmates to NHS-hospitals (by selected diagnoses including mental disorders)</i>	<i>4.3.1 (health care utilisation / inpatient care utilisation)</i>
• <i>Expenditures on prison health care</i>	<i>4.4.3 (health expenditures and financing / expenditures on medical services)</i>

A further step would include the definition of more sophisticated indicators such as the appropriate staff/patient ratios for prison mental health care or the adequate infrastructure/capacity for inpatient and outpatient prison mental health care (e.g., the number of psychiatric prison hospital beds, the

number of specific treatment programmes per 1,000 prison places etc.). However, this is methodologically challenging and requires that the cross-sector problems caused by the collaboration of prison and NHS-services as well as numerous other methodological problems outlined above be surmounted.

Another important field for common European action would be the harmonisation of courses on prison mental health care to be included in national psychiatric training curricula and made a mandatory prerequisite for medical staff working in prison.

Last but not least, national and international research on psychiatric prevalence in prisons and prison mental health care must be stimulated and increased wherever possible.

### **References**

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- Council of Europe (2006) *Recommendation (2006)2 of the Committee of Ministers to Member States on the European Prison Rules*. Adopted by the Committee of Ministers on 11 January 2006.

## **5. Concepts and Procedures in European Countries**

The following section contains a more detailed description of concepts and routine practices of providing mental health care to prisoners in the countries that participated in this study. Each country is described in a separate chapter, written by the assigned national experts.

The chapters follow more or less the same structure and are meant for outlining general approaches and specific circumstances that are too complex to summarize in the tables or figures of the result section of this report.

## Austria

### Hans Schanda

#### Introduction

The old Austrian Penal Code was in force between 1852 and 1974. Its basic principles can be traced back to even 1803 (Sluga 1977). Several drafts of a completely new version elaborated since the beginning of the 20th century never came in force - not least due to the dramatic political and societal changes in Austria during these times (Schanda et al 2000). It took about 30 years after the end of the Second World War, until principal reforms of the penal and prison laws had been passed. In 1969, a new Act on Prison Law (Strafvollzugsgesetz, StVG) (Fuchs & Maleczky 2003) came into force and only in 1975 a new Penal Code (Strafgesetzbuch, StGB, Fuchs & Maleczky 2003). All this together should establish an up-to-date penal execution and a modern and humane treatment of prisoners.

This paper attends to the situation of mental healthcare in the regular prison system. Therefore, offenders who were exculpated after having committed their crimes under the influence of a mental disorder ("mentally ill offenders") are not an issue. In Austria, such offenders are exculpated (not guilty by reason of insanity, NGRI) and, in case of further dangerousness, criminally committed according to § 21/1 StGB for an indefinite period of time, "until the illness-related dangerousness is substantially reduced" (Fuchs & Maleczky 2003). However, some legal and administrative characteristics concerning placement and treatment of this group of offenders had considerable consequences for the situation of mental healthcare in prisoners: Like in other countries, the number of non-responsible mentally ill offenders is on the rise also in Austria, and possible associations with the development of modern mental healthcare are under discussion (Arboleda-Florez 1999, Gilligan 2001, Kramp 2004, Schanda 1999, 2001a, 2005a, 2005b, 2005c). But, this in contrast to other European countries, the treatment of non-responsible mentally ill offenders is in Austria under the administrative and financial responsibility of the Ministry of Justice. Therefore, their rapidly increasing prevalence (from about 110 during the 1980s to 322 in December 2005) is absorbing a disproportionately large part of the prison budget (details see paragraph 2).

The Austrian penal law provides the imposition of criminal commitment for an indefinite period of time also in case of offenders who are responsible, though committed their crimes under the influence of a "mental abnormality of higher degree" (§ 21/2 StGB, Fuchs & Maleczky 2003). The judicial term "mental abnormality of higher degree" is mainly targeting severer forms of personality disorders. Although criminally committed for an indefinite period of time, these offenders, as being responsible, also have to serve prison sentences. For this reason they are really an issue of this paper - the more as they are treated within the regular prison system. In analogy to the development in mentally ill offenders NGRI, the prevalence of responsible mentally disordered offenders is on the rise too (from about 125 during the 1980s to 335 in December 2005) (figure 1). However, the reasons for this increase may be different from that in mentally ill offenders NGRI:

Apart from §§ 21/1 and 21/2 StGB, the Austrian penal law provides another type of criminal commitment: § 23 StGB is kind of a preventive custody for dangerous repeat offenders (maximum duration ten years after the end of the prison sentence) (Fuchs & Maleczky 2003). § 23 StGB is dead law since many years with - at the moment - only one person in prison. The law says that the

imposition of § 23 StGB is only possible if the preconditions for criminal commitment according to § 21 StGB (responsible or non-responsible mentally disordered offenders) are not given (Fuchs & Maleczky 2003). In other words, § 21 StGB is not only the 'choice of higher value', it also suggests a 'liberal', 'progressive' attitude towards potentially dangerous offenders ('treatment') as opposed to preventive custody (§ 23 StGB). However, taking into account 1) the increasing tendency to impose criminal commitment according to § 21/2 StGB in case of sex offences, 2) the increasing contribution of sex offenders to the annual incidence of criminal commitments (§ 21/2 StGB) over time (36.2 percent in 1980, 61.7 percent in 1998) and 3) the increasingly restrictive discharge policy in criminally committed sex offenders since 1990 (Gutierrez-Lobos et al 2002), one can hardly presume liberalism to be the motive for this development. Rather, the obviously increasing use of § 21/2 StGB (not only in sex offences) could be interpreted as the expression of a sometimes arbitrary 'psychiatrization' of certain kinds of offending behaviour, defining it for the most part as a 'disease' in need of whatsoever 'treatment'. Additionally, we must not forget that criminal commitment for an indefinite period of time - regardless of the end of a prison sentence (§ 21/2 StGB) - may also take on the character of preventive custody behind the mask of 'therapy', especially considering the limited possibilities for offender treatment in the correctional system (see paragraphs 2 and 3).

### The structure of the Austrian prison system

Austria, a wealthy country with about 8 million inhabitants, relatively stable social structures and comparatively low crime rates disposes of 27 prisons (table 1):

- One special institution in the capital Vienna for the treatment of responsible mentally disordered offenders according to § 21/2 StGB (prison sentence plus criminal commitment for an indefinite period of time) with 147 places (Justizanstalt Wien-Mittersteig).
- Three large prisons for inmates with longer and life-long sentences with a total of 1651 places (360 - 769). All three prisons fulfil higher (some of their departments even maximum) security standards.
- Seven additional prisons with lower security standards with a total of 1707 places (112 - 423) including one for younger (and juvenile) offenders (124 places) and one for female offenders (200 places). Another one was originally designated as a special institution (113 places) for offenders criminally committed according to § 22 StGB (substance abusing offenders, Fuchs & Maleczky 2003). However, this type of criminal commitment plays a minor role in practice (during the last years only about 20 - 25 subjects in prison). Therefore this institution is used at the moment as a regular prison.
- Austria's largest court/remand prison with 1258 places, the Justizanstalt Wien-Josefstadt, lies in the capital Vienna (about 2 million inhabitants). Like all other court prisons it is occupied not only by prisoners waiting for trial, but also by prisoners with short sentences.
- The additional 15 remand prisons are attached to the major regional courts. Their capacities vary between 63 and 513 places.

The Ministry of Justice also runs a security hospital for mentally ill offenders NGRI (§ 21/1 StGB) (Justizanstalt Göllersdorf) with 120 regular beds and, additionally, an acute ward with 17 beds. The Justizanstalt Göllersdorf is not included in the data presented in table 1. However, it has to be mentioned because its acute ward serves also for the short-term treatment of acutely mentally ill inmates of Austrian prisons (see paragraph 3).

Every capital of Austria's nine Federal States disposes of one remand prison. Due to geographic and demographic situation, the seven additional ones as well as all 10 prisons exclusively lie in the Eastern part of the country. Since a couple of years the number of imprisoned persons is on the rise, leading in some prisons to an overcrowding up to 132 percent (BMJ 2004). In December 2005, 8594 inmates (including 322 responsible mentally disordered offenders, excluding 322 non-responsible mentally ill offenders and 40 mentally ill remand prisoners) are in opposition to 8,348 places in Austrian prisons (figure 1, table 1).

The administrative structure of the Austrian prison system is centralized. Several sections of the Ministry of Justice have the right of ultimate decision in questions like employment of new staff or expenditures exceeding a certain (rather moderate) level.

This leaves relatively little freedom of decision-making in the hands of the prison directors. It is a well-known fact that, for example, changes of the working schedule of prison officers or other structural changes have an impact on the personnel costs. Vice versa, savings on the staff sector have an impact on the operational procedures of a prison and maybe also on questions of security. Therefore the division of responsibilities into several sections of the Ministry of Justice - with sometimes competing interests - may lead to a slowing down of decision-making. Naturally, this problem becomes more evident in times of budgetary restrictions. It is planned for the future to unite relevant parts of the respective sections to a control centre for all issues concerning the Austrian prison system.

In 2005, the entire prison budget came to 291,960,000 €. Since 1999, it increased by 32.7 percent. Its several items showed quite different developments: The wage costs only went up from 130,234,053 € to 144,751,000 € (plus 11.1 percent), 'general expenditures', however, from 89,713,887 € to 147,209,000 € (plus 64.1 percent). Apart from food, basic commodities, financial remuneration for prisoners etc., the item 'general expenditures' includes the costs for healthcare in prison (medication, treatment in outpatient clinics, general and psychiatric hospitals). One has to take into account that the expenditures for external hospital treatment also include the costs for the treatment of mentally disordered offenders NGRI (§ 21/1 StGB) in psychiatric hospitals. As mentioned above (paragraph 1), their number rapidly went up since the 1980s. In 1990, their prevalence was 129, in 2000 231 and in 2005 even 322 (plus 40 mentally ill remand prisoners). Until about 1990, the capacity of the justice-owned institution (Justizanstalt Göllersdorf with 120 beds, see above) suffices for the treatment of the majority of non-responsible mentally ill offenders, and only up to 25 percent had to be placed in general psychiatric hospitals. (The daily costs per bed in psychiatric hospitals exceed by far those in the Justizanstalt Göllersdorf.) Due to the steadily increasing prevalence of non-responsible mentally ill offenders the share of those treated in psychiatric hospitals went up to about 66 percent during the last few years. This development has enormous budgetary consequences: In 1989, the expenditures for the treatment of offenders NGRI in psychiatric hospitals came to 28,000,000 ATS ( $\approx$  1,900,000 €), in 1999 to 144,000,000 ATS ( $\approx$  9,800,000 €) and in 2005 even to 22,800,000 €, i.e. an increase of 132.7 percent only between 1999 and 2005. (Remember that the entire prison budget increased during the same time by 32.7 percent.)

Unfortunately, we do not dispose of regular detailed breakdowns of the item 'general expenditures'. However, in 2004 a commission reported data concerning the situation in 2003/2004: The healthcare budget in 2003 was 32,000,000 €. This amount includes 24,500,000 € for external hospital treatment, 17,800,000 € (or 72.7 percent!) of which had to be spent for the treatment of mentally ill offenders NGRI in psychiatric hospitals (BMJ 2004). That means that in 2003 2.3 percent of the entire prison and special hospital population (i.e. those two thirds of all mentally ill offenders NGRI who had to be treated in psychiatric hospitals due to the limited capacity of the Justizanstalt Göllersdorf) took up 55.6 percent of the entire healthcare budget for nearly 8,500 inmates.

Additionally, the Justice budget is confronted with increasing costs for the aftercare of discharged mentally ill offenders NGRI (§ 21/1 StGB). During the last years the general mental health system tries to pass on the administrative and especially financial responsibility for this group of mental patients to the Justice system even after discharge. In this context, the administrative bodies of Austria's Federal States usually refer to the fact that the discharge of these patients is (by law) always conditional. They take the view that the courts (or the Ministry of Justice) have to take on the costs for every further psychiatric treatment because this is the usual precondition for discharge (Schanda et al 2006). In 2005, the expenditures for the aftercare of discharged mentally ill (mostly non-responsible) offenders came to about 2,850,000 €, while the budget for the aftercare of discharged regular prisoners was only 203,000 €.



Figure 1: Prevalence (December each year) of regular prisoners and responsible mentally disordered offenders (§21/2 StGB), Austria 2000 – 2005

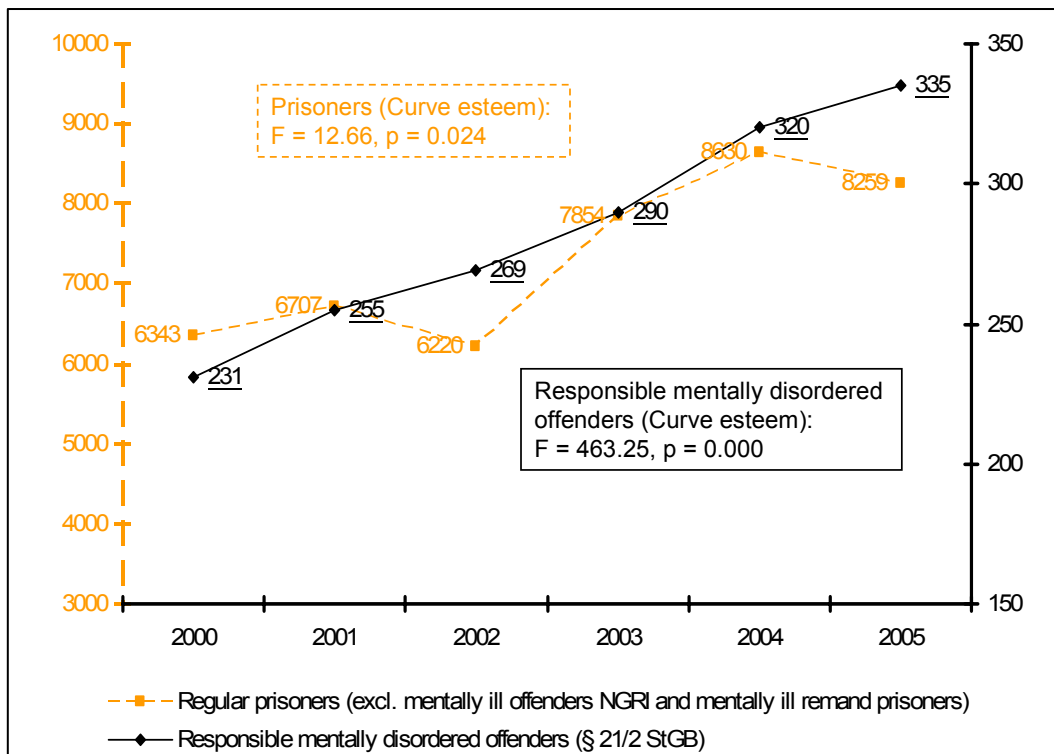


Table 1: Medical and mental health services in the Austrian prison system<sup>1)</sup>

	Capacity (min - max)	Medical wards n/beds	Psychiatric wards n/beds	Full-time equivalents of employed/contracted			
				Physicians	Psychiatrists	Psychologists	Nursing staff
<b>1 forensic institution<sup>2)</sup></b>	147	–	– <sup>2)</sup>	1.1	2.5	9.1	3
<b>10 prisons</b>	3358 (112 - 769)	7/146	–	4.46	4.34	22.78	9.5
<b>3 for inmates with longer sentences</b>	1651 (360 - 769)	3/124	– <sup>3)</sup>	3.4	2.33	7.58	6
<b>+ 7 additional prisons</b>	1707 (112 - 423)	4/22	–	1.06	2.01 (1 x 0)	15.2	3.5 (1 x 0)
<b>16 court/remand prisons</b>	4843 (63 - 1258)	13/186	(2/25) <sup>5)</sup>	6.43	3.7 (4 x 0)	17.48	36.85 <sup>6)</sup> (4 x 0)
<b>1 central court/remand prison</b>	1258	1/76	(1/13) <sup>5)</sup>	2.5	2	6	23
<b>+ 15 additional court/remand prisons</b>	3585 (63 - 513)	12/110 (2 - 25)	(1/12) <sup>5)</sup>	3.93	1.7 (4 x 0)	11.48 (4 x 0)	13.85 <sup>6)</sup> (4 x 0)
	8348	20/332 (22/352) <sup>4)</sup>		11.99	10.58	49.36	49.35 <sup>6)</sup>

<sup>1)</sup>Special institution for mentally ill offenders NGRI (§ 21/1 StGB) (Justizanstalt Göllersdorf) not included; <sup>2)</sup>Forensic-psychiatric institution for responsible mentally disordered offenders (§ 21/2 StGB = prison sentence + criminal commitment); <sup>3)</sup>All three with special departments for responsible mentally disordered offenders (§ 21/2 StGB), total capacity 177 places; <sup>4)</sup>Plus two closed wards in general hospitals, total capacity 21 beds; <sup>5)</sup>Special wards for mentally ill remand prisoners and mentally ill offenders NGRI; <sup>6)</sup>Seven out of the full-time equivalents exclusively for a special ward for mentally ill remand prisoners and mentally ill offenders NGRI in one remand prison.

Data source: Ministry of Justice 2006; Projektgruppe, Ministry of Justice 2004

## Medical and mental healthcare provision

The basic medical care is maintained in every of the 27 prisons by (mostly part-time employed) physicians (usually GPs) and dentists. Table 1 shows the equipment of the prisons with medical wards and the numbers of medical/psychiatric staff (full-time equivalents).

All three prisons for inmates with longer sentences and four out the other seven prisons dispose of medical wards with a total of 146 beds for 3,358 inmates. In the former the ratio bed/inmates is by far better (1/13 versus 1/76). The central remand prison in Vienna with a capacity of 1,258 places has a large medical ward with 76 beds (ratio beds/inmates 1/17), all other remand prisons - with the exception of three small ones - have medical wards with capacities varying between two and 25 beds (ratio bed/inmates 1/33). Additionally, the Ministry of Justice is funding two closed wards in general hospitals, exclusively reserved for physically ill prisoners (total capacity 21 beds).

As mentioned above, responsible mentally disordered offenders (§ 21/2 StGB, prison sentence plus criminal commitment for an indefinite period of time) are treated within the prison system. The special institution designated for the treatment of these offenders (Justizanstalt Wien-Mittersteig) disposes of 147 places. Every of the three large prisons has special departments for responsible mentally disordered offenders with, until 2005, a total capacity of 39 places. As the entire capacity (147 + 39 = 186 places) did not suffice for the steadily increasing number of responsible mentally disordered offenders (in 1990 129, in 2005 even 335, see figure 1), a substantial number of them had to be kept with nearly no specific treatment in the general prison setting. For this reason the special departments in the three large prisons had been enlarged in 2006 (from 39 to 177 places). However, this is for a considerable part a mere exchange of labels, as the numbers of special staff have not been substantially increased.

Two of the 16 remand prisons have psychiatric wards with a total capacity of 25 beds (table 1). However, these beds are almost exclusively designated for mentally ill remand prisoners (most of them to be exculpated and criminally committed according to § 21/1 StGB) and for already criminally committed offenders NGRI. These psychiatric wards have been set up to somewhat reduce the exploding costs for the treatment of this group of offenders in the general psychiatric hospitals (see paragraph 2). Taking all this together, the Austrian prison system does in fact not dispose of a psychiatric ward exclusively designated to the treatment of acutely or chronically mentally ill regular prisoners.

The staff of the Austrian prison system comprises about 3,000 prison officers and about 320 employees for administration and healthcare (physicians, psychologists, social workers, nurses). Table 1 shows the numbers of medical/psychiatric staff.

In general, the situation concerning specialist staff is rather poor. At present, the medical and psychiatric treatment of 8,594 inmates - including responsible mentally disordered offenders (§ 21/2 StGB) - has to be ensured by 11.99 physicians, 10.58 psychiatrists, 49.36 psychologists and 49.35 nurses (full-time equivalents). (The personnel of the central institution for mentally disordered offenders NGRI and of the two medical wards in general hospitals is not included in these figures.) Eighteen percent of the entire capacity of psychologists (9.1.out of 49.36) is bound to the special forensic institution for the treatment of responsible mentally disordered offenders (§ 21/2 StGB) (Justizanstalt Wien-Mittersteig). Therefore, only 40.26 full-time equivalents are available for the psychological treatment of the inmates of all other prisons (table 1).

Table 1 shows that only 7.58 psychologists (and 2.33 psychiatrists) are responsible for the psychotherapeutic/psychiatric care of the more than 1,600 inmates of the three large prisons. One has to be aware that the recently enlarged special departments for responsible mentally disordered offenders (§ 21/2 StGB) with a total of 177 places are located there. The situation of the seven other prisons (1,707 places) and the 16 remand prisons (4,843 places) is not really better. The prisons try to compensate the obvious deficits concerning trained psychologists by the delegation of (group) therapies to external psychologists. These are usually contracted only for a few hours per week, and their number depends on the needs and the budget of the respective prisons. The reason for this

procedure lies in the economy measures of the Austrian government concerning the numbers of employed staff in federal institutions like the prison services. At the moment, there is nearly no possibility to increase the number of full-time equivalents of employed staff. However, the prisons' budgets for extra expenditures are variable and allow - to a certain extent - the payment of external psychologists.

In table 1 one can see that nearly 50 percent of the entire nursing staff is concentrated at the medical ward of Vienna's large remand prison. Moreover, seven out of the full-time equivalents are bound to the special ward for mentally ill remand prisoners and mentally ill offenders NGRI (§ 21/1 StGB) in one remand prison. Therefore, all other prisons, even those with departments for responsible mentally disordered offenders, dispose of only a few full-time equivalents of nursing staff.

Specific professional training or additional diplomas are not legally required for work in the medical prison services in Austria. However, the Ministry of Justice tries to improve the qualification of the specialist staff by providing and supporting vocational training.

Prisoners undergo a mandatory general medical examination when entering prison and immediately before discharge. A mental health assessment is not stipulated. The contact to a psychiatrist or psychologist is only arranged if the prisoner himself is asking for it, or if a prison officer or any other member of the prison staff concludes from the behaviour of an inmate that a mental health assessment might be necessary. There are several pathways to psychiatric treatment for prison inmates:

- If a prisoner wants to contact a psychiatrist or psychologist, this is usually possible without any further screening concerning reasons or necessity. Delays may be inevitable due to the sparse presence especially of the former (usually only a few hours per week, in some cases even per month).
- Only a few prisons have the possibility to reach their physicians and psychiatrists outside their working hours. Therefore, in case of essential, urgent interventions (acute psychosis, risk of suicide, suicidal behaviour, acute withdrawal symptoms) the prisoners are sent for assessment to the regional psychiatric hospitals or to the Justizanstalt Göllersdorf (Austria's central institution for the treatment of mentally ill offenders NGRI), occasionally also to private practices of psychiatrists. The decision what to choose primarily depends on urgency, distance between the respective prison and the Justizanstalt Göllersdorf, in some cases also on a prisoner's dangerousness. If inpatient treatment is necessary, the prisoners are admitted either to the one of the regional psychiatric hospitals or to the Justizanstalt Göllersdorf. However, the willingness of the hospitals to accept prisoners as inpatients is sometimes rather low - especially in case of reservations concerning security. The prisons on their part are confronted with the problem of guarding of a prisoner while in hospital. (According to the regular duty rota of prison officers, one person ordered off to guarding blocks three officers for the routine in the prison.) A transfer to the Justizanstalt Göllersdorf depends not only on the geographical situation, but also on the free capacities of its acute ward (17 beds, which have to serve also for the non-responsible offenders treated there) (Schanda 2001b). After the improvement of their acute symptomatology the prisoners are usually sent back to prison. As a consequence of the situation described, the prison budget is additionally charged with the costs of sometimes inevitable transfers of inmates to psychiatric hospitals. In 2005, the Ministry of Justice had to pay 1,974.373 € for a total of 5685 treatment-days of regular prisoners in psychiatric hospitals. Therefore, many prisons use in less severe cases their general medical wards for psychiatric interventions.
- In case of a chronically impaired mental condition of prisoners, prison staff tries to treat them as far as possible by means of their own (rather limited) resources. In analogy to the situation in acute mental conditions, transfers to the prisons' own general medical wards represent an alternative to an administratively difficult and expensive stay in a psychiatric hospital. This situation explains that up to 80 percent of the admissions to general medical prison wards are due to mental health problems (BMJ 2004).

Until recently, no prison disposed of a physician present during the night hours and only a few had a physician on call. Meanwhile, at least the medical ward of the large remand prison in Vienna (76 beds) is supplied with physicians 24 hours per day. The situation concerning nursing staff is similar. The presence of nurses around the clock is possible only in the aforementioned large medical ward of Vienna's large remand prison.

The situation on the mental health staff sector answers for the most part the question concerning any systematic and intensive programmes within the regular prison system for certain groups of offenders like sexual offenders or offenders repeatedly exhibiting severe violence. The only exception is the special judicial institution for the treatment of responsible mentally disordered offenders: The Justizanstalt Wien-Mittersteig is able to offer a special programme for nearly all of its inmates. Starting with a behaviour-therapeutically oriented basic group, the inmates have to pass six therapeutic modules including the promotion of emotional stability, one year of behaviour-modifying group therapies (Hanson et al 2002, Marshall et al 1999), cognitive behaviour therapy for substance abuse and group therapy focussing on empathy. The whole programme lasts 24 months and is followed by supportive individual psychotherapy, to be continued over several years. Up to now, attempts to implement this ambitious programme in the special departments for responsible mentally disordered offenders in the three large prisons are at its very beginning due to the lack of specialist staff there.

Additionally, since a few years, every offender newly admitted according to § 21/2 StGB (Fuchs & Maleczky 2003) is assessed in the Justizanstalt Wien-Mittersteig for several weeks. Apart from clinical interviews and psychological testing, the assessment comprises the application of diagnostic and prognostic instruments like ICD-10 (WHO 1991), DSM-IV (APA 1994), PCL-R (Hare 1991) HCR-20 (Webster et al 1997), SVR-20 (Boer et al 1997), Static 99 (Hanson & Thornton 1999), and Stable 2000 (Hanson & Harris 2000). After the completion of the assessment the offenders are usually sent back to their prisons of origin with recommendations concerning further treatment. However, as mentioned above, the major problem is the translation of these recommendations into prison practice. Because of the limited capacity of the Justizanstalt Wien-Mittersteig, waiting times are unavoidable (approximately three months for offenders with prison sentences of less than two years, up to 12 months for offenders with prison sentences of less than five years, about 18 months for offenders with prison sentences of more than five years) (BMJ 2005).

However, the majority of sexual offenders is not criminally committed according to § 21/2 StGB, but sentenced to prison only (Eher et al 2006). To screen as many sexual offenders as possible - and also offenders exhibiting (repeated) severe violence - with respect to future dangerousness and possibilities for treatment, a Center for Documentation and Assessment located in the branch of the Justizanstalt Wien-Mittersteig was opened in 2002. The aim was to select offenders with a high probability for re-offending by means of current diagnostic and prognostic instruments to concentrate the extremely limited resources on this group (BMJ 2005). Since 2002, nearly 300 sexual offenders have been assessed, about 15 - 30 percent of them were considered to be of a high risk for re-offending (Eher et al 2006). Again, the realization of the Assessment Center's therapeutic recommendations in the several prisons is the major problem in practice.

It is not stipulated by the law to refer mentally disordered prison inmates to psychiatric outpatient services after discharge. However, nearly all of them are prepared for discharge. Especially in inmates with severe mental illness or in inmates supposed to be dangerous, the (mental health) staff of the prison services tries to achieve a premature (conditional) discharge, usually linked to conditions like medication, psychotherapy or abstinence of alcohol and drugs. In case of a conditional discharge, of course, the referral to aftercare is obligatory. Many outpatient clinics and other community services are reluctant to take over the (after)care of discharged mentally ill prisoners. Therefore the Ministry of Justice is increasingly pushing ahead the installation of own (forensic) aftercare facilities. At the moment it is funding eight outpatient clinics, however primarily for discharged non-responsible and responsible mentally disordered offenders (§§ 21/1 and 21/2 StGB). The Ministry of Justice is also funding six residences (total capacity 136 beds), again primarily for discharged non-responsible and responsible mentally ill/disordered offenders (§§ 21/1 and 21/2 StGB). Occasionally, also discharged mentally ill prison inmates can be admitted there.

## Epidemiology of mental disorders

In Austria, the situation with respect to epidemiological mental health data of prisoners is very poor. We do not even dispose of centrally collected basic information concerning diagnoses, comorbidity rates, rates of prisoners under psychopharmacological medication, etc. The charts of the physicians working in prison are only sufficient to ensure the continuity of treatment in case of the transfer of an inmate from one prison to another. The only systematic data stem from an unselected sample of only 100 remand prisoners (95 percent male, Austrian citizens only): Sixty-nine percent had at least one psychiatric diagnosis (personality disorders not recorded!) (Brandstätter et al, unpublished data). This result allows the conclusion that the mental health situation of Austrian prisoners may not be different to that of other countries (Blaauw et al 2000, Brink 2005, Fazel & Danesh 2002, Fazel & Lubbe 2005).

After being stable over a longer period of time, the annual suicide rates in Austrian prisons increased remarkably since 1975 (Frottier et al 2001), while the suicide rates of the Austrian general population remained stable during the same time. This is in concordance with international data (Matschnig et al 2006). 55.6 percent of the suicides could be registered in remand prisoners, 39.5 percent in regular prisoners and 4.9 percent in criminally committed mentally ill/disordered offenders (§§ 21/1 and §§ 21/2 StGB) (Frottier et al 2001). Therefore, the training of staff in suicide prevention is a issue of major importance for the prison administration. It is hypothesized that the increase of prison-suicides is a consequence of the increase of severely mentally ill and disordered subjects in prison (Ashraf 1999, Fazel & Danesh 2002, Frottier et al 2001, Gilligan 2001) - the latter being a consequence of an internationally observable reluctance (or inability?) of the general mental health services to provide sufficient long-term treatment for these patients (Arboleda-Florez 1999, Gilligan 2001, Schanda 1999, 2005a, Schanda et al 2006).

## Quality standards, ethical aspects

Austria signed the European Prison Rules (Council of Europe 2006) and is therefore obliged to meet the commitments established there. The principles of medical and mental healthcare in prison are defined in the Act on Prison Law (StGB, Fuchs & Maleczky 2003): §§ 66, 68, 70, 73 - 80 StVG regulate along general lines the health standards in prison and the access to social and medical care as well as issues of health insurance, § 167a StVG the transfer to general or psychiatric hospitals, and §§ 164 and 166 StVG the treatment of responsible mentally disordered offenders (§ 21/2 StGB) (Fuchs & Maleczky 2003). § 166 StVG says that these offenders have to be “psychiatrically, psychotherapeutically ... and pedagogically” treated (Fuchs & Maleczky 2003). However, the aforementioned situation with respect to specialist staff (see paragraph 3, table 1) meets these legal guidelines at best in the forensic institution for the treatment of responsible mentally disordered offenders (Justizanstalt Wien-Mittersteig), but hardly in the special departments of the three large prisons.

Rule 89.1 of the European Prison Rules says that the prison-staff should include ‘as far as possible’ a sufficient number of psychiatrists, psychologists, social workers etc. (Council of Europe 2006). However, defining ‘as far as possible’, one has to refer to the financial situation and the standards of general mental health care of a country. We know that there are remarkable differences within Europe. The question in practice is, to which extent a country is able and willing to invest adequate parts of its budget to keep the gap between general and prison mental healthcare as small as possible. Regarding this, the situation of the Austrian Ministry of Justice is somewhat difficult due to the aforementioned additional financial burden (see paragraphs 2 and 3).

In Austria, there are no adaptations, alterations or supplemental agreements to the European Prison Rules. Details with respect to quality and quality control in prison (also concerning mental healthcare) are compiled in a variable collection of ministerial decrees. Representatives of the Ministry of Justice visit the prisons unexpectedly in irregular intervals. External controls are performed by the ‘Vollzugskommissionen’ (committees consisting of judges and representatives of the general health authorities). These committees make unannounced visits to all prisons at least once a year and have the right to interview every inmate in the absence of prison staff. The prisons have to provide any

information required. The 'Vollzugskommissionen' send reports about their visits to the Ministry of Justice. Complaints concerning decisions of a prison director - also in (mental) healthcare issues - can be directed to the local 'Vollzugskammer'. The 'Vollzugskammern' are located at the regional Higher Courts and consist of independent judges and representatives of the prison administration (§ 11a StVG, Fuchs & Maleczky 2003). Prisoners can also write uncensored letters to lawyers, to all members of the Parliament, to the Ministry of Justice and to international institutions like the Human Rights Commission or the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).

Medical experiments with prisoners are prohibited in Austria (§ 67 StVG, Fuchs & Maleczky 2003). House arrests in case of infringement of prison regulations must not be executed against the physician's advice (§ 117 StVG). Forced feeding is only allowed with permission of the Ministry of Justice and under the control of a physician (§ 69 StVG). Concerning involuntary psychopharmacological treatment, different regulations exist depending on where the prisoner is treated: In a general psychiatric hospital, he or she undergoes - like every civil patient - the civil commitment regulations. Within the prison the application of an involuntary medication is only possible after a written permission of the Ministry of Justice (§ 69 StVG, Fuchs & Maleczky 2003).

The principles of medical confidentiality in prison are in general comparable to that in civil patients. However, a few exceptions do exist: 1) The director of a prison has access to the files. 2) In case of imminent violence or danger to self or others the treating physician, psychiatrist or psychotherapist has to inform the prison director who may pass on relevant information to the non-medical prison staff responsible for the prisoner. 3) As courts base their decisions concerning conditional discharge in mentally disordered prisoners for a good part on psychiatric assessments, they naturally receive the relevant information. 4) Additionally, the Ministry of Justice has the possibility to require a written report on the mental state of a prisoner.

## Comment

Officially, mental health care in prison is considered to be an issue of relevance for Austrian psychiatry and its influential representatives. However, for many years, this interest did not exceed mere lip-service. Activities came only from the Ministry of Justice and from the two special institutions for the treatment of mentally ill/disordered offenders (Justizanstalt Göllersdorf, Justizanstalt Wien-Mittersteig). Only during the last years one can notice increasing interest among psychiatrists working in general psychiatric institutions.

Concerning human rights, contacts with the outside world and standards of accommodation and hygiene, the situation in Austrian prisons corresponds with the principles of the European Prison Rules (Council of Europe 2006). However, concerning several details of mental healthcare, shortcomings are obvious (see paragraphs 3 and 5). International studies report on increasing numbers of prisoners and enormous problems with overcrowding (Blaauw et al 2000), high (and even increasing) rates of disturbed and mentally ill subjects in prison (Arboleda-Florez 1999, Fazel & Danesh 2002, Gilligan 2001) and, as a consequence, on increasing suicide rates (Ashraf 1999, Frottier et al 2001, Joukamaa 1997).

Despite the partly insufficient situation with respect to epidemiological basic data, we have enough evidence to assume that our situation is comparable to that of other European countries. In Austria, the prevalence rates of prisoners and especially of responsible mentally disordered offenders (§ 21/2 StGB) are on the rise too (see figure 1). The number of transfers to general mental healthcare institutions is high, and the general medical prison wards are occupied up to 80 percent by mentally disordered prisoners (BMJ 2004, Schanda 2001b, see paragraphs 2 and 3).

The very limited resources concerning specialist staff are for the most part concentrated on a few institutions (see paragraph 3, table 1), and the actual strengths of psychologists, nurses and social-workers lie - despite a few punctual improvements between 2001 and 2004 - behind the authorized strengths (BMJ 2004, Schanda 2001b). As a consequence, these deficits have to be increasingly compensated by prison officers. To make matters worse, the number of prison officers was reduced

between 2001 and 2004 by 4.5 percent while the prison population increased during the same period by 27.3 percent (BMJ 2004).

In 2001 and 2004, two expert reports listed a number of issues to improve the situation of mental healthcare in Austrian prisons (BMJ 2004, Schanda 2001b):

- The number of specialist staff has to be substantially increased.
- Rule 12.1 of the European Prison Rules says that ‘persons suffering from mental illness and whose state of mental health is incompatible with detention in a prison should be detained in an establishment specially designed for the purpose’, Rule 45.1 that ‘specialised prisons or sections under medical control shall be available for the observation and treatment of prisoners suffering from mental disorder or abnormality ...’ (Council of Europe 2006). As mentioned above (see paragraph 3, table 1), the Austrian prison system does not dispose of psychiatric facilities exclusively (or at least primarily) designated for the treatment of acutely or chronically mentally ill regular prisoners. Therefore it needs at least three smaller psychiatric departments for the treatment of acutely mentally ill prisoners. These departments should be attached to geographically suited court (remand) prisons and have to be sufficiently staffed to substantially reduce the number of transfers to general psychiatric hospitals. Additionally, the Austrian prison system deserves one department for chronically mentally ill prisoners, especially for those with long-term sentences and higher security needs.
- The documentation has to be adapted to international standards to ensure the availability of basic epidemiological data.

At first sight, the transfer of these issues into practice seems to be only a budgetary question. Due to the economy measures of the government the possibility to substantially improve the situation of mental healthcare for regular prisoners and responsible mentally disordered offenders (§ 21/2) is limited. However, these limitations cannot be solely ascribed to general economy measures, as the prison budget is burdened with the excessive increase of the expenditures for the relatively small group of non-responsible mentally ill offenders (§ 21/1 StGB, see paragraph 2). In other words, the ability of the Austrian prison system to sufficiently meet its legal duties concerning mental healthcare is at least partly impeded by the internationally well-known tendency to move an increasing portion of difficult-to-treat (and cost-intensive) mental patients from the general mental health services to the correctional services (Arboleda-Florez 1999, Gilligan 2001, Kramp 2004, Schanda 1999, 2001a, 2005a, 2005b). In Austria, the situation becomes even more obvious due to the fact that - in contrast to many other countries - the correctional system has taken on the full financial and administrative responsibility for an unsolved issue of general mental healthcare (Schanda 2005b, Schanda et al 2006). For this reason, the problems described cannot be reduced to a budgetary issue. The Ministry of Justice will not be able to work out solutions exclusively within its own field. A fundamental improvement deserves political strategies beyond the narrow borders of the prison system.

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## Belgium

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### Management of the penitentiaries

Belgium (10.4 million inhabitants) is a complex federal state with three regions (Flanders, Wallonia and Brussels-capital) and three communities (Dutch-speaking, French-speaking and German-speaking). The justice department is an exclusive Federal matter, but community treatment after release from a penal institution is also a matter of the distinct regions.

The Directorship-General Penitentiaries (further DG Penitentiaries) is part of the Federal Public Service Justice and is responsible for a transparent and efficient execution of prison sentences. The central management supervises and supports the local prisons, deals with individual records of detainees and manages the staff. The penitentiaries are in charge of the execution of prison sentences and measures.

The activities of the DG Penitentiaries are located on three management-levels: on a central level for corporate planning, on a regional level for tactical enforcement and on a local level for operational implementation. The organizational culture of the central management is based on three pillars. The pillar 'Development of management' is formed by account managers who are responsible for the actual management of the external services. Within the pillar 'promotion of expertise' penological principles are developed and implementation is in preparation. The pillar 'Inspection' organizes permanent internal supervision on the execution of the tasks (central and logistic tasks).

In the year 2000 the budget of DG Penitentiaries was 261,545,021 euro, which represents approximately 24 % of the global budget of the Federal Public Service Justice (1,103,550,830 euro). The budget of the DG Penitentiaries grows steady over the recent years (Ministerie van Justitie, 2000).

### Structure of the penitentiaries

On the 30<sup>th</sup> of December 2005 there are 33 penitentiaries in Belgium. They are regionally decentralized but all of them are owned and ruled by the federal state: 15 in Flanders (Dutch-speaking Belgium, 6 million inhabitants), 15 in Wallonia (French-speaking Belgium, 3.4 million inhabitants) and 3 in Brussels (bilingual capital region, 1 million inhabitants). Ten penitentiaries have a psychiatric unit for the placement and treatment of mentally ill offenders ('internees') and mentally disordered prisoners.

The Belgian penitentiaries are divided in 32 prisons and 1 institute of social protection (Paifve in Wallonia). Two prisons in Flanders (Merksplas and Turnhout) have a division of social protection. A suspected or convicted person who is held responsible for his acts will be detained in prison (prisoner). An accused person who has committed a crime or an offence and who is either in a state of insanity, or in a state of severe mental unbalance, or in a state of severe mental deficiency rendering him/her incapable of controlling his/her actions will be placed in the institute or division of social protection ('internment').

A classification based on the capacity of the penitentiaries is operated by the DG Penitentiaries:

- First class: Andenne, Antwerpen, Brugge, Forest, Gent, Hasselt, Ittre, Jamioulx, Lantin, Leuven-Centraal, Merksplas, Mons, Paifve, Saint-Gilles and Saint-Hubert
- Second class: Dendermonde, Hoogstraten, Leuven-Hulp, Marneffe, Namur, Nivelles, Oudenaarde, Tournai, Turnhout, Verviers en Wortel
- Third class: Arlon, Berkendael, Dinant, Huy, Ieper, Mechelen, Ruiselede

On the 30<sup>th</sup> of December 2005 the total capacity of all penitentiaries was 8.475 places. Nine penitentiaries (Andenne, Antwerpen, Brugge, Forest, Hasselt, Ittre, Lantin, Merksplas and Saint-Gilles) have a capacity of about or more than 400 detainees.

In Belgium, as in most European countries, the chronic overcrowding of prisons is an issue that has received a central place in penal policy and academic discussions on the prison system. At the beginning of 2007, the 'historical' milestone of a total daily population of 10,000 prisoners was exceeded. An important category considered responsible for prison overcrowding is the group of prisoners remanded in custody (Deltenre & Maes, 2004). The daily population on the 31<sup>st</sup> of June 2006 measures 9.535 persons<sup>1</sup>.

Major regional differences are registered between the north (Flanders, Dutch-speaking Community) and the south (Wallonia, French-speaking Community) of the country. Walloon penitentiaries incarcerate proportionately more long-sentence-detainees, more sexual abusers and more mentally retarded persons than Flemish penitentiaries (Ministerie van Justitie, 2000). The regional difference may partially be explained by the lack of quality control on psychiatric assessments.

## Prisons

Belgian prisons<sup>2</sup> are divided in remand prisons (24) and convict prisons (8). The majority of the prisons are so-called remand prisons: penitentiaries where people are incarcerated in application of the Pre-trial Detention Act of the 20<sup>th</sup> of July 1990<sup>3</sup> (suspects and defendants). In practice remand prisons contain a mixed population of suspects, defendants and convicted persons. Convict prisons incarcerate only people who are convicted by the court to an effective prison sentence (Ministerie van Justitie, 2000).

Convict prisons can be divided in three levels of security. Open prisons ensure the security by an educational regime which is based on a voluntary accepted discipline and where common methods of coercion are applied only if necessary. In a semi-open prison detainees spend the night in secured cells and the daytime outside or at a workplace. Closed prisons have a detention regime with high level of environmental security (escape-proof wall, bars, detection equipment, etc.).

Psychiatric units are organized in ten prisons (Antwerpen, Forest, Gent, Jamioulx, Lantin, Leuven-Hulp, Merksplas, Mons, Namur, Turnhout). Psychiatric prison units are occupied by internees and detainees (pre- and post-trial) who suffer from a mental disorder. On the 15<sup>th</sup> of July 2001 the psychiatric prison units counted 337 beds. On that time a complement of 454 patients was registered. Psychiatric prison units are fully managed by the DG Penitentiaries and quality control by health authorities is not applicable. As a consequence the overall level of provided care, from a medical point of view, is unacceptably low.

## Institute and Divisions of Social Protection

An accused person who has committed a crime or an offence and who is either in a state of insanity, or in a state of severe mental unbalance, or in a state of severe mental deficiency rendering him/her incapable of controlling his/her actions will be interned. Internment is not a punishment but a

<sup>1</sup> Prisoners on electronic monitoring in the community are excluded (n = 493).

<sup>2</sup> There are 33 penitentiaries in Belgium which are divided into 32 prisons and 1 institute of social protection.

<sup>3</sup> Pre-trial Detention Act: Wet 20 juli 1990 betreffende de voorlopige hechtenis, B.S., 14 augustus 1990, 15779.

measure of social protection for an undetermined period of time. From that time onwards the interned person is subject to the decisions taken by a Social Protection Committee which is composed of presiding magistrate, a lawyer representing the bar and a psychiatrist. The Social Protection Committees are competent to designate, in complete independence, the place of confinement (Social Protection Act, 1964<sup>4</sup>).

The Social Protection Committee may confine mentally ill offenders (internees) in an institute or divisions of social protection. On the 31<sup>st</sup> of March 2005 the institute of social protection of Paifve houses 160 internees. Divisions of Social Protection are attached to the prison of Merksplas (272 internees) and the prison of Turnhout (51 internees).

## **Medical Services and Mental Health Care Provision in Prison**

### ***Penitentiary Health Service***

Belgium has a well developed and accessible health care system for all citizens but persons incarcerated in a penal institution, be it on remand, convicted or interned, are by law excluded from the benefits of Social Security. As a consequence, the Federal Public Service Justice organizes medical services within the penitentiaries. Health care and treatment, somatic as well as psychiatric, are totally free for inmates (incarcerated patients pay nothing, while outside the prison some money must be paid according the rules of the social security system).

Until ten years ago, medical services of penitentiaries were completely managed by the administration of the DG Penitentiaries. The senior medical officer was responsible for the organization and coordination of medical services in prison and advised the Minister of Justice on medical issues within the prison system. External audit of budget and staff suggested major management changes. As a result of this, the Central Medical Service was established in 1997. The penitentiaries made more often an appeal to self-employed caregivers and the Central Medical Service managed his own finances. The work of the Commission 'Legal Status of Detainees Act' and the European recommendations on medical services in prison made an on-going evolution necessary. The Central Medical Service was in 2000 transformed to the Penitentiary Health Service. This service is responsible for the organization, management, supply and supervision of health care (more than only somatic medical care) in penitentiaries.

A senior medical officer is the leading manager of the Penitentiary Health Service. The assignments of this service are the global management of health care, the medical management (cure and prevention), internal management (quality standards and inspection), staff management, educational management, financial management, development and management of electronic databases, consultation and cooperation with internal health services (service for prevention and protection at work, Service for labour medicine) and external services (health promotion, control of tuberculosis, drug-aid).

### ***Psychosocial service***

The psychosocial service is structured on local, regional en central level. Within each penitentiary a psychosocial team is present. The prison manager, psychiatrist(s), psychologist(s), social worker(s) and administrative collaborator are part of the psychosocial service. Prisons with a psychiatric unit may complete their psychosocial service with a psychiatric nurse, ergotherapist and psychomotor therapist. The psychosocial services at the prisons of Andenne, Brugge, Hoogstraten, Jamioulx, Lantin, Leuven-Centraal, Marneffe, Merksplas, Mons, Saint-Hubert and the institute of social protection of Paifve are also specialized in the evaluation of sex offenders.

Social worker's inspectors and psychologists-directors are active on the regional level. They support the social workers and psychologists and assess the quality of their work.

<sup>4</sup> Social Protection Act: Wet 1 juli 1964 tot bescherming van de maatschappij tegen abnormalen, gewoontemisdadigers en plegers van bepaalde seksuele strafbare feiten, B.S. 17 juli 1964, 7818.

At the central level a senior medical officer, administrative officer, adjunct-director, two psychologists-directors and two administrative collaborators set out the policy of the psychosocial service.

### **Assignments**

The social worker is responsible for the reception of each detainee who enters a penitentiary. During these talks the social worker will assess the direct social consequences of imprisonment and inform the detainee on the detention environment, the existing services for assistance (social assistance, mental health service, public social service, agency of work mediation, professional education, etc.) and the role of the psychosocial service. A first assessment of the problems will be carried out and referral to a psychiatrist or psychologist is possible. In most prisons the reception of detainees by the social worker is carried out within 1 to 5 days. There is no systematic reception in the overcrowded prisons of Forest and Saint-Gilles in Brussels. Complaints about the availability of members of the psychosocial service are registered in several prisons such as Hasselt, Verviers or Andenne.

The psychosocial service offers treatment and guidance to detainees in case of psychological or social problems, crisis situation (auto- or heteroaggressive behaviour, divorce or mourning) or difficulties concerning their conditional release. In addition the psychosocial service helps the detainee in the elaboration of a rehabilitation plan. Diagnostic assessment of the personality, criminogenesis and a prognosis on the conditions for release is part of the rehabilitation plan. According to the planning, sexual offenders in prison are counselled by specialized psychosocial services to break the offenders' denial of their responsibility for their sex crime(s) and strengthen motivation for following treatment in the community after conditional release ('pre-therapy'). This plan isn't fully implemented in the Belgian prison system. The daily practice is restricted to establish a network with specialized mental health services in the community in order to prepare referrals and to exchange judicial information with specialized mental health services in the community<sup>5</sup>.

Following a new legislation on prison sentences the major task of the psychosocial service switched since January 1998 to the evaluation of prisoners in order to recommend judicial authorities on their decision to grant release on trial (leaves, half liberty, electronic monitoring, provisional and conditional release). These evaluations are based on a multidisciplinary investigation of the personality which includes risk assessment. The psychosocial service is overloaded because of preparing and writing advices on prisoners in order to protect the public.

### **Capacity**

At the end of June 2006 the Belgian psychosocial service had a staff of 32 full-time psychiatrists (24h a week), 147 full-time psychologists (38h a week) and 146 social workers (38h a week). Nearly all local psychosocial services complain about shortage of staff.

The psychosocial services handled in the year 2000 more than 21.000 cases and more than 20.000 new cases were started up. The handling of cases is counted as all possible interventions done by the psychosocial service (react to questions of detainees, interventions at crisis or problematic situations, etc).

### **Budget**

The psychosocial service controls in 2006 a budget of 7.732.000 euro. A substantial part of these finances is spend on the organization of extra-penitentiary health care programmes for interned persons and sexual abusers and the payment of self-employed physicians. The budget for the payment of staff members and the budget for the education of staff is not included because it is managed by another Federal Public Service.

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<sup>5</sup> Agreement of cooperation between the federal state and regional communities about the guidance and treatment of sexual abusers approved by the federal laws of the 4<sup>th</sup> of May 1999 and the 12<sup>th</sup> of March 2000.

## Central supervisory board of the prisons

The central supervisory board of the prisons and supervisory commissions (within each prison) were established by the Royal Decree of the 4th of April 2003<sup>6</sup> and thereby written in the general regulations of the prison system. These board or commissions have the duty to supervise the treatment of prisoners according to the applicable directives. Incidents in prison are identified and registered by their supervisory commission. Deliberations between prison managers, the central administration of the DG Penitentiaries and the central supervisory board brings up possible solutions. Relevant observations are reported to the Minister of Justice and the federal parliament.

## Future perspectives

The council of ministers of March 2004 decided to give priority to the building of a forensic hospital for the treatment of 350 to 400 internees in Flanders and the renovation of an empty wing of the institute of social protection in Paifve (Wallonia). After obtaining expert advice the Minister of Justice decided to build two high security forensic hospitals in Flanders (Gent and Antwerp), both should be operational in the year 2010 (Cosyns et al., 2007). Besides the construction of these hospitals for mentally disordered offenders, the Minister of Justice will increase the professional staff appointed in the multidisciplinary teams of all psychiatric units in prison. The aim is to improve the accessibility of mental health treatment in prison.

On the 12<sup>th</sup> of January 2005 a law concerning the legal position of detainees<sup>7</sup> was passed. The legal framework implements the European Prison Rules. According to this law detainees obtain the right on health care which must be of the same quality as health care in the free community and which should be adapted to their specific needs. The legislative framework improves the possibilities of the prisoner to consult a physician of his choice and to be transferred to a specialized prison, hospital or health care facility. The most far-reaching legal stipulation on healthcare in prison is the strict distinction between the function of health caregiver and that of expert in prison. Until now the psychosocial service of the prison fulfil both functions of health care provider and forensic evaluator. Treatment is provided in the best interest of the concerned person, while evaluation is made for the authorities. These functions are not compatible and create a role conflict within the psychosocial service. Furthermore the law concerning the legal position of detainees established the penitentiary health board. This board advises the Minister of Justice so that the quality of health care improves in the interest of the detained patient. Specific competences of the penitentiary health board stipulated by Royal Decree of the 12<sup>th</sup> of December 2005<sup>8</sup> are the organization and coordination of medical activities, quality of health care, initiatives for the promotion of the cooperation between caregivers, penitentiary and judicial authorities, ethical and deontological issues and applications for medical scientific research within the prison system. At the start of 2007 the Belgian government was working at the legal implementation. Complete implementation of the law concerning the legal position of detainees will have major consequences on the future organization of health care in the Belgian prison system.

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<sup>6</sup> Royal Decree of the 4<sup>th</sup> of April 2003: Koninklijk besluit 4 april 2003 tot wijziging van het koninklijk besluit van 21 mei 1965 houdende algemeen reglement van de strafinrichtingen, *B.S.*, 16 mei 2003, 26.981.

<sup>7</sup> Law concerning the legal position of detainees: Basiswet 12 januari 2005 betreffende het gevangeniswezen en de rechtspositie van de gedetineerden (1), *B.S.*, 1 februari 2005, 2.815.

<sup>8</sup> Royal Decree of the 12<sup>th</sup> of December 2005: Koninklijk besluit 12 december 2005 tot bepaling van de datum van inwerkingtreding van artikel 98 van de basiswet van 12 januari 2005 betreffende het gevangeniswezen en de rechtspositie van gedetineerden en tot regeling van de samenstelling, de bevoegdheden en de werking van de Penitentiaire Gezondheidsraad, *B.S.*, 29 december 2005, 56.884.

## Bulgaria

**Toma Tomov & Rumén Petrov**

### Structure of Prison System

There are 13 prisons in Bulgaria. 8 are high-security prisons (for “recidivists”<sup>1</sup> – people with recurrent law offending behaviour), 3 of them are prisons for non-recidivists; there is one prison for female prisoners and one is correctional institution for under-aged law offenders. Within them there are 20 prison living facilities (open, closed and transitional regime). There are 51 remand prisons (arrests for interrogation).

The capacity of the prison system is estimated 13,700 places. In 2004 the overall number of prisoners is 10,935 people. Accused amongst them (not sentenced yet but detained by the court under severe allegations) were 360 people; under trial – 1,568, sentenced – 9,007 people.

Prisons in Bulgaria are located within or nearby Bulgarian main cities: Vratza, Pleven, Lovech, Varna – in the northern half of the country and in Sofia, Pazardjik, Plovdiv, Stara Zagora, Sliven, Burgas – on the southern part. There is one prison close to a big industrial center (Bobov Dol – in the west of the country) and two – next to smaller towns such as Belene at the Danube river and Boychinovtzi – in the north-west.

The National penitentiary system has been subject of the administrative management of the Ministry of Justice from 1990. Prison staff had undergone demilitarization in 1999. In 2006 a total and complete demilitarization has been effected, including the police staff within prisons.

Every year the budget is granted by the Ministry of Justice. The expenditures’ planning is being done centrally while specific local needs are partially taken into account. Since 2006 a “program budgeting” scheme of prisons has been experimented. Within this methodology the overall prison system is organized within three main programmes: “Prisons”; “Remand Prisons” (arrests for interrogation) and “Probation services”.

### Medical Services and Mental Health Care Provision in Prison

There are two prison hospitals for “active treatment”: within the Sofia “Central” Prison and in the town of Lovetch prison. In every other prison there is a “medical centre”. Medical professionals in these centers are qualified in internal medicine, general medicine, psychiatry and dentistry. In every such center there are wards with 8-10 hospital beds and a small unit for separate treatment of cases suspect for contagious disease prior to their final diagnosis and specialized treatment. There are regional medical centers serving regional units of the places for preliminary interrogation (arrests).

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<sup>1</sup> Words in inverted are quotes from the official documents and vocabulary of The Bulgarian Penitentiary system.

Medical staff in the medical centers of the prisons of Sofia, Plovdiv and Varna<sup>2</sup> consists of medical doctors. Medical staff in the others MC consists of paramedicals (“assistant surgeons”). Their work is supervised by the medical center of the prison directorate in Sofia. There is good liaison with the local professional medical communities.

The research available does not consider mental health care as a strictly differentiated service. Therefore the statistics about the care staff in prisons covers its overall quantity: Medical doctors: 70 MDs (including 13 stomatologists (dental care) and 13 psychiatrists (in all prison system). Nurses are 108. Social workers are 137. Others professionals: 35 psychologists, 4 probation officers, 99 teachers.

In Lovech prison hospital (the biggest in the country) 30 out of 130 beds are for psychiatric cases. In Sofia prison hospital 15 out of 100 beds are psychiatric.

In Bulgaria there special psychiatric training for nurses does not exist. Their specialization is secondary – during their work in psychiatric wards. Psychiatric nursing is still not a differentiated profession in Bulgaria.

Mental health care in prison is provided mainly by the in-prison medical staff.

Bulgarian prison mental health care budget is not specified and not planned and evaluated separately from the overall prison health budget.

There not data for any special regulations of collaboration between medical prison services and general mental health care

Organization of mental health assessment/screening of prison inmates: During the admission period (14-30 days) in prison an assessment of the general health status by a medical and psychologists is obligatory. The main focus during this evaluation is the risk assessment. If during this assessment some questions arise then a psychiatrist is called for a second opinion and consultation.

There are some structured practices such as group work in some of the prisons that are still not organized as care programs. Upon a personal request any prisoner has free access to psychologist/psychiatrist.

The overall prisoners/psychiatrists ratio is: 600/1 and prisoners/psychologists: 250/1.

Screening of mental health status of prisoners is obligatory at the stage of admission in the prison. The protocol from such an assessment/consultation is part of the prisoner’s personal file.

Withdrawal symptoms are dealt with according to a standard protocol for withdrawal management (detox) – the same as in the places for preliminary detention of suspected (arrests). Some forms of group work with drug/alcohol dependent prisoners are also applied (a brief-therapy protocol is used in these cases). An assessment/screening for suicidal behaviour is part of the routine risk assessment procedure during the admission period. If a suicidal risk has been identified a daily monitoring of the prisoner in risk is provided.

There are specific treatment programs for sex-offenders. In the Pazardjik, Plovdiv, Burgas and Pleven’s prisons a pilot program called “Reduction of aggression” is under implementation. It is based on the cognitive-behavioral approach following a Penal Reform International’s protocol. After the pilot trial the pro-program will be evaluated and implemented in all prisons at the end of 2007.

Emergency cases are dealt with according to the overall medical regulations.

The compulsory treatment of mentally disordered prisoners is organized in the specialized prison hospital in the town of Lovech. There is not a specified protocol for this activity. According to the

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<sup>2</sup> These are the three biggest (‘main’) cities in Bulgaria.

interviewees, civil commitment laws and human rights standards are completely observed and fully applicable for prison in-mates.

According to some of the interviewees the overall quality of psychiatric care in prison is “a little above the average standard for the country”. According to others and to the research available it is rather below the standards. The isolation from the main civil service institutions is considered as the major obstacle before modernization and implementation of good practices. This isolation is structural than physical – prisons are heavily centralized institutions, all of the staff there (general health and mental health personnel including) is under the administrative power of the prison administration. According to the interviewees mental health services must be better integrated with the “social-educative activities”.

Collaboration between juridical and health care authorities or services or other relevant institutions exists on issues of qualification and training of medical and paramedical personnel and on issues of normative regulation of general medical and psychiatric activities.

National discussion on these issues is not observable except some sporadic reports prepared by the national Helsinki Committee. Reforms in the prison health and mental health care system are slow follow an agenda designed and presented as abiding by the European Union requirements.

The national mental health reform is a recent development in health and social policy field in Bulgaria. As its core value it proclaims the community integration of people with mental health disorders. As a real political endeavor it is still heavily under-funded funding and poorly accepted at many political levels (communities, professional associations and statutory institutions). In 2005 the first pilot project for integrated psychosocial care for severely mentally ill in the community of the town of Blagoevgrad has started. Being accepted and supported by the local authorities this project is only partially funded by the national funds.

Current psychiatric training of medical doctors and postgraduate specialists is still in the “old” institutionalizing paradigm. Thus it leaves the vast majority of general practitioners, psychiatrists and nurses incompetent and reluctant to apply the proclaimed mental health agenda of the central government. Civil society organizations in the mental health field are weak and scarce. The partial successes of reforms (where there are some) have been possible mainly because of the involvement of social work departments and the employed young social workers, not yet bureaucratized but still severely incompetent.

There is not a public debate over these issues, let alone some debate over the mental care in prisons. Psychosocial discourse – the language based on values such as community integration, personal, family, community needs, competences etc. is far from present in the journals and from the conferences of the Bulgarian Psychiatric Association and the Bulgarian Association of Social Workers. The research portfolio in the area is funded mostly by the transnational pharmaceutical companies. It is conducted in hospitals and consists mainly of drug trials. There are not data about the legal or illegal use of prisoners in such activities.

Probation as an integrative approach has just been introduced as a separate and differentiated program within the National Penitentiary System.

A national epidemiological survey of general psychiatric morbidity (H. Hinkov et al.) - the first in the last 20 years has just been completed and its results are about to be published in the coming months.

### **Epidemiology of mental disorders**

Registered mental health “abnormalities” amongst prison population are published in the Annual Medical Report of the National Prison System. Data for these reports are collected by the Social department at the NPS, and the reports - issued by the psychology laboratory at the NPS. Epidemiological surveys of psychiatric morbidity in prisons have not been conducted yet.



Reported epidemiological trends:

- the average number of mentally disordered prisoners per year is 200 people.
- annual suicide rate is around 200 trials per year (including “ultimatums” and “hysterical” attacks). There are 3-6 lethal exits per year.

Up to 100 % increase of severe pathology is expected, borderline states included. An increase of real and false suicidal attempts is also expected. The main reason for this increase is the policy of restriction of drug abuse within prison inmates.

Unfortunately the national epidemiological survey (Hinkov, H. et al., 2006) does not cover prisons' population. The most recent national research publication on the mental health care in prison is:

**Petrova-Dimitrova, N.** et all (2004) Assessment of the psychiatric, psychological and social services provided to prisoners and staff in the places of imprisonment, report of the Social Activities and Practices Institute, Prison Affairs, XXXVIII, book3/2004

The research evaluates both the satisfaction with the general health services and mental health care in particular and the stress related complaints of the prison staff. The methodology is mainly qualitative, researchers draw conclusions about the existing morbidity on the basis of the prisoners' personal documentation. Diagnostic instruments for the assessment of mental health status have not being used. However its conclusion is that about 30 % of the individuals from the “prisons' population” have “some mental health problems” while 7 % from the overall population suffer from severe mental disorders. The report concludes that their treatment is “mainly medical”. There is a lack of special “socio-educative” programs for mentally disordered prisoners. According to this report programs for drug addicted are rather exception than a routine practice. The report says that about 80 % of prisoners “have problems within the “personality sphere”, although researchers do not use the concept of personality disorder. However few the existing programs for example for anger management are under-attended by their prospective beneficiaries. The report concludes that there is a lack of an integral conception about the treatment of prisoners with special needs (training of the personal, programs, care etc.). The report considers the under-funding of the system and the lack of autonomy of the prison medical staff as main structural reasons for the observed shortcomings within the prison health care.

### **Quality Standards and ethical aspects**

The European standard for mental health quality in prisons is being abided by. Regular assessment from the Medical Department of the National Prison Directorate from the Ministry of Health are being made. Following personal complains the Persecution Department makes its own investigations.

Prison psychiatrists have the standard medical and psychiatric training; nurses have their bachelor degrees provided by the medical colleges. Their competences are evaluated according the number of years of professional experience. Psychologists have MA degrees from the Universities; social workers have BA or MA university levels.

Ministry of Health provides training for the medical staffing prisons. Psychologists and social workers attend 3-5 days obligatory regular trainings on current problems every year. Almost all of the prisons' staff attends some forms of additional training.

Standardized instruments for the assessment/ treatment of mentally disordered prisoners that are being applied are:

- A) A Protocol for risk assessment
- B) A Protocol for assessment of drug/alcohol dependence
- C) Some scales for assessment of aggressive behavior
- D) others standard methods (such as The Lusher test etc.)

After the evaluation the psychiatric diagnosis is coded out of concern about confidentiality. Medical confidentiality and confidential nature of relationships between social workers and prisoners is respected within the general security system and regulations of the NPS. Prison guards have access to prisoners' mental health files only for prisoners in risk of committing aggression.

According to the interviewees European Prison Rules are completely implemented as quality standards. Bulgarian Helsinki Committee and the national Ombudsman are main NGOs that address the needs of mentally disordered prisoners in our country. Their influence is not very strong: Helsinki Committee makes regular assessments of overall human rights respect in prisons. There are no data about some specific mental health case to be advocated for neither by them nor by the national ombudsman.

According to the interviewees the reforms required for improving the situation of mentally disordered prisoners in your country are:

- The improvement of the infrastructure and prison facilities.
- The decrease of prisons' overpopulation (which means construction of additional prisons).
- Decrease of prisons' size.
- Improvement of psychosocial services during the admission period and during the adaptation period after the release from the prison.
- Development of additional special programs.
- Introduction of additional, better structured trainings of the prisons' staff. Existing projects does not meet sufficiently personnel's needs. Some of them are experienced as partial and not sufficiently "pragmatic".

According to the interviewees the existing organizational structure in prisons is very recent. A trial period of at least two years is needed for a proper evaluation of its efficacy and efficiency to be done. Budget decentralization is conceived as the next step towards the overall improvement of the national prison system.

Data have been collected during interviews with senior officials from the National Prison Directorate appointed officially by the Minister of Justice: Ass. Prof. Emil Madjarov, head of the psychological services in NPD and Dr Tzetzka Simeonova, head of the Medical department at the National Prison Directorate.

Dr Petar Marinov, president elect of The Bulgarian Psychiatric Association, provided his opinion on the overall state of mental health care in prisons.

## Cyprus

Evangelos Anastasiou & Louis Kariolou

### Structure of the Cyprus Correctional System

In Cyprus there is only one Correctional Institution, which operates under a new and comprehensive legislative and regulatory frame, put in place in 1996 and 1997. This legislation incorporates the European Prison Rules and is consonant to the standards contained in the Council of Europe relevant instruments. The Cyprus Prison Department is under the administration of the Ministry of Justice and Public Order and caters for all categories of convicted and under trial prisoners of both sexes and all age groups.

The Cyprus Prison Department consists of nine wings of closed prison (eight for male offenders and one for female offenders) guaranteeing raised security conditions of detention, one open prison providing minimum security conditions of detention, and the Guidance Centre (out of prison employment) as a semi-liberty condition of detention. The capacities of the single wings in conjunction with the numbers of prisoners housed in these institutions are given in table 1.

**Table 1: capacities and prison population of the different wings in the Cyprus correctional system**

WINGS	CELLS		CAPACITY	PRESENT PRISON POPULATION
	x 1 PERSON	x 5 PERSONS		
Wings 1A	33	-	33	37
Wings 2A	30	1	35	89
Wings 1B	30	1	35	74
Wings 2B	26	2	36	81
Wings 4	10	-	10	5
Wings 5	34	-	34	62
Wings 8	50	-	50	62
Special 8	16	-	16	32
<b>TOTAL</b>	229 x 1 = 229	4 x 5 = 20	249	442
Open prison / Soldiers	56 x 1 = 56	-	56	85 / 1
<b>TOTAL</b>	56		56	86
Guidance Centre	17 x 1 = 17	-	17	22
<b>TOTAL</b>	17		17	22
Wings 3 (Women)	4 x 1 = 4	2 x 7 = 14	18	19
<b>TOTAL</b>	18		18	19
<b>GENERAL TOTAL</b>	340		340	569

## Prison programmes and services

There are several programmes implemented regarding education and reintegration of the prisoners. In the context of vocational training, all prisoners are given as far as possible the opportunity to work, in the type of work of their choosing. Fully equipped workshops are operated in the prison, where prisoners are encouraged, under the supervision and instructions of trainers, to improve the level of their vocational training. Furthermore, the prisoners are also encouraged to improve the level of their education by attending classes in prison. The lessons most preferred include computers, English, Greek for foreigners, painting, design and handicraft.

In the field of preventive health care, medical and mental health services are offered to all prisoners in need. Welfare services and support is also given to all prisoners with regular visits / contacts with their families and home leave, in order to facilitate the social integration with free society. The recreational activities include sports, theatre, musical performances, chess games, etc. The Prisons are equipped with a theatre hall and grounds for football, volleyball and basketball.

## Medical Services and Mental Health Care Provision

The Ministry of Health provides the staff needed for Mental Health Services in the Prison Department and also for the Medical Services. The Medical staff consists of:

- 1 General Physician (5 days a week, full-time 7:30am – 3:00pm).
- 1 Dentist and 1 Assistant Dentist (once a week)
- 1 Dermatologist (once a month)
- 1 health visitor for vaccinations (twice a week)

Additionally, there are 9 prison officers (wardens) trained in First Aid which work on shifts 24 hours, 7 days a week.

The Mental Health Services staff comprises of:

- 1 Psychiatrist (3 days per week, 7:30am – 3:00pm)
- 2 Clinical Psychologists (1 full-time and 1 three days per week, 7:30am-2:30pm)
- 2 Occupational Therapists (1 three days per week and 1 twice a week, 7:30am-2:30pm)
- 1 Superintendent Mental Health Nurse (full-time 7:30am-2:30pm)
- 3 Mental Health Nurses full-time (5 days per week), 7:30am-2:30pm

The facilities for the Medical Services and the Mental Health Services are within the prison yard and the prisoners of the closed prison can visit any time. There is 1 General Physician office and 1 Psychiatrist office, there is also 1 outpatient unit office for the prison officers that are trained in First Aid and it is open on a 24hour basis and in that office there is also the Dentist's office. There is also a common waiting room for the General Physician, the prison officers trained in First Aid and the Clinical Psychologist's office. Next to this there is an autonomous entrance to a big office that has a partition and it is divided into 2 offices. One of these 2 offices is the Psychiatrist office and the other is a waiting room, the office for the Mental Health Nurses and also the Occupational Therapists' office at the same time. There is also 1 medical examining room for Blocks 5, 8 and Juveniles and 1 office for the Clinical Psychologist, the Occupational Therapist and the Social Worker and there is also 1 office for the above mentioned disciplines for Block 3 (Women's Block) and 1 office for the needs of the Open Prison.

There is also a Social Worker which is send here from the Social Welfare Office, Ministry of Labour and Social Services and has his own office.

### **Medical Services**

The General Physician checks up all the new comers (both unconvicted and convicted) and also those who ask to see the Physician.

If there is a problem that cannot be resolved within the Medical facilities of the Prison Department, then the help of the General Hospital and its departments is asked (the area of expertise needed). When this is the case then the prison officers trained in First Aid escort the prisoner to the General Hospital. An also important role of the General Physician is the training of the prison staff and also the training of the offenders on health issues. It is also the communication and network with the Mental Health Services and other Medical services within the Prison Department.

The multidisciplinary team of the Mental Health Services within the Cyprus Prison Department are engaged with mental health services described in the next passage.

### **Mental Health Services in Cyprus Prison Department**

The prison mental health care system offers several services which have to be enriched:

- Screening and assessment
- Therapeutic planning
- Therapy and counselling
- Preparation for discharge
- Specialised interventions with special population groups

There is a plan for the creation of the Mental Health Centre in the Prison Department (a. Psychiatric Clinic and b. Detoxification centre and rehabilitation centre for drug addicted offenders), which will be finished in 2010.

Another topic of the mental health system is the research in the field of documentation of data regarding the mental health services and the mentally disordered offenders (i.e. overpopulation, newcomers, treatment etc) as well as the assessment and supervision of programmes from other organisations and departments (i.e. NGO's, voluntary) affecting the Prison Department.

Further duties apply the

- Continuing Professional Development of the Mental Health Services staff
- Training of prison wardens
- Field training for university students (psychologists, occupational therapists, etc) and
- to pen publications

**The Psychiatrist** assesses and examines everyone that asks for one and also all the referrals for 'strange' behaviour or for behavioural disorder coming from the prison wardens. He examines the 1/3 of the present population of the Prison Department in total, with examination frequency of once a month. The Psychiatrist uses all the Services and Departments of the Mental Health Services and the Medical Services in the community.

The psychiatrist is the scientific coordinator of the interdisciplinary team and coordinates its operation, determines and maps out the objectives and the strategy of the therapeutic programs in the correctional institution, and oversees their operation and effectiveness when applied.

The psychiatrist proceeds to diagnose psychopathology and recommends pharmaceutical and psychotherapeutic treatments for previously existing problems or for problems arising due to incarceration. The psychiatrist also ensures that therapy is continuous before the sentence is imposed on an inmate, as well as during the trial proceedings and post-conviction. Upon arrival of a detainee, referrals are received from health professionals the detainee might have had a therapeutic

relationship with, and when released, the former prisoner is referred to health professionals outside the prison system for follow-up.

Types of psychiatric interventions and psychiatric involvement are assessments, therapeutic interventions and systematic treatments, as well as forensic advice; convenes with other health professionals to discuss proper treatment(s) and referrals for hospitalization at the psychiatric hospital.

**The Clinical Psychologists** face the various psychological problems of the offenders on a diagnostic level, counselling and do individual therapeutic sessions. One of the two clinical psychologists is specialised for the addiction / abuse of substances. They have supervision sessions with the Head Clinical Psychologist of the Mental Health Services.

In their therapeutic work the clinical psychologists are capable of having diagnostic and therapeutic independence in the assessment and treatment of psychopathology. In their synergistically therapeutic work as scientific collaborators, with their suitable diagnostic and therapeutic expertise (which only the scientific field of clinical psychology can possess), they are called onto contribute to and seal the therapeutic work of the psychiatrist as well as that of other members of the interdisciplinary team. Also they are called onto undertake specialized assessments, essential to the psychiatrist in cases where he/she is summoned as an expert witness in judicial processes.

As integral members of the therapeutic team at the prison department, with unquestionable scientific knowledge both clinical and academic, they are able to propose, participate, determine, oversee and bring to an end a multitude of tasks, of therapeutic, educational or informative character.

They can represent the therapeutic team in its interconnection with the MHS in seminars and conventions, as well as in academic or other settings which have as an object of interest the correctional system and its extensions. A clinical psychologist can also attain further scientific training in specialized subjects relevant to the prison department.

**The Occupational Therapists** accept referrals from the Psychiatrist and from the Clinical Psychologists for assessment and evaluation of the offender's occupational performance (occupational meaning not only his/her job skills) and developing their skills (cognitive, sensory-motor and psychosocial). There are both individual and group sessions considering the outcome of the occupational therapy assessment. The main aim is the smooth social and vocational rehabilitation of the offenders.

Occupational Therapy (OT) uses activities as its remedial weapon of choice. It uses a multitude of analytical parameters on each activity and interlaces them in the therapeutic programme tailored for each client. The induction in an OT treatment programme almost always begins with a self-assessment and various projective techniques. Also, of decisive importance is the unearthing of information which concerns an individual's familial, social, occupational and penal background. This information, combined with the result of the assessment, will not only determine the fundamental problems of each individual and facilitate in the realistic planning of individualized intervention, but also play a decisive role in determining whether to integrate an individual in a group therapy program.

The evaluative results concern the regions of functional performance. The most common objectives are:

- Enhancement of cognitive and sensory-motor abilities with particular attention paid in the fields of concentration, problem-solving and perceptual organization. These fields are negatively influenced by stimuli deprivation due to the enclosed space of prison
- Improvement of psychosocial skills which, in most cases, constitute a fundamental objective of OT programs
- Enhancement of ability to undertake and implement functional performance life roles, particularly of self-care, social relations, training and educational as well as occupational and recreational activities

Apart from the individual therapeutic programs, the OT organizes group meetings with clients. During the program-planning phase the OT considers the motives for active attendance of the group members, the likelihood of what type of social and occupational environment that awaits detainee upon release, as well as the extant support systems.

The OT program in the prison can include training in daily life skills, competence under interpersonal, recreational and social circumstances, as well as training in occupational expertise. Other important OT interventions in the prison are the acquisition of confidence for expressing one's self and for operating independently, encouraging in this way the application of adapted behavior in their daily life. Creative means can be implemented in order to facilitate getting to know one's self, recognizing the needs of fellow detainees, as well being able to better express one's own opinion.

An equally important role of OT in the prison is the occupational re-establishment (Lloyd, 1986 Lloyd and Guerra, 1988), which contains programs related to work skills (Jacobs, 1991) in order to develop and/or recover work habits, skills and dexterities.

The Mental Health Nurses are engaged with:

- Carries out history record interviews (personal, family, social and medical) and the Treatment Demand Inventory (TDI) for drug abuse and dependence.
- Studying the extant literature concerning the aforementioned history record interview so as to be most beneficial to the client
- Attending the activities and proceedings of the psychiatric outpatient unit of the Prison Department
- Participating by research programmes, collecting statistical data, attending training seminars
- Counselling
- Preparing the ground for meetings with detainee clients for the psychiatrist (telephone communication, preparation of files, etc).

### ***The non-homogeneousness of the prison population***

The detained population is non-homogeneous with regard to age, offence, psychopathology, health problems, socio-economic status, religious and cultural perceptions, occupational skills, origin and many more. This non-homogeneous community is characterized by its criminal delinquency, as well as by the penal code imposed on it in the process of attempting to protect society. It satisfies the social feeling of justice being served, and simultaneously, rehabilitates and cures. The prison department is a unique frame for the Mental Health Services (MHS); extant of 7 wings in the closed prison, and separate wings for women, young men (under the age of 18), the Open Prison and the Centre of Guidance and De-institutionalized Employment and Reestablishment of Detainees (CGDERD).

Through this non-homogeneous population one can discern groups with common problems as:

- Detainees with alcohol problems and the use and abuse of illicit substances  
These detainees, beyond their unsolved familial and socio-economic problems, also carry with them to the Prison health problems, remnants of their use and abuse of illicit substances. This implicates pathological health problems, psychiatric and psychological disturbances, which sometimes require direct, sometimes intensive, and always long-lasting specialized therapeutic intervention. The final objective is the strengthening of their mechanisms of defence against any form of dependence, as well as the strengthening of their ego and self-image, having as an ultimate outcome their reunion with their families, and their successful reestablishment within the community and society as a whole.
- Detainees with chronic psychiatric problems  
These are detainees with chronic psychiatric or psychological problems, problems that reappear due to their incarceration and require direct, intensive, and specialized therapeutic intervention having in mind as a final objective their rehabilitation and return to the community.

- Sex Offenders  
Sex offenders constitute a major subject in the past decade. The European Council has been compelled to assemble a Committee of Experts from each country in order to enact legislative and therapeutic measures to confront the problem of sex offenders, inside and outside the correctional institutions.
- Other Groups including financial crime detainees, defendants awaiting trial, aliens detained due to illegally entering, staying or working in the Republic of Cyprus, underage detainees, female detainees

### ***Departments of the Mental Health Services***

The Mental Health Services have departments all over the island except from the Turkish occupied part. The departments are fulfilling variegated duties and responsibilities, e.g. as there are psychiatric clinics, therapeutic communities, day centres, detoxication centres, child and adolescent departments, out patient units, rehabilitation units, and the prison department.

Among other duties, the Mental Health Services at the Prison Department has to collaborate with the various other mental health services. In this regard, the prison mental health service has to face following tasks:

- Exchange of information, referrals, networking and maintain the therapeutic continuum.
- Collaboration with the other departments of the Mental Health Services and other Governmental Departments (i.e. Welfare Services, etc)
- Collaboration with Universities for training and research subjects
- Collaboration with private and voluntary organisations that are engaged with prison matters

### ***Application of Human Rights***

The Multidisciplinary team of the Mental Health Services in the Cyprus Prison Department respects, values and applies all the regulations concerning Human Rights.

In Cyprus one can find the following mechanisms:

- The Office of the Commissioner for Personal Data
- The Office of the Commissioner for Human Rights
- The Office of the Commissioner for Administration (Ombudsman)
- Committee for the Supervision of the Rights of the Mentally Disordered
- Prison Committee, the members of this committee are not prison staff, they come from other governmental units (i.e. Ministry of Health, etc) and investigate the complaints of the prisoners, the quality of life, etc.
- The Council for the Prevention of Tortures (CPT;) visit Cyprus and inspect what has been made for the better quality of imprisonment, etc.
- Service for the Rights of Applicants of Political Asylum.

All the mentally disordered prisoners have immediate access to the mental health team but they also have the right to refuse an examination and ask for a psychiatrist or psychologist from the private sector. In case their mental health requires assessment and therapeutic intervention, they are forced to an examination with a court decision.

The screening of mental health status is not obligatory for all the prisoners, but it is obligatory for all that ask to see the psychiatrist or the other members of the multidisciplinary team. The therapeutic interventions that take place in the Cyprus Prison Department are psychiatric, psychological and occupational therapy interventions, individual and group.



For the time being we deal the withdrawal symptoms with pharmacotherapy and counselling. Every offender that states a will to suicide, or have already made an attempt we do an assessment and screening for suicidal behaviour. We have already started screening the sexual offenders on a voluntary basis, but as far as we know there are not any specific therapeutic programmes in Cyprus. As far as the existence of specific therapeutic programmes that are focused for mentally disordered prisoners.

### **Regulations and practice routines for emergency cases**

In case of an emergency, the inmates firstly visit the Physician for a screening of their general health situation at that time and then they visit the Psychiatrist for a screening and intervention. In case this is not feasible due to the fact that the doctors are not at the Prison Department for any reason, then the offender is transferred to the Emergency room escorted by the prison wardens trained in First Aid with the offender's medical record for immediate attending.

The regulations regarding compulsory treatment are the same as for civilians. The examination is taking place without the presence of a prison warden, except if there is a great security issue. The offender is entitled to ask for the presence of his / her lawyer, private psychiatrist that he chooses and also pays for. For these right he is informed previous the examination.

There is a shortage of staff and lack of infrastructure (i.e. lack of specific organised programmes, Psychiatric Clinic etc.). As far as the out-patient unit is concerned, the quality of the service provided to the prisoners is equal, or even better from the one given to the public (in the community).

There is a good network mechanism between our department and the juridical system, the Ministries (of Health, and Justice and Public Order), the Welfare Services (Social Care) and other relevant institutions.

### **Epidemiology of mental disorders**

Due to the fact that the mental health screening is not obligatory we cannot have epidemiological information for all the prison population. We have very good epidemiological information for the prisoners that have or have been examined from a member of the Mental Health multidisciplinary team.

The number of the mentally disordered prisoners per year is 200-225. The annual suicide attempts are around 20 in the population of 600, the last 5 years we did not have any successful suicide attempts.

### **Quality standards and ethical aspects**

There are quality standards concerning the management of mental health care in the prison setting. They are monitored by the management committee of the Mental Health Services, which includes the Director of the Mental Health Services (Psychiatrist), the Head of the Psychology Department, the Head of the Occupational Therapy Department and the Head of the Mental Health Nursing Department.

The Psychiatrist responsible for the multidisciplinary team of the Mental Health Services in the Prison Department has a degree in Medicine and the one year training in Neurology and then 4 years for the degree in Psychiatry. He also attended a 2 year seminar in Child Psychiatry and he is one of the founder members of the Cyprus Psychoanalytic Society (1992), official member of the EPP. He is also the representative in the European Committee for Sex Offenders.

The Clinical Psychologists have a first degree in Psychology (Bachelor) and a Master degree in Clinical Psychology.

The Occupational therapists have a degree in Occupational therapy (Bachelor) and one of them also has a Master degree in Mental Health (MSc) and also hours of training by NADAAC (USA) for the treatment of addicted persons and she is also a member of the British Association of Occupational Therapists and also the representative of the Cyprus Association of Occupational Therapists in the European Network of Occupational Therapists in Higher Education (ENOTHE).

Mental Health Nurses have a diploma in Mental Health Nursing.

There are some seminars that take place during a year period for the treatment of mentally disordered or/ and for addicted persons in general and fewer regarding mentally disordered offenders. Those seminars are optional and are organized by the Mental Health Services.

As far as the confidentiality is concerned we follow the professional regulations regarding the ethical part of our profession, individually and we also have the law for protection of personal data.

The Laws and Legislations of the Cyprus Prison Department incorporate the European Prison Rules and are consonant to the standards contained in the Council of Europe relevant instruments.

There are plenty of NGOs and lobby groups that are addressing the needs of the mentally disordered offenders and their influence is strong enough towards the decision makers in the government and the community in general.

This research is the major research that is taking place at this point regarding the above mentioned field. We also supervise other researches made by postgraduate students regarding Mental Health and we also have a number of small scale researches that we carry out for better monitoring our work in the prison setting.

We inform the Management committee of the Mental Health Services for our opinion regarding the reforms that need to take place for the better provision of our services. There are quiet a few reforms that have already being decided for the best interest of the mentally disordered offenders. In the year 2010 we expect the completion of the Psychiatric Clinic within the Prison Department and also the detoxification and/ or rehabilitation centre for the addicted offenders.

## Czech Republic

Jiří Raboch, Kateřina Grohmannová & Karel Netík

### Structure of Prison System

#### *Overall Structure of the Correctional System*

- The prison system comes under the competence of the Ministry of Justice of the Czech Republic.
- Prisons are administered by the Prison Service of the Czech Republic (an armed security body)
- The tasks of the Prison Service are:
  - (1) to administer and guard prisons;
  - (2) to guard, transport and escort individuals;
  - (3) to subject offenders serving their prison terms and certain groups of individuals held on remand to sentence plans in order to create the conditions for them to lead a law-abiding life once they are released;
  - (4) to conduct penological research;
  - (5) to ensure order and security in buildings housing courts, public prosecutors' offices and ministries;
  - (6) to create conditions for inmates and pre-trial detainees to be able to work and pursue other purposeful activities;
  - (7) to provide employment for offenders serving their prison sentences;
  - (8) to maintain records of individuals serving prison sentences;
  - (9) to provide training for both PS officers and civilian staff;
  - (10) to deliver health care to inmates, as well as PS officers and employees; to provide specialized care in community healthcare facilities;
  - (11) to investigate officers' criminal activities; in liaison with the Police of the Czech Republic, to prevent and detect crime in prison
- The Prison Service consists of:
  - (1) Prison Security (guarding prisons; guarding, transporting and escorting people);
  - (2) Judicial Security (maintaining order and safety in courts, public prosecutors' offices and ministries);
  - (3) Administrative Service (including organizational, economic, training, educational and medical support);
  - (4) PS delegated bodies (status of a police authority in proceedings concerning criminal offences committed by the officers)
- The Czech Republic has a total of 35 prisons, of which 10 are primarily intended for pre-trial detention and 25 for offenders sentenced to imprisonment.
- Depending on the type of external guarding, security measures and application of reintegration programmes, prisons are divided into the following categories: (1) minimum-security; (2) medium-security; (3) high-security, and (4) maximum-security.
- Apart from the basic types of prisons, there are special young offenders' institutions (2 establishments); one prison may house different categories.
- Men and women are placed separately and juveniles are kept away from adults; there is an effort to separate repeat offenders from first-time offenders and inmates convicted of wilful offences from those having committed crimes of negligence; permanently unemployable offenders, individuals with mental and behavioural disorders and those under compulsory treatment tend to be set apart, too.

**Provision with Specific Prison Services**

- drug prevention counselling centres (each prison)
- drug-free zones (in 32 prisons)
- specialized wings (a total of 39 wings). Intended for:
  - (1) sentences served by offenders with personality and behavioural disorders induced by psychotropic substance use (in 3 prisons);
  - (2) sentences served by offenders permanently incapable of being employed (in 5 prisons);
  - (3) sentences served by mentally retarded offenders (in 3 prisons);
  - (4) sentences served by offenders with mental and behavioural disorders (in 8 prisons);
  - (5) compulsory institutional drug treatment (in 3 prisons);
  - (6) compulsory institutional alcohol treatment (in 2 prisons);
  - (7) compulsory institutional pathological gambling treatment (in 1 prison);
  - (8) compulsory institutional treatment for sex offenders (in 1 prison);
  - (9) sentences served by offenders from among mothers of minors (in 1 prison);
- drug services in prison – counselling and social programmes delivered by non-governmental organizations
- various programmes provided by both governmental and non-governmental organizations (no summary of the scope and focus of activities is available)

**Prison Capacities**

- remand centres: 3,258 places, occupancy rate 87.8%
- prisons: 15,526, occupancy rate 103.5%

	2000	2001	2002	2003	2004	2005
<b>Total number of people in custody</b>	21,538	19,320	16,213	17,277	18,343	18,937
<b>- held on remand</b>	5,967	4,583	3,384	3,409	3,269	2,860
<b>- serving a prison sentence</b>	15,571	14,737	12,829	13,868	15,074	16,077

**Regional Variability of Facilities**

If possible, the Prison Service seeks to place offenders into the prisons nearest to their domiciles. However, because of the current overcrowdedness of prisons this is rarely possible.

**Administrative Structure**

The Prison Service is headed by the Director-General (appointed and recalled by the Minister of Justice); each organizational unit within the Prison Service is headed by its own director (appointed and recalled by the Director-General).

The General Directorate is responsible for the fulfilment of tasks common to other organizational units, as well as for the methodological guidance and inspection of the units.

Organizational units are:

- (1) General Directorate;
- (2) Remand Centres;
- (3) Prisons;
- (4) Prison Service Training Institute

The General Directorate is divided into departments (see PS structure) which provide methodological guidance for and inspection of technical sections within the organizational units of the PS, perform analyses of findings and propose relevant measures, participate in the consideration of complaints and suggestions, design internal regulations, and participate in amendment proceedings concerning legal regulations.

The Director-General, on behalf of the Prison Service, enters into legal acts in the name of the State; prison governors and directors of other organizational units are authorized to follow relevant procedures and enter into legal acts concerning all but those matters which do not fall within their competences by virtue of the law or a decision of the minister and/or the Director-General.

### **Prison Budget**

- Budget expenditure: CZK 7,177,455,000.00
- Budget income: CZK 1,011,080,000.00

### **Medical Services and Mental Health Care Provision in Prison**

- Medical centres are available in all of the 35 prisons
  - provision of basic health care, i.e. assessment and treatment/preventive care
  - human resources: medical prison staff + external medical staff as needed (part-time) or liaison with local mental health outpatient centres to which offenders may be escorted for examination
- 2 In-patient facilities / hospitals exists
  - provision of specialized and in-patient care
  - both facilities vary in terms of the specialization of the services provided (Praha-Pankrác Remand Centre: internal and surgical wards; Brno Bohunice Remand Centre: internal, isolation, mental health, TBC, recovery and after-care wards)
  - total hospital bed capacity in the Brno Remand Centre: 175
  - total hospital bed capacity in the Praha-Pankrác Remand Centre: 111
- Mental health ward of the Hospital of the Prison Service of the Czech Republic with the Brno Remand Centre:
  - capacity: 58 beds
  - human resources: 3 specialized physicians, 1 clinical psychologist, 17 nurses (including 3 ward sisters)
- Apart from the in-patient facilities, mental health care is also delivered on an outpatient basis
- In operational terms, the availability of mental health care is sufficient.
- Specialized compulsory treatment wings:
  - (1) Institutional drug treatment – in 3 prisons;
  - (2) Institutional alcohol treatment – in 2 prisons;
  - (3) Institutional pathological gambling treatment – in 1 prison;
  - (4) Institutional sex offender treatment – in 1 prison, 1 wing, capacity 80 people; provision of mental health care in liaison with a teaching hospital in the community (prison psychiatrist + physicians from the department of sexology of a community hospital – on a part-time basis)
  - Compulsory treatment wing capacity: 197 slots, in a total of 5 prisons
  - The status of these wings, i.e. the acceptance of institutional compulsory treatment being delivered within prisons, is an issue which has been discussed for a long time; changes may be expected in response to the adoption of new legislation on compulsory institutional treatment.

The standard staffing of wings specialized in providing compulsory treatment is designed as follows: The wing is headed by a professional / manager. The prescribed numbers of wing personnel are determined according to the following key: 1 educator for 10 offenders, 1 psychologist for 40 offenders, 1 special teacher for 40 offenders, 1 educator/therapist for 20 offenders, 1 tutor/instructor for 20 offenders, 1 social worker for 80 offenders. However, this standard is not always observed.

- As a whole, in 2005 the Prison Service was employing (excluding service contract employees):
  - 312 medical staff, 75 physicians, 107 psychologists

- There are full-time psychiatrists in 3 prisons; in the other prisons they are contracted on a part-time basis
- It is not possible to determine the number of staff involved in working with mentally disordered prisoners, as the staff members fulfil multiple tasks
- prison mental health care budget (percentage of total prison health care budget), if specified  
Approx. 20% of health care cost

### ***collaboration of medical prison services with general mental health care***

In general, the collaboration is good despite the fact that there is no generally binding regulation requiring community healthcare facilities to participate in the care of the prison population. The relationships are based on personal contacts and the willingness of the respective physician or healthcare facility to work with a prison establishment. Economic factors are a major issue.

### ***organization of mental health assessment /screening of prison inmates***

Psychiatric assessment is carried out when a GP finds it appropriate, particularly in the case of individuals whose personal history includes mental health treatment or substance use. The assessment is performed as part of the medical examination on admission. Any subsequent assessment is at the discretion of a psychiatrist. Psychological assessments on admission are required for all incoming prisoners whose sentence exceeds 3 months; they are not performed for shorter prison sentences.

### ***Availability of Treatment Programs***

- Drug-free zones
  - for offenders who (1) have never used drugs but are at risk of using them; (2) have used drugs but are currently motivated to abstain; (3) have completed court-ordered or self-referral drug treatment, or have gone through a specialized wing where offenders with psychotropic substance-induced personality and behavioural disorders serve their prison sentences.
  - in 32 prisons, capacity 1,440 places
- Specialized wings for:
  - (1) sentences served by offenders with personality and behavioural disorders induced by psychotropic substance use - in 3 prisons;
  - (2) sentences served by mentally retarded offenders - in 3 prisons;
  - (3) sentences served by offenders with mental and behavioural disorder - in 8 prisons;
  - (4) compulsory institutional drug treatment - in 3 prisons;
  - (5) compulsory institutional alcohol treatment - in 2 prisons;
  - (6) compulsory institutional treatment for sex offenders - in 1 prison;
  - (7) compulsory institutional pathological gambling treatment - in 1 prison;
  - (8) sentences served by offenders permanently incapable of being employed - in 5 prisons;
- Access to a psychiatrist: at the convicted offender's (or pre-trial detainee's) own request transmitted via the professional prison staff (such as a psychologist, educator and tutor), or assessment is requested by a psychologist or educator themselves
- Withdrawal management: detoxification is provided by the Praha-Pankrác Hospital (internal ward, in collaboration with a psychiatrist), as well as the Brno hospital (psychiatric ward, in liaison with the internal ward)
- Suicidal behaviour
  - is assessed during the entrance examination; subsequent continuous monitoring is performed by all the staff working with inmates (including tutors, psychologists and educators)

### ***Regulations and Practice Routines for Emergency Cases***

- Procedures for the provision of care for individuals attempting self-harm or suicide, as well as the operation of emergency units, are governed by instructions from the Director-General of the Prison Service
- Care in practice: delivery of individual psychological care in cooperation with the healthcare centre and a psychiatrist, placement in the prison emergency unit, or admission to the in-patient facility with the Brno Remand Centre.
- Emergency units
  - In all of the prisons, taking up some 2-3% of the overall prison capacity.
  - Their operation is the responsibility of a psychologist who works closely with a medical centre physician or a psychiatrist.
  - Intended for individuals showing symptoms of an emergency condition, i.e. an individually experienced stress situation and an attempt to cope with it by possibly inappropriate behaviour.
  - Placement of individuals in emergency units: on the basis of a proposal made by a member of the prison staff which is considered by a psychologist or psychiatrist.
  - Such a placement does not require the offender's consent.
  - A physician must assess the offender's health status before he/she is placed in the unit.
  - The unit must be attended by staff 24 hours a day.
  - To placate anger or severe agitation where a person poses danger to both himself/herself and the people around, specific isolation cells (special constructional and material equipment) are used for whatever period of time is absolutely necessary.

### ***Regulation of Compulsory Treatment of Mentally Disordered Prisoners***

Compulsory treatment is one of the so-called "protective measures" which may be imposed by a court (Act No. 140/1961, Coll.). This measure can be imposed in addition to the sentence. However, in the Czech Republic no separate legal regulation has yet been introduced covering the practice of compulsory treatment. It is currently going through the legislative process. The issue of human rights in the prison system has been dealt with by the Czech Helsinki Committee. However, at the moment it is not particularly focusing on exercising the rights of the mentally ill.

### ***Overall Quality of Psychiatric Care in Prison compared to General Mental Health Care***

Essentially, the quality of psychiatric care in prison is comparable to the quality of care in the community. The problem is to find high-quality specialists for certain positions. The main drawbacks are inadequate financial remuneration and low social prestige.

### ***Networking mechanisms, collaboration between juridical and health care authorities or services or other relevant institutions.***

- Forensic expertise (pre-trial proceedings)
- Compulsory treatment: outpatient form - Alcohol and Drug Offices; institutional form – mental hospitals

### **Epidemiology of mental disorders**

#### ***availability and quality of epidemiological (diagnostic) information or prison mental health care utilisation data***

In particular, the Prison Service collects and analyses (in both quantitative and qualitative terms) data on inmates' suicidal behaviour. As for the collection of data concerning health care, the organization only gathers basic data on the utilization of the services. We see shortcomings in the collection of data concerning substance use, as they do not account for the level of risk of use. The quantitative data are available from the Prison Service's annual report and annual bulletin. Other

data on drug use are also published in the annual report of the National Focal Point for Drugs and Drug Addiction.

### ***Epidemiological Trends***

Care utilization data, psychiatric ward of the hospital with the Brno Remand Centre

For data for each year from 2000 to 2005 (number of individuals admitted) see the questionnaire, Question No. 66

- Diagnoses cover the whole psychiatric diagnostic range, with a higher rate of personality and adaptability disorders.

### ***Data on prisoners' suicidal behaviour***

- - In 2005: 6 cases of accomplished suicides (2 pre-trial detainees, 4 convicted offenders), men only; 56 cases of attempted suicides (32 pre-trial detainees, 24 convicted offenders), 3 of them women.
- - In 2005, the number of accomplished suicides was one of the lowest since 1997; the rate of attempts did not differ significantly from the previous period.
- - According to the information provided by the Prison Service, suicidal behaviour affects inmates of all age categories; the age group with the highest representation is 18-30 years.
- - Highest-risk group: offenders sentenced to terms of imprisonment of up to 3 years.
- - The most frequent ways of committing suicide included hanging and cutting, followed by the use of pills.
- - Qualitative analysis of the cases suggests that it is particularly risky for a prisoner to stay on his/her own following a dramatic personal event or any change which may be unacceptable for him/her, such as transfer to another prison); A high-risk period is the first two months in custody (both remand and prison).

<b>Suicides</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
Attempted suicides	82	49	57	55	69	56
Accomplished suicides	9	5	13	11	16	6

### ***Substance Use Data***

- According to the data provided by the Prison Service, the number of registered drug users in prison is increasing. As opposed to the year 2000, the increase is almost twofold.
- The register of drug users includes: (1) individuals who reported using drugs; (2) individuals with a previous record of drug use in their medical files, and (3) individuals who tested positive in screening carried out in prison.
- Screening in prison is performed: (1) on receiving individuals into prison; (2) on a quarterly basis on approximately 10-15% of randomly selected inmates in each prison, and (3) on a targeted basis if a specific case of drug use is suspected.

Given the method of data collection, the relevance of this information is rather limited. In fact, it only shows that illicit substance use is a widespread phenomenon and that the prison environment is no exception in this respect.

Research shows that the most frequently used substances include amphetamines, barbiturates and cannabis (National Focal Point for Drugs and Drug Addiction, 2005).

	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
Number of prisoners	21,538	19,320	16,213	17,277	18,343	18,937
Number of drug users	5,477	5,524	5,481	6,688	6,834	9,480
Proportion of drug users among the prison population	25.4 %	28.6 %	33.8 %	38.7 %	37.3 %	50.1 %



- priorities of epidemiological data collection: suicidal behaviour, drug use in prison population
- publications: Vězeňská služby ČR (2006) Výroční zpráva VS ČR za rok 2005. Praha: Generální ředitelství VS ČR [Prison Service of the Czech Republic (2006) 2005 Annual Report of the Prison Service of the Czech Republic. Prague, General Directorate, Prison Service of the Czech Republic]
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## Quality Standards and ethical aspects

### **Hospital psychiatric ward:**

- 3 prescribed physician positions (head physician, two house physicians), one prescribed position of clinical psychologist
- 2 physicians have two specialist certifications in psychiatry, 1 physician will have completed the relevant specialist certification programme in 2007 (her present specialization is in general medicine, with 4 years of work experience at a psychiatric department)

### **Medical staff**

- 17 nurses, including 3 ward sisters
- Training: ward sisters + 5 other nurses have completed a post-secondary school specialization course in psychiatry; the other nurses are currently preparing to acquire this expertise. Two nurses meet the criteria for long-term preparation for psychotherapy. In addition, the nurses attend professional courses and seminars.

There is a training scheme designed for staff working with the mentally disordered. However, training is not obligatory; the General Directorate provides an offer. The training obligation applies to those engaging in therapy (including psychotherapy).

No standardized procedures or methods for the assessment/ treatment of mentally disordered prisoners have been prescribed, but standardized variables have been set out. Presently, standards for physicians and nurses are being developed.

### **Medical Confidentiality**

The healthcare facilities proceed in compliance with Act No. 260/2001, Coll, on public health care, Section 67 a, b, setting out procedures for the processing of personal data related to the provision of health care and maintenance of medical records.

The method of providing the central epidemiological agency with the data from the Register of Drug-Using Prisoners is governed by an order of the Director-General.

The content and procedure of maintaining pre-trial detainees' and convicted offenders' personal files is governed by guidelines laid down by the head of the Remand and Imprisonment Department. Other guidelines stipulate the rules for maintaining and handling written materials on the part of professional staff (such as psychologists, special teachers, social workers, sociologists, educators, tutors and chaplains).

### **Implementation of the European Prison Rules**

The prison rules are regularly monitored through the CPT (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment).

***NGOs, lobby groups etc. addressing the needs of mentally disordered prisoners***

The services for drug users in prison are provided by several non-governmental organizations. SANANIM, LAXUS and Podané ruce offer the most advanced services. These organizations are grouped under the section Drug Services in Prison as part of the Association of Non-Governmental Organizations. The section currently comprises 6 member organizations operating in a total of 14 prisons. The other areas are not covered by the activities of NGOs. The Czech Helsinki Committee has certain plans for the future in this respect.

***Major Research Activities***

In the past 10 years the Prison Service of the Czech Republic carried out no research concerning mentally disordered prisoners. Research is conducted for the Prison Service of the Czech Republic by the Institute for Criminology and Social Prevention, which, in the past ten years, dealt with research into drug use and abuse in prison and long-term sentences (also studying their impacts on prisoners' health conditions). Currently, (psychological) research on female prisoners is under way, employing measures such as MMPI-2 and PSSI, including scales focusing on the assessment of personality disorders and a range of psychopathological variables. The results will not be available until 2007.

## Denmark

**Peter Kramp**

### Introduction

Denmark is a Scandinavian well-fair country with around 5 million inhabitants. Greenland and the Faeroe Islands are part of the nation but with wide self-government and are not included in this survey.

The crime rate is at the same level as the other Scandinavian countries, i.e. a rather low rate of serious crimes such as homicide, particularly brutal violence and rape. The total number of reported crimes is, however, quite high, mainly because many petty crimes, e.g. shoplifting and stolen bikes are reported to the police.

Denmark use short-lasting prison sentences more often than many other European countries, two-third of all prison sentences are three month or shorter. Life imprisonment exist in Denmark, but is limited to 16 years imprisonment with possible probation at  $\frac{3}{4}$  (12 years), it is furthermore seldom used (16 "lifers", point prevalence, December 2005). Security detention (safe custody), a sanction of unlimited duration, is imposed upon (very) dangerous offenders with severe personality disorders. This sanction is also not used very often (26 preventive detainees, point prevalence, 2005).

In Denmark psychotic and mentally retarded offenders are not punishable by law (penal code, § 16), instead they are sentenced to treatment (for details, see [1]). Mentally ill (psychotic) criminals are thus transferred to psychiatric facilities within the general mental health care service. Along the same line inmates, who become psychotic, will, according to Act on Enforcement of Sentences, etc., section 78, be transferred to ordinary psychiatric facilities, governed by the health service.

### Structure of the Danish Prison System

The Prison and Probation Service is placed under the Ministry of Justice rendering the minister of Justice as the political responsible. The service is made up of five closed and nine open prisons, 38 remand prisons, the Probation Service and a Staff Training Centre. The Prison and Probation Service also run two institutions for asylum-seekers and eight halfway houses (200 places). The halfway houses are administratively part of the Probation Service. The halfway houses are partly used for reabsorption of inmates into society, partly as institutions for suspended sentenced, who for whatever reasons need institutionalized care for a while. Neither the asylum-seeker camps nor the halfway houses are included further in the following.

The whole system is headed by a Director General with a central, nationwide organization, the Department of Prisons and Probation (figure 1). The Department lay down general instructions for the prison services concerning e.g. legal matters, employment and education of the inmates and the health service. The Department has a general medical and a psychiatric adviser, an AIDS and a dental adviser and a nursing adviser. These advisers are to function as experts for the Department

in matters of a general nature, each within his field. The Department also lay down the economical framework for each prison, but within the framework each prison has a large degree of control on the budget in accordance with the general instructions. As to the health services it mean, that there might be some differences in the organization and health care provision between different prisons according to different needs. Denmark has implemented an "Offender Data System" including all inmates (and clients under supervision by the probation service). This system holds data on persons, who are or have been in contact with the prison and probation service. The data recorded are among many others: Suicidal behaviour, substance abuse and mental disorder known by the prison staff. For reason of confidentiality the Offender Data System neither holds any medical data nor information from data sources outside the prison and probation service. Accordingly many data concerning health issues – including mental health – of the inmates are unknown; similarly discrepancies concerning mental health care provision between the prisons are unknown.

The five closed prisons have a total capacity (2005) of on average 922 places. One of the five closed prisons is the Herstedvester Institution (around 130 places), a treatment oriented prison with e.g. five psychiatrists and seven psychologist appointed (see below). None of the five prisons are maximum security.

The nine open prisons have a total capacity of 1,527 places (2005). These prisons are "open", only surrounded by a low fence. However, two of the open prisons have "semi-closed" wards with a total capacity (2005) of 135 places.

The 38 remand prisons ("gaols") have a total (2005) capacity of on average 1,700 places. Most of the 38 remand prisons are small with a capacity between 15 and 45 places. On the extreme hand is West prison, formally the remand prison for greater Copenhagen and as such one of the 38 remand prisons, the largest institution within the Prison and Probation Service.

The West prison has, apart from remanded prisoners, a few special wards for dangerous and dominating ("strong negative") prisoners serving long time sentences, e.g. members of motorcycle gangs ("rockers"). Denmark's only prison hospital (36 places) is located at the West prison.

Some of the prisons and remand prisons are old and not meeting today's standards concerning e.g. sanitary, suitable logistics etc. The Parliament has passed a large replacement and recondition programme, and in the autumn of 2006 one of the old prisons was replaced by a new one, another new prison is on the drawing board.

The number of prisoners is 4,149, divided among 2,449 sentenced and 1,700 remanded inmates (point prevalence December 2005). The capacity of places is thus utilized around 95 %, but within overcrowding.

Among the inmates 5 % are women. One of the closed and one of the open prisons receive women, a few mentally disordered do their time in the Herstedvester Institution. The women have their own wings, but are otherwise not separated from men, unless they want it themselves.

Around 30 % of the inmates are of non-Danish ethnicity, mainly immigrants or descendants.

For all sentenced prisoners work or some kind of education is mandatory. For the remand prisoners work or education is optional. The prisons and larger remand prisons have libraries and other various leisure-time activities.

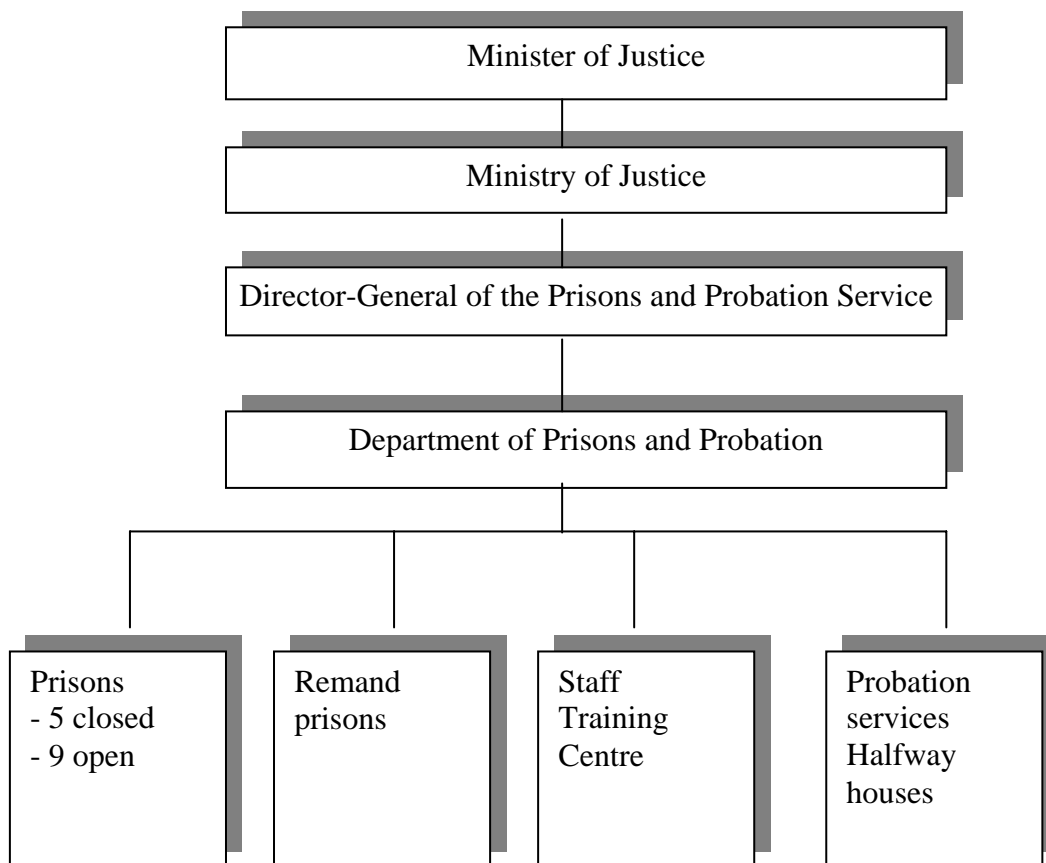
The larger prisons have a prison church with full-time or part-time employed (Lutheran) chaplains. Three larger closed prisons (incl. West Prison) have full-time or part-time employed imams for the large share of Muslim inmates. Other religious persuasions are served by priests from the society, these priest are going into the prison to visit the inmates.

In Denmark as in many other European countries law and order has been ranking high on the political agenda during the past 5-10 years. The length of the penal sanctions has been increasing, consequently the number of prison places has increased by approximately 10 % during the last five

years, even though the number of reported crimes has undergone a minor decrease. For the time being no further increase is planned.

In general the Danish correctional system is not a hot issue in the public debate, but single issues may cause a tremendous, but often short-lasting, media storm. However there are problems, which are often discussed within the system itself more than in the media. One of these is to find the optimal balance between normalization of prison life and protection of the weak inmates, e.g. sex-offenders or drug-abusers. In all Danish prisons (excluding remand-prisons) the inmates have a large degree of freedom within “the walls” or – in open prisons – within the (low) fences. The inmates buy food in the prisons grocer’s shop, cook themselves, they clean their own clothes in the wing’s laundry etc. This of course is a positive development. But this regime also opens the possibility that “strong” dominating inmates can dominate and exploit the “weak” inmates. Sex-offenders are ranking lowest in the prison hierarchy and are from time to time even beaten by their fellow inmates. The Prison and Probation Service is fully aware of these problems and have taken steps to solve them. Most sex offenders are doing their sentences in special wings in open prisons where they are easier to protect. Motorcycle gang members (“rockers”) e.g. serve their sentences in a special wing at Copenhagen (West) Prisons. But nonetheless it is still a problem – or perhaps a dilemma since there is no good solution.

**Figure 1: Organisation – Prison and Probation Service**



## Medical Services and Mental Health Care Provision in Prisons

The health care is administrated by the Prison and Probation Service. The annual total prison health service's budget is 80 million Dkr., the total prison budget being 2.2 billion Dkr. (operating costs). The prison mental health budget cannot be separated from the total health service budget.

A basic principle in Denmark is that inmates have access to the same quality of medical care and treatment as other citizens. This has been practice for years, and is now stipulated in The Act of Enforcement of Sentences, etc. from 2000. This is achieved by referring inmates in need of specialized treatment to the national general health service including, if appropriate, specialists in private practice. Inmates in need of hospitalisation (for whatever reason) are always admitted to ordinary hospital (and guarded by prison officers if necessary).

Denmark's only prison hospital is treating inmates from the whole country with minor somatic diseases including aftercare of operated patients; the hospital however does not have e.g. intensive care units. The head of the hospital is specialized in internal medicine. There are nurses on duty and doctors on call day and night.

All other prisons (except the Herstedvester institution, see below) and all remand prisons have part-time prison doctors 2-12 hours per week depending on the size of the institution. Most prison doctors are General Practitioners from the local area, who are prison doctors as a sideline. All prisons and the larger remand prisons have full-time nurses, the smaller remand prisons part-time nurses. Some of the prisons and the West prison, (excluding other remand prisons), have part-time psychologists. Finally the Prison Service employs some part-time dentists and a few laboratory technicians, physiotherapists etc.

The total number (full-time equivalents) of physicians is around 26, of this 10-12 are psychiatrists, furthermore (full-time equivalents) 84 nurses and 14 psychologists. The health staffs do not receive any special training, but full-time employed have to attend a course about the Prison and Probation Service – organization, rules and regulations, security and – not least – aims and values. The Department of Prisons and Probation however arrange conferences every or every second year for both prison nurses and physicians with topics related to the prison health including mental health.

At entry into a prison every offender, sentenced or remanded, either has a general health screening performed by a nurse or is informed that he can consult a nurse or doctor on request. In cases of health problems the nurse will refer the inmate to the prison doctor. The inmate himself can also ask to see the doctor. Remand prisoners may consult their own general practitioner, but the prison doctor has the overall responsibility for any treatment given.

During the imprisonment the inmates have the right to unsupervised consultations with a nurse or the prison doctor. The illness or disorders treated in the prison will be equivalent to those treated by a general practitioner in his practice. All treatment is carried out in accordance with the guidelines from the Danish National Health Board; there are no special rules from the Prison and Probation Service concerning "prison medicine".

## Mental health

The overall point of view is that mental health is part of the inmates' general health. At entry the nurse will assess the inmate's mental health. A general mental health screening procedure is currently under consideration. The prison doctor might choose to treat minor psychiatric problems, but if an inmate is suspected of having a more serious psychiatric disorder, he will be referred to a psychiatrist.

As mentioned previously, psychotic offenders are not punishable by law; they are according to a court order transferred to the general mental health service as inpatients or outpatients. Consequently, there should in principle not be psychotic inmates serving sentences, but it does

occur, that the legal system miss (or ignore?) that an offender is psychotic and hence sentence him to imprisonment.

There are psychotics among the remanded prisoners, and they will be transferred as soon as possible to a closed psychiatric facility within the general mental health service. However, due to capacity problem within the psychiatric service there are often waiting lists (which from time to time cause public debate). Inmates, who become psychotic while serving the sentence, or who were psychotic at the time of the offence, but were missed (or ignored?) by the legal system, will likewise, according to the Act of Enforcement of Sentences, etc. be transferred to an ordinary psychiatric facility, but again – it might take a while due to capacity problems within the mental health service.

Inmates with severe personality disorders serving long term sentences will do their time at the Herstedvester Institution and the Prison Service has concentrated the mental health treatment staff at that institution (see below).

All prisons (incl. as an exception the remand West prison) have part-time employed psychiatrists (2-10 hours, the West prison 24 hours, per week). Their job is to offer short-time therapy to inmates with e.g. a mild depressive disorder or a shorter lasting adjustment disorder. Furthermore they assess inmates suspected to suffer from more serious disorders and – depending on the case – admit such inmates (the psychotics) to ordinary psychiatric facilities or transfer them (the personality disordered) to The Herstedvester Institution (which also has a waiting list). Acute cases will be taken to an ordinary psychiatric emergency unit. If psychotic inmates fulfil the criteria in the Danish Mental Health Act for civil commitment, they will if necessary be involuntarily admitted to an ordinary psychiatric ward. During such an admission offender patients have exactly the same rights as ordinary patients. Involuntary psychiatric treatment cannot be used within the Prison Service.

Inmates are not regularly assessed/re-assessed by psychiatrists/psychologists during imprisonment. All prisoners are however evaluated regularly by the prison officers, social workers and others as to work, education, behaviour etc. If relevant, medical, including mental health information can be included in the evaluation, but due to medical confidentiality only if the prisoner accepts it. Psychiatrists may be asked by the prison administration to assess an inmate in relation to e.g. release on parole. A prisoner can ask to see a psychiatrist, and will then be referred from the prison doctor, to consult the psychiatrist within a few days, at most a week.

## **Special groups**

### ***Substance abusers***

Among prisoners in closed prisons around 60 % had a substance abuse before entry, 35 % of all misused opioids. In the open prisons the figures are respectively 53 % and 21 %, in the remand prisons 55 % and 25 % [2]. Withdrawal symptoms are therefore often seen after entry. Milder symptoms are treated in the prisons, whereas inmates with severe (psychotic) symptoms are admitted to general psychiatric facilities.

The prison services have launched various treatment programmes for inmates with substance abuse. Non-medical staff members most usually direct these programmes, e.g. “the Minnesota model” for treatment of drug abuse. The access to such treatment programmes is not formally regulated – if an inmate is motivated he can access the programme. The prison staff or those responsible for the programme may of course exclude somebody who e.g. fakes motivation in order to obtain the advantages combined with the programme. The efficacy of such programmes is uncertain. Inmates in substitution treatment, usually with Methadone, at entry often continue this treatment, particularly in case of short sentences, i.e. some months. In some cases the prison health staff initiate substitution treatment, e.g. before release. In order to ensure aftercare, such treatment will be arranged with the responsible ordinary drug treatment agency. In accordance with the basic principle of prison health care, Denmark does not have any kind of prison medical aftercare.

During recent years many other programmes have been established e.g. cognitive skills or anger management courses. The efficacy of these programmes is also uncertain.

In order to reduce the risk of transmission of HIV and hepatitis B inmates have access to a disinfectant in small bottles. Information material about how to rinse needles and syringes translated into 16 languages is available. Information about risk reduction in general is given to inmates by the health staff and written information material about Hepatitis B and C and HIV is also available in 16 languages. Some drug abusers are offered vaccination against Hepatitis B. Condoms are given.

### **Sex offenders**

In 1997 Denmark launched a nationwide treatment programme for sex offenders. The treatment is carried out in collaboration between the psychiatric health care system and the Department of Prisons and Probation. Offenders who have committed non-violent sexual crimes and who are motivated for treatment might receive suspended sentence on condition of psychiatric/sexological treatment. The treatment takes place at one of three psychiatric facilities, all of which are departments of university psychiatric clinics. Based on individual needs, the clinics offer counselling, cognitive therapy, psychoanalytically oriented psychotherapy or group therapy, together with psychopharmacological treatment if indicated. An offender is also under the supervision of a probation officer, who is responsible for social support and help in cooperation with the local social authorities.

Offenders who have committed more serious sexual crimes receive ordinary sentences. The imprisonment, however, starts with a short stay in a special unit at the Herstedvester institution with purpose of examining an offender's motivation for treatment, and if needed, to motivate him for treatment. Treatment-motivated offenders then serve their sentence in open prison and receive psychiatric/sexological treatment as previously described.

The most dangerous sex offenders are not included in the programme, but are still offered treatment during their imprisonment in Herstedvester.

A research project on the efficacy of treatment of sex offenders has from the very beginning been integrated into the treatment programme. Preliminary results [3], show that neither the rate of recidivism for sexual crimes nor the type of reoffending differs among those who have received treatment and those who have not. Based on the results from the study some referral and treatment procedures have been changed, in example there is now greater emphasis on alcohol abuse. The research project continues, but due to the fact, that relapse into sexual crime may occur after years, results will not be available for some years.

### **Suicides**

The average number of suicides in Danish prison 1995-2005 is 7-8 (min 3, max 10), An older study of prison suicide showed that a relatively large proportion of suicides occurred among remand prisoners shortly after entry, and that many, who had committed suicide, had psychiatric problems and/or had been admitted to psychiatric wards, underlining that mentally ill criminals should not be imprisoned.

Today suicide prevention is part of prison officer training, and information material describing risk factors, risk behaviour etc. is available for staff members in all prisons. Severely depressed inmates with suicidal thoughts and/or behaviour will be admitted to psychiatric facilities, parasuicidal behaviour as part of a short-term adjustment disorder is normally not an indication for admission.

All suicides and serious suicide attempts are reported to the Danish Ombudsman, who scrutinizes whether staff members including the health staff or "the system" could be responsible or criticised.



## The Herstedvester Institution

In Denmark inmates with even severe personality disorders are not regarded as forensic patients, i.e. belonging to the general mental health service, instead they serve their sentence within the Prison and Probation Service. However, the most disturbed (and dangerous) serve their sentence in a special prison, the Herstedvester Institution, which opened in 1936. The chief psychiatrist 1942-1972 was the well known Georg Stürup, who has described Herstedvester at that time in his book "Treating the untreatable [4]. Herstedvester is not a prison hospital, it is a prison operating under exactly the same regulations as other prisons, and additionally it is a well-staffed treatment-oriented institution, with a staff/inmate ratio of 2 to 1, which is considerable higher than in other Danish prisons. Currently, around 130 inmates are serving sentence at Herstedvester including nearly all lifers and preventive detainees. This implies that with a total of around 1,000 closed prison places, 11-12 % of all inmates (in closed prisons) are placed in Herstedvester. The treatment staff consists of five psychiatrists and seven psychologists, together with psychiatric nurses and social workers. Moreover a doctor, specialised up GP, is working full time at Herstedvester, treating the inmates' physical illnesses and – not the least – controlling and treating inmates receiving medical antihormone therapy (see below). The prison management is composed of the prison governor and the chief psychiatrist.

A basic principle at Herstedvester is that "treatment" is seen in a broader sense than just a contact between a therapist and a patient. All staff members participate in creating a "therapeutic atmosphere", and participate in some way or another in the treatment of the inmate. Furthermore prison officers may have information, which are valuable for the psychiatrists/psychologists and visa versa. At entry the inmates are therefore orally and in writing informed, that social workers and prison officers are informed by the psychiatrists/psychologists about the mental state of the inmates. This arrangement has been approved by the Commissioner for Human Rights, Council of Europe. Each wing has a psychiatrist or psychologist attached, and at each wing all inmates are reviewed every day at a "daily meeting". Rarely, when information falls under the patient/doctor confidentiality, "secret notes" are kept.

The Herstedvester Institution offers the inmates a variety of psychiatric treatment, being psychopharmacological or psychotherapeutic. As previously mentioned involuntary treatment cannot be used within the Prison and Probation Service, including Herstedvester.

There is a very narrow exception from this general rule as to Herstedvester. This prison receives some inmates supposed to be mentally ill from other prisons for further examination. If an inmate is found to be psychotic he will be transferred to the ordinary psychiatric service. However, if a psychotic inmate is very dangerous, fulfilling the criteria for being placed at the only high-security psychiatric facility in Denmark, short-lasting (e.g. weeks) involuntary treatment can be initiated at Herstedvester, if it supposed, that this treatment will improve the inmates mental condition to such a degree, that he can be transferred to an ordinary psychiatric facility. The procedure in such cases is the same as to involuntary treatment of psychiatric patients within general psychiatry [5]. However, this is mostly theory, because involuntary treatment has never been used at the Herstedvester Institution.

A special group of offenders consists of those sentences for serious sexual crimes. For years, this group has served their sentences at Herstedvester. Consequently, the institution has a long history of experience in the treatment of sexual deviants. Previously surgical castration was used. The treatment now used in the most serious cases is anti-hormone drugs (Cyproteron 300 mg depot injection i.m. every two weeks and Leuprorelin 11.25 mg depot injection s.c. every three month), always combined with an offer of psychotherapy. The anti-hormone therapy can only be initiated with the offender's oral and written consent. A recent study has shown, that anti-hormone therapy is very effective – when compared to a control group, anti-hormone treated sex-offenders have significantly fewer relapses to sexual crimes, the relapses are postponed and are less serious [6]. As regards to treatment of sex-offenders, Herstedvester has established a formal collaboration with three psychiatric facilities around the country. This link means that a sex offender can be released on probation under the stipulation that he continue the anti-hormone therapy initiated at Herstedvester.

As previously mentioned Herstedvester also has a special unit for non violent sex-offenders, who have received ordinary sentences. During a few weeks stay these inmates are assessed as to suitability and motivation for psychiatric/sexological treatment.

Another special group – partly overlapping with the serious sex-offender group – is the very dangerous offenders. Nearly all offenders sentenced to life or (time unlimited) security detention (save custody), serve their time at Herstedvester. Risk-assessment (and often also risk-management) is therefore an important task for the whole staff. In some cases prisoners from other prisons are transferred to Herstedvester for a risk-assessment. Denmark has no formal procedures as to risk-assessment, and it is for the clinicians at Herstedvester to decide how to do it, depending on the individual case.

In some ways Herstedvester serves as an air lock between the prison system and the psychiatric system. Disturbing, but not clearly psychotic prisoners from other prisons can – if necessary acutely – be transferred to the institution for diagnostic evaluation and possibly treatment of a short-lasting psychotic episode e.g. due to substance abuse. Offenders with more serious psychiatric disorders (psychotics) will be referred to psychiatric facilities.

Herstedvester is both a prison and a treatment-oriented institution. This combination of punishment and treatment, being each others opposites, has occasionally generated debate and criticism. (A broader discussion of this theme, which applies to the whole mental care within a prison system, is outside the scope of this article). The advantage is that offenders with severe personality disorders are treated within the prison system and not brought together with psychotic offenders, who are treated entirely within the psychiatric health care system.

### **Quality standards and ethical aspects**

As previously mentioned the basic principle concerning prison health care – including mental health care – is equivalence of care, i.e. that inmates should have the same care as the population in the society at large. This basic principle originates from the “Act on Enforcement of Sentences etc.” and other regulations belonging to the law. The Law Office, Department of Prisons and Probation, always ensure that Danish prison rules, including health care, are in accordance with the European Prison rules. The Danish National Board of Health lay down the overall guidelines for care and treatment. These guidelines also apply to the prison health services, including mental health services. Every citizen – and thereby also every inmate - has the opportunity to complain about both somatic and psychiatric health care provision to the National Board of Patients’ Complaints of the Danish Public Health Authorities, which is an independent body. Finally it should be mentioned that medical officers of health, employed by The Danish National Board of Health, inspects prisons (and other institutions) as to sanitation etc.

Only fully trained health staff members, authorized by the Danish National Board of Health, are responsible for the treatment of mentally disordered offenders. On the other hand no special training as to prison mental health is required or offered apart from previously mentioned meetings for the health staff.

Medical ethics including medical confidentiality is exactly equivalent to the standards and rules in society at large. Only the health staff – not prison officers or the prison administration – has access to the health record (the special issues concerning Herstedvester has previously been described). An inmate has the right to acquaint himself with his medical record. Any prisoner must give (written) consent to forward any medical, including mental health, information to others, including other physicians. This written consent is valid for one year only. In practice, however, the medical record follows the prisoner if he is transferred from one prison to another unless he opposes.

The prison governor – never the health care staff – has the responsibility for any disciplinary or coercive measure imposed on a prisoner. The prison staff may call a doctor to assess e.g. a secluded prisoner for physical damage or psychotic symptoms, and in case of the latter, the prisoner

will be (if necessary involuntary) admitted to a psychiatric ward. The doctor, however, will never express his opinion as to “the fitness” of the inmate to any coercive measure.

### **Epidemiology of mental disorders**

Valid epidemiological data about prevalence or incidence of mental disorders among Danish prisoners does not exist. Such data could only be obtained if representative samples of prisoners, remanded as well as sentenced were regularly assessed by psychiatrists utilizing e.g. ICD-10. However the practical value of such very expensive studies is limited. Many prisoners diagnosed as having a personality disorder, might not be motivated for treatment, and prisoners, who are motivated for psychiatric/psychological treatment can, independently of the diagnosis, serve time at the Herstedvester institution, provided the sentence is longer than a few years. Offenders with shorter sentences often serve time in open prisons, and if needy and motivated for treatment, they will, again independently of the diagnosis, be referred to the ordinary treatment system.

However, a recent thesis [7] – Mental Health in Prison Population – has evaluated close to 300 papers about the subject. The author (and co-workers) examined a representative sample of remand prisoners in West prison (receiving persons from greater Copenhagen). The aggregated current rate of psychotic disorders (section F20-F29 in the ICD-10) was 7 % (schizophrenia including schizotypal disorder 4 %), mood disorders (section F30-F39) was 10 % (mainly dysthymic disorder), and neurotic, stress – related and somatoform disorders (section F40-F49) was 16 %. The prevalence of psychopathy was 12 % using the proposed PCL-R cut-off score for European standards.

Gosden [8] studied a total sample of 15-17 years old remand prisoners from the eastern part of Denmark including Copenhagen. A total of 71 % could be diagnosed according to ICD-10 (prevalence last year). Among these 41 % had a co morbid disorder, most often substance abuse (41 % of the total sample). Schizophrenia was diagnosed in 2%, schizotypal disorders in another 2 %, 3 % were mildly mentally retarded and 36 % fulfilled the diagnostic criteria for personality disorders.

Finally it should be mentioned that Munkner [9] in a register based study has showed that 37 % of men and 7 % of women later diagnosed as schizophrenics, committed a crime before first contact to the psychiatric hospital system.

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## England & Wales

David James

### Introduction

It is difficult to fault the principles upon which the system for dealing with mentally disordered prisoners in the United Kingdom is based. Indeed, its aims could scarcely be more laudable. Unfortunately, the gulf between theory and practise is vast and probably unbridgeable, and the treatment of mentally disordered prisoners would surely be a national scandal, if the population or the news media cared sufficiently about the problem to afford it any attention. The following account will concentrate describe the system in theory, and will contrast this with the everyday reality.

### *The system for dealing with mentally disordered people who offend in the UK*

In the United Kingdom, prisoners, whether on remand or sentenced, who are suffering from serious forms of mental disorder (i.e. psychotic illnesses or severe mood disorders) and deemed in need of hospital treatment, are transferred out of the prison system into National Health Service (NHS) psychiatric hospitals, either general or forensic, depending on the clinical needs of the patient. Compulsory treatment is not permitted in prisons under the Mental Health Act 1983, because there are no hospitals in prisons. Prisons contain "health care wings", but these are not designated as hospitals and there are no psychiatric "wards" within the prison system.

In addition, the United Kingdom differs from many other countries in the European Union in that concepts of criminal responsibility in adults are irrelevant in the disposal of mentally disordered offenders by the courts, other than in cases of homicide. In consequence, people with mental illness who are found guilty of a criminal offence and who meet the criteria for treatment in NHS hospitals under the Mental Health Act 1983 are sent to hospital by the courts in lieu of any other form of disposal, and all links between the convicted person and the criminal justice system are thereby severed.

Those sentenced to prison terms who are subsequently found to be suffering from serious mental illness are transferred out from prisons into NHS hospitals. Once there, some may be returned to prison when they improve, but many will complete their sentences in NHS hospitals.

The care of the mentally disordered in prisons therefore falls into two halves: the identification of serious mental disorder and the implementation of mechanisms to transfer prisoners out of the prison system: and efforts to offer treatment for less serious mental illness, personality difficulties and substance abuse problems within the prison estate.

The United Kingdom is split into three main legal jurisdictions: England & Wales, Scotland and Northern Ireland. Legal differences are greatest between the first two. Only the prison service in England & Wales will be considered in this chapter. England & Wales, Scotland, Northern Ireland, the Isle of Man and the Channel Islands each have their own prison administrations.

## **Structure of the prison system in England & Wales**

### ***History***

Transportation to the colonies, initially North America until 1788 and then Australia until 1868, was a common form of punishment in the late eighteenth and early nineteenth centuries. However, this was removed as a sentencing option, first by the American Revolution and then by changes in the growing Australian colony. In addition, by the middle of the nineteenth century, capital punishment was regarded as an inappropriate sanction for many crimes, and imprisonment replaced capital punishment for most serious offences - except for that of murder.

In 1877, prisons were brought under the control of the Prison Commission. For the first time, all prisons were controlled centrally. At the end of the nineteenth century, there was recognition that young people should have separate prison establishments - thus the borstal system was introduced in the Prevention of Crime Act 1908. The Criminal Justice Act 1948 abolished penal servitude, hard labour and flogging. It also presented a comprehensive system for the punishment and treatment of offenders. Prison was still at the centre of the system.

### ***Organisational structure***

The modern Prison Service (if that is not an oxymoron) has for many years come under the aegis of Home Office (Interior Ministry). But, in April 1993, it became an Executive Agency of the Home Office. This new status allowed for greater autonomy in operational matters, while the government retained overall policy direction. The Prison Service is responsible for providing public sector prison services in England and Wales. Its main statutory duties are set out in the Prison Act 1952 and rules made under the terms of that Act.

The Prison Service Management Board is the senior management committee. It has eight members and is chaired by the Director General of the Prison Service. Its role is to monitor performance, to decide upon the Service's priorities (within the policy framework and resources agreed by Ministers), and to set goals and performance targets to ensure that decisions are carried through (Leech, 2005). These are reflected in the Prison Service's published Vision Statement and Statement of Purpose.

The prisons estate is divided into twelve geographical areas, each of which is overseen by an area manager, who will be an experienced prison governor. The area managers form the link between the Management Board and the local prison establishments, each of which is run by its own governor.

In 2004, the National Offender Management Service (NOMS) was announced by the Home Secretary, with the intention of introducing "end-to-end offender management". In effect, this combined the Prison Service and the Probation Service in one organisational structure from June 2004 onwards. NOMS spans several organisations and controls around 69,000 staff. Its aim is to ensure the provision of a range of services to adult offenders and those on remand in England and Wales, including offender management, custody, community custody and programmes and interventions (Leech, 2005). NOMS issues annual business plans, corporate plans and performance targets, which aim to push through modernisation and change. The Prison Service has always been primarily an operational organisation: this is now more so than ever, as consideration of policy has now been transferred to NOMS. The Prison Service, in effect, now operates as a provider of custodial services, as do the new private sector prisons.

### ***Funding***

Prison service funding from each financial year from 2005 to 2008 has been allocated by NOMS, following the outcome of Government Spending Reviews, which decide the allocation of resources between the various government departments and the services for which they are responsible. The Prison Service, as with other agencies within the wider Home Office has been required to contribute to "efficiency savings". The service has been in a difficult financial position, having to cope with an

increase in staff wages and to make allowance for a significant extra increase in liabilities for staff pensions, at a time of financial restrictions. This comes at a time when the prison population has been rising steadily for fifteen years and the existing prison stock is operating at full capacity.

In 2003-04, according to the Home Office's Annual Report, the total resource budget for correctional services – including prisons, probation and the Youth Justice Board – had risen by over 50 per cent since 1998-99, up from £2.33 billion to £3.5 billion (and was planned to increase by 65 per cent by 2005-06).

The resource budget for prisons has risen by £340 million and the budget for probation has more than doubled from £328 million in 1998-99 to £816 million in 2003-04. Capital expenditure on prisons for 2003-4 was £266 million, only fractionally higher than the £260 million allocated in 1998-99 – despite the large rise in the prison population. The capital budget for 2004-05 and 2005-06 was projected at £270 and £167 million respectively.

It costs an average of £37,305 to keep a person in prison (Social Exclusion Unit, 2002). The average cost of each prison place built since 2000 is £99,839 (Hansard, House of Commons, written answers, 30<sup>th</sup> June 2005, column 1669W).

### **Categories of prisoner**

Male adult prisoners (those aged 21 or over) are given a security categorisation when they enter prison. These categories are based on the likelihood of their trying to escape, and the danger to the public if they did escape. The four categories are:

- **Category A** prisoners are those whose escape would be highly dangerous to the public or national security
- **Category B** prisoners are those who do not require maximum security, but for whom escape needs to be made very difficult
- **Category C** prisoners are those who cannot be trusted in open conditions but who are unlikely to try to escape
- **Category D** prisoners are trusted enough to wander freely within the prison but must attend several daily roll calls

Female adult prisoners are categorised along similar lines into category A, closed and open.

Young offenders (under the age of 21) may be sent to three forms of establishment:

- **Secure Training Centres (STCs)** – privately run, education-focused centres for offenders up to the age of 17.
- **Local Authority Secure Children's Homes (LASCHs)** – run by social services and focused on attending to the physical, emotional and behavioural needs of vulnerable young people.
- **Young Offender Institutes (YOIs)** – run by the prison service, these institutes accommodate 15-21 year olds. They have lower ratios of staff to young people than STCs and LASCHs, and are more akin to adult prisons.

Below, the account will be limited to prisoners over the age of 21.

### **Types of prison**

- *Local prisons* are so called because they tend to be located in towns and cities. They deal with men who are sent directly from court, either when remanded in custody before trial or after conviction or sentence. They are responsible for categorisation of prisoners before their transfer to other prisons to serve their sentence (except for category A prisoners who are classified at Prison Service Headquarters). Local prisons can also keep those given short sentences for the duration of their sentence. Local prisons tend to be old buildings with poor physical conditions and the most deprived regimes. There are 32 male local prisons and six female local prisons.

- *Dispersal prisons* – rather than concentrating the most dangerous prisoners in one establishment, the policy has been to “disperse” category A and B prisoners amongst different establishments. There are five dispersal prisons, all of which number amongst the eight high secure prisons. Dispersal prisons tend to take those serving the longest sentences, and so the regimes in terms of educational opportunities and work are of a higher standard.
- *Training prisons* have training facilities and vocational courses. A training prison is one that a prisoner may be transferred to after initial assessment at a local prison. There are eight category B training prisons and 35 category C training prisons for male prisoners. Category C prisons tend to have lower levels of staffing and less perimeter security. For female prisoners, there are six comparable closed prisons.
- *High security prisons* – there are eight such prisoners, constructed to high security specifications. The five dispersal prisons are amongst these. Some include small special security units which are, in effect, prisons within prisons, and are intended for prisoners who present particular control problems.
- *Open prisons* – these are category D prisons in which there is little in the way of perimeter security. Inmates may not be locked up and may hold keys to their cells. Prisoners are only sent to such establishments if there is thought to be no chance of their absconding. Many such prisoners will be released into the community each day to undertake community work or training. There are eight male open prisons and two female.
- *Privately-run prisons* – within the categories summarised above, there are eleven privately-run prisons accounting for nearly 10 % of total capacity. The first was opened in 1992. They are subject to the same regulations and monitoring structures as state-run prisons.

### **Population and capacity**

The rate of incarceration in England and Wales is 148 per 100,000, which is the highest rate in the pre-accession European Union and above the mid-point of the world list. Since the start of 1993, the prison population of England and Wales has risen by 90 %, from 41,600 to 79,714 in October 2006. The operational capacity in October 2006 was 80,055 and 87 prisons (or 60 % of the total) were overcrowded in terms of holding more prisoners than their target limit, although more than 17,000 extra prison spaces have been built since 1997. Of the prison population, 16.6 % were remand prisoners (10.5 % untried, 6.1 % convicted unsentenced). 5.6 % were women. 12.5 % of all prisoners were foreigners (but nearly a quarter of all women prisoners were foreigners, this relating to the ‘drug mule’ issue). 3.2 % were under eighteen years of age. (In addition to these 2,511 juveniles, a further 268 were being held in Secure Training Centres and 230 in Local Authority Secure Children's Homes).

There are about 90,000 annual prison receptions and therefore an annual total of around 160,000.

By 1<sup>st</sup> December 2006, the total prison population for England and Wales exceeded 80,000 for the first time ever. Current Home Office projections as of June 2006 (Home Office, 2006) predict that prison populations will continue to rise: three scenarios are modelled, giving the following projected figures for mid-2013: low 90,250; medium 98,190; high 106,550. In previous modelling exercises, the high rate has proved to be the closest approximation to the actual rate.

It is of note that the rise in prisoner numbers has occurred over a period when crime rates and court work-loads have been falling. The increase in numbers is primarily a result of increased readiness on the part of sentencers to pass custodial sentences and, when they do, to pass longer sentences. The changes are a result of an increasingly punitive government attitude to issues of crime and punishment, and consequent changes to legislation on sentence length and to sentencing guidelines (Millie, Jacobsen and Hough, 2003).

### **Scotland and Northern Ireland**

At 27.10.2006, the Scottish prison population was 7,131: this represents a population rate of 139 per 100,000. There has been a marked increase in numbers from 5,357 in 1992 (105 per 100,000). In



October 2006, 21.7 % of the total population were remand prisoners (19.5 % untried, 2.2 % convicted unsentenced). 4.5 % were women. 2.6 % were under eighteen years of age. 1.3 % were foreigners. The prison system was operating at above capacity.

At 27.10.2006, there were 1,466 prisoners in Northern Ireland, a population rate of 84 per 100,000. 39.8 % were remand prisoners. 2.7 % were women, 5.2 % under eighteen, and 0.8 % foreigners.

## **Medical services and mental health care provision in prisons**

### ***History***

At the inception of the National Health Service in 1948, prison health care remained outside the new arrangements and was financed through the Home Office (Interior Ministry). In effect, the prison service had its own primary care system, and any assessments from secondary psychiatric services were requested from NHS hospitals and paid on an item of service basis. For hospital treatment, transfer to NHS facilities outside the prison system was necessary. However, standards in the prison health care service gradually fell far behind those in the NHS. For instance, until 1999, all that was needed to work as a doctor in prisons was a medical degree, with no further training. This contrasted with the system for general practitioners in the NHS, which required three years on a specialist training rotation and the passing of higher examinations. In terms of mental health, the position became particularly concerning, and a number of epidemiological surveys high-lighted the degree of psychiatric morbidity within the prison population (e.g. Brooke et al, 1996; Singleton et al, 1997).

During the 1990s, a number of influential reports on prison health care were published. The government adopted the principle of 'equivalence of care' (Home Office, 1990, 1991; HM Prison Service & NHS Executive, 1999). Prisoners should receive the same level of health care as they would were not in prison – equivalent in terms of policy, standards and delivery (Health Advisory Committee for the Prison Service, 1997). The prison population is conceptualised as a community, and the health care provided within prison should be equivalent to primary care in the NHS, including specialist out-patient services. Any prisoner requiring more than primary care is to be transferred from prison to hospital to receive it.

It was eventually accepted that the principle of equivalence was not attainable whilst the prison health service remained separate from the National Health Service. The National Health Service Reform and Health Care Professions Act 2002 contained the necessary orders for the transfer of budgetary responsibility for health care from the Prison Service to the National Health Service. This transfer happened in stages, but was completed in April 2006. From that point, health care in the prisons has been the responsibility of the NHS – or, to express the situation more formally, the commissioning of health services for prisons in England and Wales has become the responsibility of the Primary Care Trusts, the purchasing organisations that commission health care provision for their areas on behalf of the NHS.

### ***Current situation***

In each area of England (generally, county size in most of the country and at borough level in London), the local Primary Care Trust (or PCT) is responsible for purchasing NHS services from health care providers (mainly NHS hospitals) for the population of the area concerned. Where a prison happens to be located in the area for which a particular PCT is responsible, it is the responsibility of that PCT to commission appropriate health care in the prison from local NHS providers. There are 93 PCTs in England with a prison in their area. There are therefore a similar number of different commissioning processes and service configurations within prisons.

A prison is to be seen simply as another section of the general community, and the medical services provided to it are to be the equivalent in availability and quality to those available to anyone in the population. This is reflected in the structure of the services supplied.

- The first level of care is 'primary care', meaning general practitioners (family doctors). Most prisons have their own primary care doctors, who are now trained general practitioners who work in the prison. In some prisons, family doctors from outside the prison will come in to do surgeries.
- Secondary care involves the equivalent of hospital outpatient appointments and hospital inpatient care. Consultants from a number of specialities attend prisons to conduct outpatients' clinics. For others, prisoners must be taken to clinics at outside hospitals.
- There are no hospitals in prisons. Any condition requiring acute hospital care results in a transfer to an outside hospital.

Each PCT makes decisions of its own concerning the configuration of services that it introduces to prisons and the choice of a supplier for those services.

### ***Prison health care budget***

There is no central prison health care budget. Notional sums were made available to PCTs at the time responsibility for health care was transferred. PCTs drew up their own budget projections. It is unclear to what extent these relate to actual sums spent. The first year of the new arrangements will not be completed until the end of March 2007. There is as yet no summary available of budget projections from all the local PCTs. The matter is complicated by responsibility for the care of prisoners transferred to hospital lying with their previous area of domicile. Some programmes (such as Hep B inoculation) are funded from central budgets. Responsibility for secure psychiatric care is about to be centralised under new national arrangements.

### ***Structural problems***

The prison health service is undergoing the most ambitious re-organisation in its history. However, the manner in which it is doing so, as far as mental health is concerned, is beset with problems:

- 1) The fact that different PCTs are responsible for different prisons means that there is no uniformity of services across the country, and services are in consequence fragmented.
- 2) The psychiatric service responsible for a given prisoner is that which serves the area in which he previously resided. It is policy to disperse many prisoners around the country, meaning that they are often imprisoned away from their home areas. This leads to difficulties in liaising with the relevant psychiatric services – either to arrange transfer, or in order to hand over cases at the end of sentence.
- 3) Few prisoners remain in one prison for the duration of their sentence. Therefore, treatment approaches to psychological problems in one prison are interrupted or discontinued every time that the prisoner is moved.
- 4) PCTs in many areas are choosing to purchase different parts of their 'inreach' services from different organisations. For instance, general psychiatry, forensic psychiatry, and drug/alcohol treatments are often commissioned separately. This means a lack of co-ordination and coherence in attempts to provide comprehensive care.
- 5) Local general adult psychiatry services have in many areas been pressed reluctantly to provide services in an environment which is alien to them, to a population with which they have little sympathy. Whereas forensic psychiatry services might broadly be typed as seeking out mentally ill people to transfer to hospital, the general adult services have always tended to the opposite stand-point – looking for reasons not to transfer to hospital. There is a conflict in ethos.
- 6) There is a dire shortage of beds in NHS psychiatric hospitals into which prisoners can be transferred. This applies both to forensic units and to general adult units. With the latter in particular, there is an appreciable tendency to alter diagnosis according to bed availability. For instance, a man

with schizophrenia might be re-diagnosed as suffering from a personality disorder if he were white, and as suffering from drug intoxication if he were black. And dual diagnosis in itself is often seen as an exclusion criterion to hospital transfer.

7) There is very little treatment available for people with personality disorders, either in prison or outside. There are few services for those with non-psychotic mental disorders.

8) The custodial environment of prisons makes attempts to introduce defensible standards of care into prisons extremely difficult. Those attempting to provide inreach services within prisons have been hampered by attempting to work in a culture where security is the predominant factor. The clash of cultures has hampered health care.

9) Chronic over-crowding in the system has made the internal functioning of prisons difficult. It is reported that appointments with psychiatrists in some prison clinics show a 35 % default rate, as there are insufficient staff available to move prisoners across the prisons to the clinics (Rickford & Edgar, 2006).

10) Each prison governor has been left with the power to interfere with the form and details of the mental health service being introduced into their prison. The mental health input is therefore subject to the whim or personal interests of each prison governor.

### ***The principle of 'equivalence'***

It is far from clear that the idea of equivalence of care between the community and the prisons is attainable as an aim in the current circumstances. With the prisons full to over-flowing, contingency plans to hold prisoners in police stations, and discussions about commissioning prison ships and converting former holiday camps into temporary prisons, it is a difficult time to attempt to introduce improvements in health care. It seems unlikely that the prison health care system can be reformed until such time as the prison system itself is reformed.

A further issue is whether equivalence is in itself a sufficiently ambitious aim. The needs of the prison population are greater than those of the general population in terms of mental health care (see below). The services available to the community would, even if adequate to the community itself, prove inadequate to the prison population. And it is currently quite apparent that the services available to the community are inadequate across the board. This relates not only to the shortage of beds and of after-care services. The National Health Service is currently transferring the care of all psychiatric problems other than severe enduring mental illness (i.e. active psychosis) to general practitioners, who have neither the time nor the expertise to take on this task. There are virtually no services for people with personality disorders, who are generally simply excluded from care. Those with non-psychotic disorders generally find themselves with limited access to services. In addition, the whole health care system is currently being subjected to covert privatisation, with the predictable accompanying compulsory "efficiency savings" (i.e. cuts in services).

### ***Epidemiological issues***

Approximately 90 % of prisoners have either a psychosis, a neurosis, a personality disorder, or a substance misuse problem (Singleton et al, 1998). 72 % of male and 70 % of female sentenced prisoners suffer from two or more mental disorders (compared with 5 % and 2 % respectively of the general population). About one in ten (7 % of males and 14 % of an estimated 3,000-3,700 prisoners require urgent transfer to NHS hospitals (Singleton et al, 1998; Rickford & Edgar, 2006; Prison Reform Trust 2006). This figure is based upon epidemiological surveys, and many cases of mental illness are simply not identified by the health care system. Even using the conservative parameter of the number of recognised cases in health care centres needing transfer to hospital, at least 500 people fall into this category (Reed, 2003). The Chief Inspector of Prisons has estimated, based on visits to local prisons, that 41 % of prisoners being held in health care centres should have been in secure NHS accommodation (HM Inspectorate of Prisons, 2004). 40 % of male and 60 % of female

sentenced prisoners have a neurotic disorder, more than three times the level in the general population. 64 % of male and 50 % of female sentenced prisoners have a personality disorder. A high proportion of prisoners have previously been treated as inpatients in psychiatric hospitals (20 % of male and 15 % of female sentenced prisoners).

At any one time, there are around 40 prisoners who have been waiting for more than three months for transfer to NHS psychiatric hospitals after assessment. There are also long waiting lists for assessment. The rate of transfer of sentenced prisoners to hospital has hardly increased since 1994.

A study for the Home Office found that 47 % of recently sentenced male prisoners had used heroin, crack or cocaine in the twelve months prior to imprisonment (Ramsay, 2003). Nearly two-thirds of sentenced male prisoners (63 %) and two-fifths of sentenced female prisoners (39 %) admit to hazardous drinking which carries the risk of physical or mental harm. Of these, about half have a serious alcohol dependency.

Most prisoners belong to the group termed the 'socially excluded'. 27 % of the prison population were taken into care as children (compared with 2 % of the general population). 30 % truanted regularly (3 % in the general population). 49 % of male sentenced prisoners and 33 % of females were excluded from school (cf. 2 % in the general population). 48 % of prisoners have a reading age below that of an eleven-year-old (cf. 22 %) and 65 % a numeracy level below that age (cf. 23 %). 67 % were unemployed before imprisonment (cf. 5 %) and 32 % were homeless (cf. 0.9 %).

The suicide rate for men in prison is five times that for men in the community. For boys aged 15 to 17, the rate is 18 times that in the community. The overall prison suicide rate per 100,000 increased from 111 in 1997 to 127 in 2003. 72 % of those who commit suicide in prison had a history of mental disorder (Shaw et al, 2003).

Attempted suicide over a twelve month period ranged from 7 % in male sentenced prisoners to 27 % in female remand prisoners. Self harm during the current prison stay ranged from 5 % in male remand prisoners to 10 % in female sentenced prisoners (Brooker et al, 2002).

A summary of a wide range of epidemiological data relating to prisons in general and prison health care is to be found in Prison Reform Trust, 2006

### ***Ethnicity***

People from black and ethnic minority communities are over-represented in prisoners in England and Wales. Men from ethnic minorities account for 19 % of prison receptions, a 300 % over-representation. Women from ethnic minorities account for 25 % of receptions. In London, about 45 % of those discharged from prisons are from ethnic minorities (London Resettlement Board, 2005).

### **The shape of services**

Theoretical consideration has been given to the pathway through which mentally disordered prisoners might path in the newly reconstituted health services to prisoners (Department of Health, 2005). But there has been little in the way of implementation guidance to direct the new psychiatric teams or those commissioning them (Sainsbury Centre, 2006).

### ***Reception and screening***

Upon arrival at prison, a questionnaire is administered to prisoners about their health, including questions concerning mental health. This is brief. It is sometimes administered by nurses, but often by prison officers. Prisoners are then supposed to be examined by a doctor within 24 hours. These examinations are often cursory and insufficient to pick up any except the most disturbed mentally ill.

Many mentally ill people probably pass through health screening undetected when they are received into prison and remain on ordinary location (on prison wings) without ever coming to the attention of a doctor (Birmingham et al, 1996). This means that, although mentally ill offenders are supposed to be diverted to hospital, end up in prison by default, especially those who have committed relatively minor offences.

There are various reasons for the difficulty with screening. One is the volume of arrivals, which in some prisons is as many as 80 at the end of a working day. This is not conducive to questioning in a relaxed manner, nor to arriving prisoners feeling able to disclose their problems. A new screening tool has been introduced in recent years (Carson et al, 2003), but there are concerns as to how effective it is in identifying mental health problems, particularly in the circumstances mentioned above.

There is no further screening of inmates during their sentence, unless specific reasons come to light why such an examination should be conducted. Prisoners are supposed to be examined before release. If there are mental health issues, the prisoners are supposed to be subject to the Care Programme Approach, a system of multi-agency monitoring used with the seriously mentally ill in the community. This does not always happen and where it does, its implementation is of limited effect, because of fundamental difficulties in the prison health service co-ordinating with over-stretched and under-staffed community agencies. Half of those sentenced to custody are not registered with a GP prior to being sent to prison (Social Exclusion Unit, 2002).

### ***Primary Care in Prisons***

Primary care is probably the weakest aspect of prison mental health care. The system currently relies in part on locum doctors. Many of those providing primary care to prisons have not had any training in psychiatry. There is little connection with main-stream primary care in that approximately half of sentenced prisoners are not registered with a general practitioner in the community. Nurses are used to run clinics for some physical problems (e.g. diabetes), but there are very limited services for dealing with non-psychotic disorders. In part, this is due to the complexity of the prisoners problems, with a mixture of chaotic lives, neurotic and personality disorders and substance abuse, which goes beyond the skills of prison primary care personnel to deal with. There are some counselling services, but these are limited. Prisons employ psychologists, but these engage in group work and do not have the time for individual therapies. In consequence of all of the above, the threshold to refer to secondary services is generally lower than it might be in the community, in cases where a problem is recognised.

### ***Secondary care: prison inreach teams***

Prison inreach teams are said to be at the heart of the government's attempts to improve prison mental health care. Inreach teams have now been provided to most prisons in England and Wales. The basic idea was that the inreach team would be analogous in composition and function to community mental health teams outside prison. These comprise psychiatrists, psychologist, social workers and nurses and are supposed to provide comprehensive mental health services from community outpatient bases.

In practice, inreach teams have soon encountered problems, and most have found that it is not possible to operate a community mental health team model in a prison. Reasons are various: the limited mental health skills of primary care and prison health care staff; the restrictions of the custodial environment; the high levels of comorbidity; the high number of referrals for assessment; the levels of prisoner turn-over; difficulties in gaining access to historical information; and the simple fact that prisons in themselves are not conducive to good mental health (Sainsbury Centre for Mental Health, 2006). Emphasis in most cases has been on those with serious mental health problems (psychosis). The role has been limited to assessment, medication management and extensive liaison with outside services. Where this has been about potential prisoner transfer to NHS psychiatric hospitals, all interactions are difficult and complicated, with outside services reluctant to take on the

care of this group and the shortage of beds resulting in major delays. Barriers are erected by NHS hospitals, for in stance insisting on re-assessing the prisoner themselves, rather than accepting the assessment of the inreach psychiatrist. Where liaison has been about aftercare for prisoners being discharged from prison, the same forms of problem prevail. And, given the somewhat itinerant lifestyles of many prisoners before arrest, matters are complicated by disputes about which catchment area service should be responsible for the person concerned.

### ***Substance abuse***

Substance abuse programmes have been introduced into most prisons and tend to be provided by outside agencies separate from psychiatric care. This creates problems, because many people with mental illness also have substance abuse problems and such cases tend to fall into a gap between the two services, receiving proper attention from neither. The need for a coherent single service dealing with both sets of problems has yet to be recognised.

The Prison Service does not keep records of the percentage of prisoners with drug problems who actually receive treatment. But, according to a Home Office research study, only 10 % of prisoners with drug problems were engaged in intensive drug rehabilitation. More than 40 % of those who had used drugs in the previous year wanted treatment, but were not receiving any (Ramsay, 2003). Transfers between prisons due to overcrowding often disrupt drug treatment, and a recent study found that one-third of prisons were unlikely to be able to continue the treatment of prisoners referred to them (National Audit Office, 2002).

### ***Learning disability***

11 % of remand prisoners and 5 % of sentenced prisoners have an IQ of 70 or less (Singleton et al, 1998). There is little evidence of any specific consideration given within prison health services to the needs of this group.

### ***Sex offender programmes***

Sex offender treatment programmes are mandatory for most categories of sex offenders. Whilst forensic psychiatry services may have a role in providing multi-disciplinary sex offender treatment programmes, sex offender programmes are not generally part of overall health care commissioning arrangements. Sexual offenders do not generally have mental health problems, and sexual paraphilias and disorders of sexual preference are specifically excluded from the scope of the Mental Health Act. Services are provided in prison on a group basis, generally by non-clinical psychologists employed by the prisons.

## **Quality standards and their regulation**

### ***a) General standards***

There are three bodies that monitor standards within prisons:

#### ***Independent Monitoring Board (formerly Board of Visitors)***

The Independent Monitoring Board used to be called the Board of Visitors, but its name was changed to reflect the role of the Board and to avoid confusion with Prison Visitors.

Every establishment in England and Wales has its own Independent Monitoring Board. These are independent watchdogs drawn from the local community who are appointed by the Home Secretary to monitor the welfare of staff and prisoners and the state of the premises. Members have

unrestricted access to all parts of the establishment, with the only exceptions being on grounds of security or personal safety.

Board members will raise prisoner and staff concerns with management, the Governor, Area Manager, Headquarters, or even Ministers and the Home Secretary. In the event of a serious incident at an establishment, a Board member must be invited to observe the way it is being handled.

### ***Prisons and Probation Ombudsman (PPO)***

The Ombudsman is appointed by the Home Secretary, and is an independent point of appeal for prisoners and those supervised by the Probation Service.

For the purpose of investigations, the Ombudsman has full access to Prison Service information, documents, establishments and individuals, including classified material and information provided to the Prison Service by other organisations, such as the police. For medical records, the prisoner's consent is required for disclosure.

### ***HM Chief Inspector of Prisons (HMCIP) for England and Wales***

HM Chief Inspector of Prisons is independent of the Prison Service and reports directly to the Home Secretary on the treatment of prisoners, the conditions of prisons in England and Wales, and such other matters as the Home Secretary may require. The reports of the Chief Inspector are often savagely critical of the poor state of prisons in England and Wales and of standards of care.

The problem with these various bodies is that their highly critical reports on health care in various prison establishments do not in themselves bring about any change, although their combined effect over the years has been of significance in forcing recognition that the system needed changing.

### ***b) Voluntary groups***

There are a number of non-governmental organisations which monitor issues such as health care in prisons. These include the Prison Reform Trust and the Sainsbury Centre for Mental Health.

## **Conclusion**

The state of mental health care in prisons in England and Wales has for many years been a national disgrace, despite the exemplary principles on which it is theoretically based. The health care system for the mentally disordered is inadequate, incoherent and over-whelmed.

Health care to prisons is now undergoing major changes, as a result of its incorporation into the National Health Service. Whereas it could previously have been said to have been long-neglected, this is no longer the case. There is a plethora of police document on various aspects of care being circulated by central government. However, there is a reliance on local NHS commissioning agencies assessing the needs of their local prisons and providing care accordingly. The wisdom of devolving the task of commissioning care to bodies with no knowledge and little understanding of prisons is open to question. There is a depressing lack of central control as to how services are provided. The principle of equivalence is only useful in so far as the services in the community are in themselves adequate. And it appears to take insufficient cognisance of the fact that those in prison have a far greater level of morbidity and more complex problems when compared to community samples.

A further effect of the localised provision of health care is that it is difficult to audit. In contrast with many other countries, annual national statistics on such matters as levels of morbidity, treatments provided, failures to provide needed treatment and the prescription of psychotropic medication are not available. There is reliance instead on the commissioning of epidemiological research studies. This is perhaps a recognition that, for instance, in a system that is unable accurately to detect mental

illness in its prisoners, any prison data returns on the issue would be of limited value. But it is also a measure of the lack of system coherence.

Despite the reorganisation and all the newly issued policies, it is not yet clear whether there is any political will to bring about real change. It is also doubtful that any real change can be effected until the current chaos of the prison system as a whole is subject to major reform.

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## Finland

### Riittakerttu Kaltiala-Heino

#### Legislative control of and agreements concerning prison services

Regulation of criminal sanctions in Finland is stipulated in a number of laws and bi-laws (Appendix 1). The current act on implementation of prison service (Laki rangaistusten täytäntöönpanosta (39/1889)) will from 1.10.2006 on be replaced by a new act (Vankeuslaki 767/2005) that covers starting, serving and terminating the sentence, placement and transfer within prison system, basic care and accommodation, activities and occupation, property and income, health care and social services, leisure time, communication to outside prison, discipline, supervision and control, and administrative issues. In addition, of health care there are regulations in act on prison sentence administration (Laki rangaistusten täytäntöönpanon hallinnosta (135/2001)). Health care in prison is regulated, as all health care, in the act on status and rights of the patients (laki potilaan asemasta ja oikeuksista (785/1992)), act on health care professionals (laki terveydenhuollon ammattihenkilöistä (559/1994)), mental health act (mielenterveyslaki (1116/1991)), act on communicable diseases (tartuntatautilaki (583/1986)), and act on occupational health services (työterveyshuoltolaki (1983/2001)). The criminal sanctions agency gives more detailed instructions on health checks and health services in prison. A number of international agreements on prison activities and human rights in prisons are followed.

#### The prison system

In Finland, the body responsible for management and development of criminal sanctions is Criminal Sanctions Agency (Rikosseuraamusvirasto), under the Ministry of Justice. The Criminal Sanctions Agency is divided to four units responsible for management of Prison Service (Vankeinhoitolaitos), management of Probation Administration (Kriminaalihuoltolaitos), carrying out the prison sentences and community sanctions and the shared administration for prison and probation services. Prison sentences, fine defaults and remand imprisonments are carried out by Prison Service (Vankeinhoitolaitos). Probation administration (Kriminaalihuoltolaitos) is responsible for community sanctions (supervision of conditionally sentenced young offenders and parolees, young offender punishments, and community service sentences).

The prison system in Finland comprises 16 closed and 19 open prisons as well as a psychiatric hospital in Turku (Vankimielisairaala) and Vantaa (Vantaan vankilan psykiatrinen osasto) and a general hospital for prisoners attached to one of the prisons. The prisons are located all over the country (excluding the very far north), with more capacity on more densely populated areas. Of the closed prisons, 9 are primarily meant for remand prisoners, and 7 are primarily for offenders sentenced to prison service and fine defaulters. In three of the prisons there are security wards for prisoners placed to confinement.

The prison services are currently divided to three administrative districts managed by district manager, whose responsibilities comprise coordination and development of services, budgeting and budget follow-up, and resource allocation. In each administrative district, certain prisons are nominated as responsible for placement of prisoners.

From fall 2006 on, the administrative system will change so that under Prison Service (Vankeinhoitolaitys) there will be five regional prisons, each comprising a number of actual prison units and an assessment and allocation unit that has the responsibility of evaluating the case of each prisoner in order to find appropriate placement in the system regarding needs related to sentence, security, health care, family network, rehabilitation and planning for post-sentence adjustment (see below, Assessment of risks and needs), with the goal of reducing risk of reoffending.

In 2004, the average total number of places in closed prisons was 2,509 (varying between 65-345 places per unit), average daily prison population was 2,771 (men, 2,603; women, 168). The places are not exclusively dedicated to certain purposes, so it is not possible to exclusively define provision of special prison services such as places for remand prisoners etc. The average total number of places in open institutions in 2004 was 818, average daily population in open institutions was 805 (men, 767; women, 38). On census day (31.12.2004), the prison population was distributed as follows: prisoners serving a sentence, 2,953; fine defaulters, 35; prisoners held in preventive detention for dangerous recidivists, 24; juvenile prisoners, 62; remand prisoners, 461. The proportion of foreign prisoners has increased over past 30 years, from less than 0.5 % in the end of 1970's to 6.1-8.5 % in 2000's. The most common principal offences of the prisoners serving their sentence in 1 May 2004 were homicide (18.1 %), narcotics offence (17.9 %) and other violent offence (17.2 %). 31.9 % were serving their first sentence.

In 2005, the prison system's costs were 177.7 million euros. Income comprising productive work in prisons, see-out of services, rents and prisoner charges in open institutions was 18.1 million euros. Costs per prisoner were on average 45,500 €, income per prisoner 4,650 €.

### **Risk and needs assessment**

In 1997, a semi-structured Assessment of Working Capacity of Prison Inmates was introduced and gradually taken into all broader use in creating the sentence plan of prisoners serving a sentence beyond a defined length. Broader than its name suggests, this assessment considers working capacity, substance dependence and drug use, social attachments and life situation and need for institutional security. Followed by Risk and needs assessment system based on OASYS by Home Office, UK, the Assessment of Working Capacity of Prison inmates has brought about a systematic assessment of aspects of the inmate's crime, life, health, social relationships and alike that relevant for interventions in order to reduce reoffending.

The OASYS-based Risk and needs assessment is a more comprehensive and in-depth assessment than the Assessment of Working Capacity of Prison inmates. It covers the areas of previous criminal behaviour, dwelling situation before imprisonment and after release, and coping with everyday functions, income and managing financial matters, education, employment and related skills, social relationships and lifestyles, alcohol use, drug use, thinking and behaviour, and attitudes, for instance, towards criminal behaviour and society. With the new act on prison sentences (Vankeuslaki 767/2005) entering into force in October 2006, the Ministry of Justice obliges the new assessment and allocation units to carry out the risk and needs assessment for all prisoners sentenced for more than 2 years of imprisonment.

In Assessment of Working Capacity of Prison Inmates, an important aspect of sentence planning and interventions offered for the inmate has been the shared understanding of the inmate's situation created by multi-disciplinary participation to the Assessment of those who actually work with the prisoner during sentence. Although the new OASYS-based Risk and needs assessment will be broader and carried out centrally with a great professional expertise in the allocation units, there may be a risk that the transfer of the assessment from the prison where the prisoner serves his sentence to allocation units creates discontinuities in understanding of the prisoner's needs, and might endanger the fulfilment of the sentence plan created based on the risk and needs assessment. But this remains to be seen.

Health needs of prisoners are assessed at arrival to placement prison. Evaluation of health status comprising interviews, assessments by prison nurse and general practitioner and necessary

laboratory tests as well as information of prison health services and motivation to seek testing for certain infectious diseases as well as participation on programmes for substance users are provided to all prisoners. Risk and needs assessment will be available for the prison health personnel, but due to data security and intimacy reasons relevant aspects recorded in health services can not be directly available to professionals assessing risks and needs in allocation units.

### Health of the prisoners

In 2002, an evaluation on health of the prisoners' was completed using a survey on a representative sample of prisoners, completed based on information available in medical and nursing files of the prison health care. Due to the study being based solely on file information and due to problems in ensuring admission-time health checks for all prisoners (leading in incomplete file information), factual prevalences of health problems may exceed the figures reported. 59 % of the prisoners used medication prescribed by a physician. The most prevalent disorders were substance use disorder (46 %), alcohol dependence (39 %), signs of any other psychiatric disorder (symptoms, psychiatric medications, actual diagnosis) (39 %) and viral infections (spreading through i.v. injecting of drugs) (28 %; hepatitis C, 26 %; hepatitis B, 4 %, HIV, 1 %), followed by accident-related conditions (13 %), lung diseases (8 %), musculoskeletal diseases 8%, neurological conditions (6 %) and cardiovascular diseases (4 %).

Based on medical files, schizophrenia, bipolar disorder or severe depression was documented for 6.9 % of prisoners. The committee responsible for the evaluation, however, considered this figure likely to be an underestimate, but there is at present no better epidemiological data available.

Previously, a large epidemiological study on prisoners' health was carried out in mid-80's. In this study, which was based on information from multiple sources as well as on clinical examination of the prisoners in the sample, health problems were also common. Self-reported long-term illness was recorded for 39 % of male and 46 % of female prisoners. About 15 % of the prisoners had any cardiovascular disease. Of male prisoners, 28 %, and of females, 24 % had any lung disease, most commonly bronchitis. Any diagnosis related to digestive system was set for 14 % of males and 18 % of females. Urogenital diseases were detected in 1% of males and 12 % of females. 4 % of males and 21 % of females suffered from musculoskeletal conditions. Neurological conditions were diagnosed in 19 % of prisoners. Of mental disorders, alcoholism was the most common (44 %). A diagnosis of personality disorder was set for 18 % of the prisoners, neurosis was diagnosed in 7%, narcomania in 6 %, and psychosis in 2.4 %. The study concluded that 35 % of the prisoners clearly were in need of some medical treatment and 42 % had a probable need. Of the prisoners, 15 % were considered unable to work due to their health conditions, and 42 % were classified with lowered work capacity. The most common health problems resulting in reduced working capacity were mental disorders, in 8 % of males and 18 % of female prisoners.

Suicide rate in prisons has in Finland been high as compared to general population as well as to prison population in the other Nordic countries. From 1970's to 1990's, 7-8 prisoners committed suicide per year. In the beginning of 2000's, however, suicides in prison have comprised 4-5 case per year. There is also evidence of considerable reduction of self-harming behaviours such as self-cutting and swallowing of sharp objects, although these events are not likely to be as carefully recorded as suicides. It has been suggested that this positive development relates to increased use of non-dependence inducing antidepressants and mood stabilisers.

Preliminary results of an ongoing large prisoner health study, The Health, working capacity and healthcare needs of Finnish prisoners, were presented in the 29<sup>th</sup> Nordic congress of psychiatry in August, 2006. The project (led by Professor Matti Joukamaa in Tampere School of Public Health) will comprise extensive health status assessment of about 500 prisoners, both males and females, and special groups like life sentenced, fine defaulters and persons serving community sanctions. Of the subjects in the studied prisoner groups, from two thirds up to 9 in 10 suffered from substance use disorders. Personality disorders were very common, particularly ASP (up to 2/3). Primary psychotic disorders seem not to be very common, and not significantly more common than in the previous study conducted in the 1980's. The data collection continues until the end of 2006.

In an interesting register study, the national hospital discharge register and prison register were linked in order to study psychiatric morbidity among young (15-21 years old) prisoners in mid 1980's and mid 1990's. A period of five years before and five after the prison sentence were covered. Prisoners were also compared to population controls. While there was no increase in psychiatric hospitalisation among controls from 1980' to 1990's, there was an increased risk for hospitalisation among prisoners (OR 1.9, 95 % CI 1.3-2.3). The risk for treatment due to psychosis was 2.7 (1.4-5.1) in the latter prisoner cohort, for substance dependence 3.0 (2.0-4.6). The risk for treatment for psychosis in prisoners as compared to the controls was in the former cohort 3.0 (1.6-5.7), in the latter 12.5 (5.6-28.0). The risk for treatment for substance dependence in prisoners as compared to the controls was in the former cohort 19.9 (9.3-42.8), in the latter 54.6 (21.7-137.2).

In another register study, mortality of young offenders was studied over 1984-2000. SMR for young male prisoners was 7.4 (95 % CI 6.7-8.1) (for females, this could not be calculated). The SMR was slightly higher for those young prisoners who also had had a psychiatric hospitalisation (8.3 (7.3-9.4)) than for those who had not been hospitalised (6.3 (5.4-7.3)). The median age at death was 26.6 years. The causes of death were mostly unnatural and often violent. Suicide accounted for 34 % of deaths, accidents for 36 %, homicides for 12 %. – Mortality has also been shown highly increased among adult male habitually violent offenders.

Otherwise, Finnish research concerning offenders and aspects of health have mostly focused on forensic psychiatric patients and offenders assessed in formal forensic psychiatric assessment of criminal responsibility. Studies among forensic examinees have demonstrated a very high prevalence of schizophrenia, major affective disorders and personality disorders among violent offenders as compared to normal population. Associations between severe mental disorders, particularly schizophrenia, and violent offending have been shown in these samples. Particularly malicious regarding risk of repeated violence is a combination of schizophrenia and substance use disorder. A study of female offenders pointed on high prevalence of intelligence levels below normal among personality disorders in perpetrators. Population studies in the Northern Finland 1966 birth cohort study have also suggested an association between psychoses and (violent) offending, particularly when alcohol misuse is present. 1966 birth cohort study also supported the increased mortality of criminal offenders, particularly among offenders with mental disorders. Like in prisoner studies, deaths were mostly unnatural. This population study also demonstrated an association between offending and being admitted to psychiatric treatment. Noticeable biological studies, however not relevant in the present context, have drawn attention of the scientific community.

### **Prevalence of substance abuse among Finnish prison inmates**

In the year 1985, 44 % of recently admitted prisoners were diagnosed with alcoholism and 6 % with drug addiction. Fifteen years later, the proportion of prison inmates with serious substance abuse problems was estimated to be 70 %. Substance abuse problems are most common among recidivists with several imprisonments. One third of all male prisoners and more than 40 % of male juvenile prisoners reported using drugs while in prison. One fifth reported initiating drug use during imprisonment. According to a survey conducted in 2002 among health care personnel in Finnish prisons, approximately half of the convicts abused narcotics or were addicted to drugs and 40 % were addicted to alcohol. A minimum of 25 % were infected with hepatitis C. The amount of prisoners convicted of narcotics offences has increased significantly in the past two decades. In 2005, the proportion of prisoners with narcotic offences as their principal offence was 16 % of all prison inmates.

### **Medical services in prison**

The prison health services aim at promoting prisoners' health, preventing diseases during prison sentence, and providing the necessary medical treatment during sentence. The health services aim at contributing to supporting successful adjustment to the community after release. The Act on status and rights of the patients (1993) concerns patients in prison health services equally like patients in other health services.

Medical care is provided primarily by doctors employed by the prison service. Each prison unit has at least one nurse working full-time in the unit. Medical doctors are often available only part time. A psychologist is planned for each unit but in practice, there are unfilled positions. The prison system has four posts of psychiatrists for ambulatory psychiatric in the prison units, but recently (2005) 2 of the posts were vacant. Specialist level services are provided by prison hospital, and there is also an option for using public and private health services outside prison system in emergencies or when otherwise necessary. Acute dental care is provided on the expenses of the prison, provision of elective dental care is individually decided. In 2005, 4,250 prisoner health checks were recorded, as well as 34,410 contacts to medical doctors and 198,529 visits to a prison nurse.

Vankisairaala (Prison hospital) is a hospital service for prisoners from all Finish prisons, led by a GP. Main services are assessment, treatment and rehabilitation of medical illnesses, mental disorders and substance use disorders. There are 68 inpatient beds divided in 5 wards, of which one (5 beds) is for females only. Admission is by referral from prison doctor / nurse, or directly for after-care from a civil hospital with physician's referral. The hospital employs two general practitioners and a psychiatrist as well as a part-time specialist on pulmonary diseases. Consultations are available by specialists in internal medicine, surgery (orthopedics), oto-rhino-laryngology, dermatology, radiology and gynaecology. In addition, services by occupational therapist, physiotherapist, psychologist, therapist for substance use problems and social worker are included. Psychiatric treatment is provided primarily for female prisoners and only on voluntary basis. Male prisoners are referred elsewhere for psychiatric treatment (see below). In 2005, 414 admissions to Vankisairaala were recorded. Inpatient days totalled 17,851. During 2000's, inpatient days in Prison hospital have not shown any clear increasing or decreasing trend.

Psychiatric care is provided by prison physicians and nurses, prison psychologists, prison psychiatric ward in one of the prisons, above mentioned Prison hospital (Vankisairaala), and Mental Hospital for Prisoners (Vankimielisairaala).

Mental Hospital for Prisoners (Vankimielisairaala) is a 40 bed psychiatric hospital for male prisoners. In addition to treatment of prisoners with mental disorders, it contributes to the provision of forensic psychiatric assessments, along with the two state mental hospitals and certain forensic psychiatric wards. Patients are admitted from prisons, primarily on voluntary basis on referral by a prison physician. Involuntary psychiatric treatment takes place with same principles and procedures as in other psychiatric hospitals, as stipulated by the Mental Health Act (1991). Patient turnover is about 300 per year. If the patient's sentence continues at discharge from Vankimielisairaala, he returns to prison; if sentence terminates and need for treatment continues, he is transferred to civil psychiatric hospital according to his place of residence. In 2005, 311 admissions were recorded, as well as 11,373 inpatient days.

In addition to Vankimielisairaala, there are psychiatric beds for (male) prisoners in the psychiatric ward of Vantaa prison. The 15-bed ward is available for inpatient treatment for prisoners from certain six prisons and admits patients on similar basis as psychiatric wards in general. Involuntary treatment is not available. In 2005, 144 admissions and 4,419 inpatient days were recorded. Ambulatory observation and treatment is available for female patients who remain residing in the prison ward. Psychiatric inpatient days in prison system's psychiatric beds have not shown any clear trend over 2000's.

The prisons provide to varying degree possibilities to participate in rehabilitative and recidivism preventive programmes such as rehabilitation programmes for substance users, cognitive skills training, aggression management and anger control courses, sex offender treatment programmes, courses aiming at improving the social support the prisoner can receive from, and give to her/his family and other networks, and education. In 2005, 2,030 prisoners participated in programmes for substance users, 248 in programmes for violent offenders, 96 in cognitive skills training and 24 in treatment programme for sexual offenders.

Substance abuse and substance use disorders are recognised as an extensive problem among prisoners. In 1999, the first comprehensive strategy for prevention of substance use and treatment and rehabilitation of substance use disorders in prisons was worked out, followed by a second

strategy in 2004. The strategy covers reducing availability of substance and drug crime in prisons, preventing harm due to substance use in prisons, reducing request and market for substance in prisons, guaranteeing the stepwise treatment and rehabilitation of prisoners with substance use disorders over the sentence and to release from prison, and networking of prison services for substance users with authorities providing services outside prison system. A number of immediately demanding weaknesses were identified in the current practices, centering around too scarce resources for rehabilitative work, too little opportunities for the prisoners due to too few programmes and too few places on special drug-free prison wards, inconsistent practices across prisons in the various steps of prevention and rehabilitation, weak recording of the extent of substance use problems and disorders as well as treatments given and lack of systematic family work and network counselling. In longer perspective, the specific needs of groups like women, young prisoners and certain ethnic minorities require intensive attention.

An important focus of prison health care is prevention and management of hepatitis and HIV infections. Testing for these conditions is voluntary, but prisoners are encouraged to see for testing and following appropriate health care. In health check in the beginning of the sentence, and along imprisonment in contacts with health professionals, hygiene packages and motivation for testing and health education supporting change of risk behaviours are provided.

### **Administration of prison health services**

As studies and evaluations of prisoners' health showed unfavourable developments towards the 21<sup>st</sup> century, and costs of prison health care also showed a sharply increasing tendency in the early 2000's, a committee was set in 2004 to plan re-structuring of prison health services. A plan was created that all prison health services would be united to an independent unit within prison system. The administrative structure would be organised to comprise two hospitals and five regional prison health care units, all led by one medical director, reporting to Prison Service (Vankeinhoitolaivos). The plan is to be set in action in fall 2006. The prison psychologists, however, will remain employed by specific prison units, directly under the prison unit's director.

Health care costs in totalled 12 million euros in 2005. Services purchased from outside prison system's own health care created costs of 2,622,240 euros, this included dental care and visits to private practitioners in various fields of medicine as well as inpatient days in outside prison hospitals. Costs of medication totalled 1,875,251 euros.

### **Scarcity of resources**

In their final report, the committee planning for re-structuring of prison health services expressed a concern for too scarce resources of the prison health care. Based on their evaluation of health service needs in prisons, they suggested an increase of resources. While the health care personnel in prison health services totalled 146 full time employees, 3 part-time and 13 basically employed in another fulltime position but dedicating some time to prison health services on specific agreement, the committee recommended adding to the personnel by 2.5 positions of chief physicians, 1 doctor in training, 1 psychologist, 1 ward manager, 23 nurses and an occupational therapist. It was seen as a problem that prison health services need to employ many doctors who basically have another position and only make visits to prison, as in this arrangement, commitment to development usually remains low. Therefore, it was seen relevant to reduce the number of doctors with this agreement by altogether five positions.

### **Prevention of substance abuse and dependence and rehabilitation of substance abusers in Finnish Prisons**

The first official strategy paper concerning the role of correctional institutions in preventive and restorative intoxicant work was ratified at the end of the 1990's in Finland. The strategy consists of four parts: 1) rationale, goals and principles of intoxicant work in prisons, 2) handbook of intoxicant

control for penal institutes, 3) information of all rehabilitation services available in Finnish prisons, 4) quality assurance of the rehabilitation programmes by applying a special criteria of accreditation. The aims of the strategy were to hinder drug criminality led from the prison and carried out within the prison, to enhance the assessment and increase the effectiveness of the preventive and rehabilitative work in prisons, and to ensure continuity of rehabilitation after release. Also the amendment of legislation affecting preventive work in prisons was targeted.

On reception into custody the level of substance dependency of all convicts with sentences of six months or longer should be assessed with a standardised tool. For offenders with sentences of two years or more, the risk and needs assessment in the allocation units includes assessing the need for substance related treatment and rehabilitation and other services needed. Continuing substitution or maintenance treatment supported by opioid medication initiated outside prison can be arranged in all penal institutions. Initiating opioid treatment during imprisonment, on the other hand, is exceptional. Withdrawal treatment, when necessary, is arranged on arrival to custody. Life threatening withdrawal symptoms are treated in one of the prison hospitals.

Rehabilitation in prisons is arranged on voluntary bases but the motivation to take part in it is enhanced by for example giving information of health risks and other consequences related to substance use and the rehabilitation services available. Some form of rehabilitation services is available in every prison. In addition, it is recommended that there should be a coordinator of substance abuse services appointed in every prison. The special rehabilitation programmes for substance abusers are mostly based on cognitive behavioural therapies, group therapy and therapeutic communities and are managed by the state or by non-profit organizations such as the Alcoholics Anonymous or Narcotics Addicts. In 2005 approximately a third of all prison inmates participated in short informative meetings or groups concerning various substance related themes, and one in four prison inmates participated in the rehabilitation programmes for substance abusers.

Intoxicant control is targeted at decreasing the supply of intoxicants and criminal activity related to intoxicants inside penal institutions. Intoxicants are tested randomly in intoxicant-free institutions and wards, as a precondition to certain privileges and whenever substance use is suspected. Trained dogs are also used to find drugs in prisons. A personal search may be conducted and the cell and belongings of the prisoner may be searched for intoxicants. Also the belongings and person of visitors may be searched. The prisoner's mail may be scanned for drugs but it can be opened only if there is a justifiable reason to suspect that it contains intoxicants. To prevent constant intoxicant use or criminal offence related to illegal drugs, a prisoner may be placed in solitary confinement. Intensified drug control has succeeded in reducing the supply of illegal drugs in penal institutions.

A prisoner has the right to be placed, if he so desires, in a special intoxicant-free institution or department, where sobriety is checked for instance by urine tests. All open institutions are intoxicant-free and require commitment to sobriety. There is also an intoxicant-free department in almost all of the closed institutions. In 2003, approximately 15 % of the closed wards are intoxicant-free. The prisoners in the intoxicant-free wards consider them useful in giving the opportunity to practise life without intoxicants and contemplating the future.

Since 1999, a prisoner with substance abuse problems may, with certain preconditions, have been placed outside prison for treatment or participated in rehabilitative training outside prison provided with appropriate supervision. Only 20-40 prisoners per year have been able to use this possibility. A bill has been made to make it possible to enforce a sentence in substance abuse treatment instead of penal institution.

On approaching release, rehabilitation should be concerned on promoting intoxicant-free living by prevention of and preparing for relapses, enhancing networking and social support and arranging continuing care in the home municipality. In reality, there is a lack of resources in penal institutions and the co-operation between the prison staff and social workers and non-profit organizations in the municipality may be insufficient. The rehabilitation during imprisonment is funded by the state. After release, the municipality of residence is in charge of the costs. Resources in substance rehabilitation in municipalities may be scarce. Also, the co-operation between the criminal sanctions agency and the probation service may be insufficient. The continuity of rehabilitation may thus not be ensured.

## Evaluation of preventive and rehabilitative work among substance abusing prisoners

Since 1995 there have been special substance rehabilitation programmes in Finnish prisons. The government has allocated increasing resources to rehabilitative work. Even before the significant increase in positions allocated in substance rehabilitation programmes, the ratio of prisoners to mental health staff professionals was good compared to other European countries.

In the 21st century, the government has emphasized coherent and evidence based development of intoxicant work in correctional institutions. Until now, no research on the effect of preventive and rehabilitative work in reducing harm, preventing recidivism or increasing the well-being or health among Finnish prisoners exists. Lack of register data has hindered the research but since 1997 structural data has been gathered about intake assessments made on reception into custody. Results from studies on this data have not yet been published.

Several evaluations projects on substance abuser's treatment and rehabilitation programmes in prison have been carried out in early 2000's by the Probation Service, Criminal Sanctions Agency and some municipalities. These evaluations have pointed some shortcomings including unsystematic recruitment of prisoners into the programmes, need for firmer theory base, more training for the staff, and a more systematic evaluation of effectiveness. Critical problems arise at discharge to the community, and lack of common understanding and co-operation between services in prison and after release is pointed.

The allocation units are a step towards a more comprehensive, more structured way of offering support to prisoners with substance abuse problems but it does not solve the problems of prisoners with short sentences. In some prisons, the proportion of offenders with sentences shorter than three months may be as high as 75 %. Increasing amounts of prisoners without equally increasing facilities hampers arranging any kind of activities to prisoners. In addition, the old question of whether the primary mission of correctional institutes is enforcing sentences or preventing recidivism through rehabilitation may be raised again.

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### **Appendix 1. Legislation regulating prison services.**

*Laki rangaistusten täytäntöönpanosta (39/1889)) will be from 1.10.2006 on be replaced by a new act (Vankeuslaki 767/2005)*

*Vankeuslaki*

*Vankeinhoitoasetus (878/1995)*

*Laki rangaistusten täytäntöönpanon hallinnosta (135/2001)*

*Asetus rangaistusten täytäntöönpanon hallinnosta (275/2001)*

*Laki tutkintavankeudesta (615/1974)*

*Asetus ehdonalaisesti vapautetun vangin valvonnasta ((279/1931)*

*Laki nuorista rikoksentekeijöistä (262/1940)*

*Asetus nuorista rikoksentekeijöistä (1001/1942)*

*Laki (1055/1996) ja asetus (1259/1990) yhdyskuntapalvelusta*

*Asetus yhdyskuntapalvelun täytäntöönpanosta (1260/1990)*

*Laki (1196/2004) ja asetus (1284/2004) nuorisorangaistuksesta*

*Laki vaarallisten rikoksenuusijain eristämisestä (317/1953) sekä asetus pakkolaitoksesta (448/1071)*

*Laki ja asetus Suomen ja muiden pohjoismaiden välisestä yhteistoiminnasta rikosasioissa annettujen tuomioiden täytäntöönpanosta (326/1963 ja 620/1964)*

*Asetus vankeusrangaistuksen täytäntöönpanosta (447/1975)*

*Asetus tutkintavankeudesta (701/1999)*

*Laki henkilötietojen käsittelystä rangaistusten täytäntöönpanossa (422/2002)*

*Laki vankeinhoidon koulutuskeskuksesta (136/2001) ja asetus vankeinhoidon koulutuskeskuksesta (375/1990)*

## France

**Pierre Lamothe & Frédéric Meunier**

### **Structure of Prison System**

In France, Penitentiary Administration is a department of the Ministry of Justice. It manages 188 closed correctional facilities providing 51,312 detention accommodation places. There are 3 types of facilities: 115 “Maisons d’Arrêts” (correctional facilities for inmates remanded in custody pending trial or sentencing, completing short-term sentences or waiting to be dispatched to longer-term facilities, 32,777 places); 60 “Etablissements pour Peine” (penal establishments): “Centres de Détention” (CD, detention centres, medium-term sentence facilities, 15,600 places) among them one (Chateauthierry, 85 places) is specialised for “psychopaths” and “Maisons Centrales” (MC, higher-security facilities for long-term sentences, usually over 15 years, 2,110 places). Two of them, “Maison Centrales à petit effectif” (MCPE), “small capacity centers” are reserved to most dangerous detainees with peculiar survey.

The term “psychopath” used to define inmates of Chateauthierry is an historic terminology which does not exactly refer to a psychiatric diagnosis. Detainees in this establishment are admitted on proposal of penitentiary services using files with psychiatric advice on the detainee’s behaviour and personality but without any clear and explicit diagnosis which still is considered as part of medical secret.

All these establishments are twinned to nearby general or psychiatric hospitals providing varying levels of psychiatric services to all.

### **Medical Services and Mental Health Care Provision in Prison**

#### ***General organisation***

A 1994 law put all aspects of health care in prisons in the hands of the public hospital system. The guiding principle is that the supply of care must be of the same standards as available to the population at large and financed by the social security system (the penitentiary administration contributing per capita to the general social security system).

In each prison there is a consultation and ambulatory care unit (Unité de Consultation et Soins Ambulatoires - UCSA) staffed by their twinned general hospital. Usually, psychiatrists working in the UCSAs belong to public psychiatric hospitals and are detached to the correctional facility from one of 95 general psychiatry civil sectors (nationally, there are about 900 psychiatric sectors). The range of psychiatric services and personnel available depends largely on the correctional facility’s size and can include nurses and psychologists with staff available from a few hours per week to several full timers under a senior doctor. The hospital system is also responsible for providing paramedical staff, medical logistic and equipment, furniture, laboratory tests and analyses or drug prescriptions

There are 9 regional secured hospital units (Unités Hospitalière Sécurisées Interrégionales – UHSI) sited in large university hospitals which can receive inmates for somatic treatment and stays of varying lengths. Such units are not meant to receive psychiatric patients but psychiatric care can also be dispensed as needed, for example to suicidal, badly injured or psychotic or demented patients. In these units, all staff belongs to the hospital except for guards belonging to penitentiary administration staff.

### ***The specialised psychiatric “sectors” devoted to prisons***

In each of nine penitentiary regions, one or two correctional sites (26 in all) contain a Regional Psycho-Medical Services (Service Médico-Psychologique Régional - SMPR) organised, like general psychiatric hospitals, in sectors covering a particular geographical population catchment area. Sector catchment population for regular psychiatric hospitals is 70,000. There is one children and teenagers sector for two adult sectors and, as mentioned, 26 psychiatric sectors in correctional facilities responsible for providing local services to their assigned facilities and for taking care of inmates coming from their geographical catchment area through specialist units installed within the Maison d'Arrêts. The general regime in such units is formally considered as a hospitalization under the rules and regulations of day-hospitals, with cells in principle not accessible to care personnel at night, except in emergencies. SMPRs are not supposed to have night doctors or nurses.

Apart the work in their unit, SMPR can make consultations or group therapy or any other therapeutic activities in the site where they are settled, but most of them have also an antenna in one or more other establishments, which can be a detention center. Indication of any treatment is always determined by SMPR doctors but a majority of the patients is asking for it and there is a provision which allow the judge responsible for the placement in jail to ask for a psychiatric observation. It is not an assessment and the judge is not supposed to have direct access to the result of this observation, except if the patient authorize or ask the psychiatrist to give information to the judge. Experts named by the judge have no rights to access the medical record of the patient they have to evaluate, even if the judge has given to them the mission of read and comment it. The access is restricted by the consent of the patient and if the judge want to have the dossier taken into account and discussed he have to seize it with a special and formal procedure.

SMPR remits have been largely diversified and, next to treatment units of 25 places on average, they are responsible for inmates' general mental hygiene, the detection of psychiatric disorders and care of patients who are therefore supposed to be consenting pursuant to the provisions of article D 362 and D 398 which will be developed further in the present chapter. In reality, most SMPRs take charge, sometimes over long periods, of more or less severely regressed psychiatric patients whose condition is sometimes more severe than many psychotics treated in general psychiatric hospitals. But the largest part of their charges is composed of personality disorder patients, including psychotics. If, after clinical examination SMPR practitioners judge a legal expertise to be necessary, they notify the prosecuting judge.

SMPRs' remit includes detecting and treating addictive disorders, whether alcoholics or drug users and they can freely prescribe substitution treatments according to the same rules applying outside prisons. There are no legal dispositions requiring mandatory treatment of addictive disorders nor particular provisions for leniency towards persons voluntarily undergoing treatment even if, in practice, many do mention such voluntary treatment to the judge in charge of sentence application (Juge d'Application des Peines, JAP) whose role it is to consider possible adaptations of sentence applications and, in particular, early release.

There are however, special provisions contained in numerous recent texts regarding sexually violent offenders. Following a new law of 1998, they can be subjected to mandatory treatment which can substitute to a custodial sentence or come in addition to it, and which can extend to lengths of up to 20 years in criminal cases. But such measures are not a prescription of any medical protocol or treatment. It is just a demand to be treated by any physician, with an evaluation conducted by a psychiatrist chosen by the judge on a special list. They imply patient consent (absent which a longer sentence is imposed), and are not applied in prisons where the Penal Code says that treatment must

be proposed to the patient who is incited to undertake it if he wishes to be the beneficiary of sentence reduction measures. There is therefore moral coercion of the inmate which can negatively impact his relations with prison practitioners.

There is an extant «methodological guide», a text spelling out the application of health regulations in correctional facilities which provides for the dispatching of inmates remanded under the terms on article D 398 towards the local sectorial hospital to which each correctional facility is assigned according to the national geographical health map. Particularly serious cases for whom long-term commitment is considered, or whose dangerousness is great and clear, are dispatched to one of four Difficult Patients Units (Unités pour Malades Difficiles – UMD), specialised facilities with reinforced security and personnel. The conditions are not those of a prison hospital but of a normal psychiatric hospital that treats patients without medico-judicial histories as well as those having being declared legally irresponsible or recognised, in a correctional facility, as being in a state of mental alienation.

### **Regulations**

Mental health services available to incarcerated persons in France are founded on a quasi-philosophical premise positing a clear dichotomy between independent clinical assessments and judicial decisions. The legal system has no statutory powers to prescribe either type or modalities of clinical intervention. This is as true for the general population as it is for prison inmates. Nationally, no compulsory treatment provisions currently exist on the statute book.

This state of affairs might possibly change over the next few years, due to strong pressures for legislative provisions of social safeguard in the wake of a few highly publicized cases and their strong impact on public opinion. Such moves are however hotly debated and meeting with firm opposition from most professionals in the field of psychiatry.

The regulatory position is based on two articles of the Penal Proceeding Code (Code de Procédure Pénale – CPP), article D 362 and D 398, which fix limits of psychiatric intervention in prison with the principle that there is no sense to a punishment which cannot be understood and lived through and that the prison is enough constraint by itself not to add treatment by force which would be a menace for human rights. These two articles were profoundly revised in December 1998 as a result of pressure from prison psychiatrists and in the face of an increase in the number of psychotics incarcerated in correctional facilities. But the will of psychiatrists, to just take into account that in some severe cases prison was unable to provide appropriate care and that the patient should be transferred to hospital, was not listened and the text of rules have been stiffened in the opposite way! Paradoxically, the modified provisions of these two statutes have compounded the situation's ambiguities and, far from of facilitating transfer from prison to psychiatric hospital, have made it more difficult.

These two articles were formerly redacted thus:

- Article D 362: A detained person must consent to any act of medical diagnosis or treatment.
- Article D 398: A person cannot be remanded in detention when in a state of mental alienation.

Whereas the new redaction disposes:

- Article D 362: Except when he is found incapable of giving consent, the detainee must consent to any act of medical diagnosis or treatment.
- Article D 398: If the condition of a detained person falls under the provisions of article L 3213 of the Public Health Code (Code la Santé Publique), he cannot be remanded in detention and must be transferred to a civil psychiatric establishment, under the regulatory provisions for Compulsory Hospital Commitment (Hospitalisation d'Office, HO).

CCP (Penal Proceeding Code) says that detainees staying in psychiatric hospital under D 398 article are not under police custody as they are in chirurgical or medical services which are not designed to host patients without their consent. This is again a sign of legislative will as a society trait not to stigmatise any of mentally ill person as soon as he is cured under 1990 law. (Especially people who have been recognised not responsible with their acts who so become clear of any judicial following of their case and of their person.)

But these rules and spirit trend to be considered as romantically and dangerous and there is a media and parliament pressure to ask for new social defence dispositions.

The amendments to article D 398 presuppose that the appreciation criteria of the state of mental alienation now take into account danger to other persons and not anymore simply losing touch with reality or immediate dangers for the patient himself such as suicidal attitude, failure to properly maintain one's bodily integrity through extreme lack of hygiene or severe eating disorders.

Prior to these changes, psychiatrists working in correctional facilities intervened in crises requiring emergency measures, such as intramuscular neuroleptic injections, under the guise of not abandoning the patient and the provisions of the general article of the Penal Code punishing failure to assist persons in danger. In such cases, the psychiatrists' view is that the necessary treatment has to be immediately administered, as is also the case for the population at large. But as the new article D 362 opens the door to treatment not consented to nor motivated by a clear and present emergency, psychiatrists find themselves in the position of being both prescribers of treatment and judge of a patient's ability to consent. On the prison population this power is exercised absent the existing controls and protections afforded the general population pursuant to the general legal provisions of the 1990 law on the mentally ill. This law contains numerous clear recourse provisions which do not apply to the prison context.

A hotly contested debate still exists as to whether the 1990 law providing for internment without consent of the mentally ill in psychiatric hospitals de facto authorizes hospital psychiatrists to impose compulsory treatment or whether their remit stops simply at compulsory placement and professionally qualified supervision. The question is not completely resolved in the statutes, but court jurisprudence thus far has always been favourable to doctors, none having ever been condemned for forcing treatment on a patient hospitalized under the statutes of mandatory hospitalization (Hospitalisation d'Office - H.O.), a provision reserved for dangerous patients - whereas doctors have been prosecuted for failing to treat patients and been taken to court by families of suicides for instance.

With these new legal regulatory provisions, some psychiatrists have switched criteria, restricting their interpretation of the dangers from which they must preserve their patients exclusively to those cases of clear and present danger to life and limb and not to dangers associated to behaviour disorders likely to cause difficulties within the prison environment, in particular with correctional officers or inmates. The detainee suffering from this behaviour disorders take the attendant risks of "acting out", assault on persons, arson in the cell and so on, likely to lead to further convictions which will lengthen the stay in prison and could have been avoided by treatment permitting to control oneself by this patient. Psychiatrists treating prison inmates in general psychiatric hospitals under the provisions of the Compulsory Hospitalization statute (Hospitalisation d'Office) can, for their part, refer them back to prison more easily by appealing to the self-same criteria.

Tentative "proof of diagnosis" treatments absent of consent were often applied formerly, with the hope of reaching consent after a few days with the improved state of the patient, for instance with the attenuation of psychotic dissociation or delirious state. Some psychiatrists in prison continue with this practice but many others consider that responsibility doesn't worth the risk. It seems, at least in the medias, that the doctors in prison should be criticised more often than in free world, any patient who commit suicide being presumed not to have received enough medication and others complaining to receive treatment against their will!

## Actual problems and tentative prospective solutions

After years of prospective studies, the continuing presence of numerous psychotics inadequately cared for and the ambiguities of the new law articles D 362 and D 398 have had an impact on the system. Initially, SMPRs appeared to be a third way between prison and hospital with their attending advantages and shortcomings. But new limits have appeared which have led to a need for a new type of institution based on the UHSI model: UHSA - Unité Hospitalière Spécialement Aménagée (Special Designed Hospital Units). These units are supposed to take charge, within general hospital walls but under custody of penitentiary administration, psychiatric patients for potentially longer stays than in SMPRs. Treatment in these units could be either consented or not-consented to. The patients could be regarded as under the provision of the two way of involuntary placement for free citizens: Hospitalisation d'Office (HO) stiff administrative placement or Hospitalisation sur Demande d'un Tiers (HDT), which is purely medical, on request of the family and more flexible. Detainees have no access so far to the benefit of HDT and, as we have seen upper in the present chapter, may stay in prison without appropriate treatment if they are not dangerous and article D 398 don't apply.

A common circular of the Ministries of Health and Justice from March 2006 has been issued and makes the creation of some UHSAs quite probable within the next two years.

They will be probably small units comprising one or two wards of 20 inmates each, with security access and architecture despite the location in a hospital.

Such projects are very costly and have not been universally supported by a number of prison psychiatrists who remain defiantly opposed to any form of compulsory treatment in prison. In 2002, a snapshot epidemiological study of aiming to estimate the number of mentally disordered inmates potentially needing care by the proposed UHSAs revealed wide regional discrepancies. In this study, estimates of national need ranged between 200 and 1,000.

## Epidemiology of mental disorders

The important variation in the evaluation of the number of inmates who could take benefit of UHSA may be an indication of the continuing dominance of ideology over clinical evaluation which remains an endemic idiosyncrasy of French psychiatry. Reliable and systematic statistical studies are only starting to become a policy tool of French public psychiatric hospitals, which in that respect lag far behind general hospitals. And what is more there is no agreement of the professionals about what should be exactly the patient's condition which is not acceptable behind the prison's wall.

WHO International Classification of Disease (ICD10) have been endorsed by France as the official routine for diagnosis in the medical files and statistic tool for the "medical program for information systems" (Programme Médicalisé des Systèmes d'Information, PMSI) which is already used in somatic medicine ("MCO", for medecine chirurgie obstetrique). But PMSI is designed for evaluation of costs of each pathology and treatment to save public money and properly invest in the priorities; it is not designed for epidemiological survey. What is more, psychiatric part of this classification is not precise enough to get a good view of real prison population and a great number of psychiatrists continue with "individual diagnosis" in the medical files which can hardly be grouped and collected as data.

Further, there is no routine cross linkage of data between the justice and health systems which means, for example, that no-one knows for sure how many murderers are schizophrenics in French prisons.

Traditionally in France the actual wording of the law emphasises the spirit and general meaning rather than more precise and closed diagnostic descriptions. The state of mental alienation was not defined in reference to a particular pathological state, whether from a qualitative (type of destructurement, loss of contact with reality) nor a quantitative point of view (evaluation of cognitive impairment or handicap). This is seen as precious flexibility and not as unsharpness and in fact permits to share description and evaluation of personality and description of behaviour. But this

make even more difficult to follow inmates' population with a recognised and standard epidemiological tool.

Numerous studies have been conducted anyway, either on university scientific purposes either on behalf of penitentiary administration or health ministry. All of them have been conducted on samples and none could be regarded as an exhaustive screening of French prison population. They are getting more and more precise and demanding under the urge of reducing suicides or improving care of psychotics serving long term sentences. The largest one have been conducted in 2002-2004 but the final report has not yet been published, even if the most spectacular data have been widely commented in the press. This study will be summarized in annex of this chapter. But psychiatrists in France are not far to adopt aphorism that the prison population is composed of Bad (perverts, antisocial personalities and professional of the crime, 15 %), Mad (psychotics, 15 % with probably as many as 7 % of schizophrenics), and Sad (border-lines, depressive, personality disorders, psychopaths 60 %). This leaves only 10 % for "normal" mature personalities which usually are not delinquent!

## **Quality Standards and ethical aspects**

### ***Importance of professional secret***

Emphasis is put anywhere in the process of care, sentence serving and exchange between professionals of the two world, judicial and medical to respect an absolute professional secret. This is a warranty for person respect and similar to the philosophy and law statutes in the free world. But it is also a constant difficulty that the detainee himself can eventually suffer. Proper accomplishment of each mission, judgement, custody and care need to share information, very often for the benefit of the detained person who should be the one choosing what he wants to use and disclose to somebody. This is more and more the common way. But daily situation are sometimes difficult to deal with, for instance when wards want to know who is dangerous or suicidal and ask psychiatrist advice.

### ***Quality and ethical survey***

As part of public hospital system, penitentiary medicine services are evaluated under health ministry administration rules by inspectors. A public health medical inspector, who is a medical doctor, is in charge of each prison with the task of verifying that practice is globally adapted to needs, rules and standards of quality. Hospital reports annually to her or him who is also entitled to receive patients' complaints. But she or he has no real power on institutional balance and on detainees' life. He cannot order independent medical assessment which can or must be ordered by judge in charge of sentence application (Juge d'Application des Peines, JAP) but he can visit establishment at anytime and debate with a formal survey commission whose president is the state local executive authority (Prefet).

### ***European penitentiary rules***

France has declared that French prisons will meet European penitentiary rules as soon as possible... except when there is an irreducible conflict with French law or practical prison system. Some difficulties can be question of budget or equipment with no theoretical reserve such as possibility to stay alone with one cell per inmates. Some others are more alike impossible to apply without major changes in rules and mentalities which have very few chances to quickly occur. For instance, facilities to communicate, active role of the inmate family, survey by an independent body will not be easy to accept and organise.



### ***Limits of psychiatric care in prison***

As regards somatic pathologies, the law of March 4<sup>th</sup> 2002 named “health democracy” (démocratie sanitaire) contains special provisions allowing for the suspension of detention terms where the inmate’s state of health is such that his life would be endangered by his continuing detention or, more generally, if the necessary medical treatment cannot be provided by the correctional facility. But this law specifically excludes psychiatric afflictions from these provisions suspension. Mental disorders, and this is even truer of personality disorders, must be treated within correctional facilities if they do not fall within the purview of article D 398. Still, the law of March 2002 has important implications as regards treatment of mentally disordered persons. As for the general public, there is in principle a right of access to personal information contained in patients medical files. In practice however, significant restrictions apply and restrict the application of this right in prison. One of these restriction is more alike a reserve from psychiatrists to accept that the detainee would have interest to present the care like their other efforts to return to society (such as working in the prison, studies and exams). A “useful” care may be polluted and an honest care should be disinterested.

One of the main (and daily) ethical questions for the psychiatrists in prison when, for example, faced with aggressive behaviour, is deciding which particular situation requires medical treatment or disciplinary measures. Between these two cases, there is a wide grey area and few objective pointers facing psychiatrists with uncomfortable choices where the distinction between clinical decision and personal moral standpoint becomes blurred. The psychiatrist position can then be very lonely, often having to face down or bow down to pressures coming from either inmates or prison personnel and authorities.

### ***Problems of care after release***

General psychiatric hospitals managing the “sectors” usually don’t volunteer to receive detainees under D 398 article. There is a trend to oversee pathology of them with a moral judgement, not only because of the weight of what they have done but also because they are supposed to escape serving the sentence with hospital condition which is more comfortable than the prison. Things are not better when, having served the sentence, the disordered offender is released and still need care in the civil world.

Whoever they are from the clinical point of view, they are regarded first as delinquent and people in the hospital fear their possible violent or perverse behaviour, even if there are few rational bases to this fear in the patient history. This psychotic who was six month ago cured normally in the sector to which he belongs, become “persona non grata” because he is staying in prison even for a petty survival crime. Staff will not trust him anymore, he is expected to assault or robe other patients and so on.

Even if these considerations may be anecdotic, day to day operations in psychiatric hospitals have become more and more sophisticated and are not focused on acting but on speech. Care is more efficient and easy with patient free collaboration than with the handicap of constraint. Architecture, practice and philosophy of psychiatric care as well as relationship between patient and staff in these public services cannot any longer be framed by external authority such as in prison. Treating psychopathy and behaviour troubles in closed wards trend to become a true speciality, in France like in other democracies respecting human rights.

## Germany

Norbert Konrad

### Prison system structure

In Germany, the federal penal law regulates the penal system. The practical embodiment of the penal system is incumbent on each federal state and its own ministry of justice. Penal institutions in Germany differ regionally: There are often separate institutions for remand prisoners, juveniles and women as well as minimum security prisons. Social-therapeutic institutions are often facilities in (closed) regular prisons. Table 1 shows the development of forensic clientele.

**Table 1: Forensic patients (Old West-German states including West Berlin), prisoners and patients in general psychiatric hospitals (Old West-German states including West Berlin 1970-1990, as of 1995 unified Germany)**

Year	Forensic psychiatry according to §§ 63,64 German Penal Code		In comparison	
	Psychiatric hospital (§63)	Detoxification center (§64)	Prison	General Psychiatry (available beds)
1970	4,222	179	35,209	117,596
1975	3,494	183	34,271	115,922
1980	2,593	632	42,027	108,904
1985	2,472	990	48,212	94,624
1990	2,489	1,160	39,178	70,570
1995	2,902	1,373	46,516	63,807
2000	4,098	1,774	60,798	54,802
2005	5,640	2,473	63,533	53,021 (2004)

Source: Federal Office of Statistics, Wiesbaden, Germany

There was a total of 63,533 prisoners in German penal institutions as of March 31<sup>st</sup>, 2005. As in other European countries, the number of prisoners has increased in recent years. Including prisoners in pretrial detention, Germany had an imprisonment rate of about 100 per 100,000 inhabitants.

In Germany, mentally disordered offenders are subject to special legal regulations (Konrad, 2001), which are based on the concept of criminal responsibility: Offenders who are not criminally responsible and not considered dangerous are hospitalized, if at all, in general clinical psychiatric institutions. If serious offenses are expected from offenders who are considered to have at least

diminished criminal responsibility, they are admitted, regardless of therapeutic prospects, to special forensic psychiatric security hospitals (§ 63 German Penal Code) under the authority of the health ministry. The number of prisoners housed there was 5,640 as of March 31<sup>st</sup>, 2005 ([www.destatis.de](http://www.destatis.de)).

Offenders dependent on psychoactive substances with sufficiently good therapeutic prospects are admitted to special withdrawal facilities of the forensic-psychiatric security hospital which are also under the authority of the health ministry. As of March 31<sup>st</sup>, 2005, the number of prisoners housed there was 2,473 ([www.destatis.de](http://www.destatis.de)).

All other mentally disordered offenders, such as schizophrenics who are considered criminally responsible despite their illness, may be sentenced to prison, if no milder sanctions like a fine are ordered by the court. In individual cases, it may depend on coincidental constellations whether a mentally ill person is committed to a forensic psychiatric or penal institution.

### **Medical Services and Mental Health Care Provision in Prison**

If one accepts that mentally ill prisoners should be treated in penal institutions (possibly even hospitalized), then the principle of "equivalence" should prevail in the care of incarcerated mentally ill persons. It is doubtful whether the majority of prisoners with psychiatric illnesses in Germany receive appropriate care such as that mandated by the European Convention on Human Rights and other international charters (Fazel & Danesh, 2002).

In-prison treatment has to address inmate-specific problems and circumstances, including post-release services. This includes both an orientation to the function level and the severity of psychiatric symptoms (Harris & Lovell, 2001). The high prevalence of mental disorders speaks in favour of the standardized application of diagnostic screening instruments as a component of the admission procedure in prison. German criminal law prescribes a medical examination, but not standardized psychiatric diagnostics, for every prisoner upon entering prison. Outpatient psychiatric treatment in prison is provided after the prisoner is referred by the staff physician to a psychiatrist.

The obligatory physical examination upon entering prison also includes an evaluation of a history of addiction in order to combat a possible dependency disorder or withdrawal symptoms. This is usually done according to a predetermined schema (for example, the use of methadone and/or diazepam in decreasing doses for opiate withdrawal). The prison physician must diagnose the suicidal risk, even if standardized instruments (e.g. Dahle et al. 2005) are not used.

Compulsory treatment of mentally disordered prisoners is regulated by the penal law, whose pertinent provisions correspond to the standards for compulsory treatment within the framework of civil commitment laws.

Inpatient psychiatric care of prisoners is subject to wide regional variations in Germany. Only four federal states (Baden-Württemberg, Bavaria, Berlin, Saxony) have psychiatric departments in penal institutions under the legal authority. In the other federal states, inpatient and outpatient psychiatric care of prisoners is provided by external institutions and consulting specialists (Missoni & Rex, 1997). External institutions for inpatient psychiatric care include forensic-psychiatric security hospitals and general psychiatric facilities.

Inpatient psychiatric care of prisoners in general psychiatric facilities frequently conflicts with the safety concerns of prison authorities. Their objections are reflected in the attitude of care-providing institutions, which - if they do not flatly refuse to treat prisoners like 2/3 of the facilities in North-Rhine Westphalia and Rhineland-Palatinate - question the treatment indication, willingness to be treated or responsiveness of the hospitalized patient and point out effects detrimental to the institution ranging from spoiling the therapeutic atmosphere to demotivating compliant patients and provoking their recidivism (Konrad & Missoni, 2001). It has been specifically stated that prison transferees disturb other patients, cause disciplinary difficulties and have a more demanding attitude. Based on the total number of hospitalized prisoners in North-Rhine Westphalia and Rhineland Palatinate in 1997, 0.1 %

to 2.3 % received inpatient psychiatric treatment depending on the competent prison (Konrad & Missoni, 2001).

There are currently ten university institutes of forensic psychiatry and/or psychotherapy in the Federal Republic of Germany, which mainly provide expert opinions, if they are involved in the prison system at all. Their involvement in psychiatric-psychotherapeutic care of prisoners as well as research projects and training of prison personnel is limited in scope: only 2 to 7 prisoners are psychiatrically and 15 psychotherapeutically treated on an outpatient basis per year. No university psychiatric institution in Germany offers inpatient psychiatric care for prisoners (Missoni & Konrad, 1999).

There are no binding criteria in the German penal system for admission to a(n) (inpatient) psychiatric ward, especially no legal codes comparable to those governing hospitalization under civil law. In practice, prisoners are frequently admitted who pose a danger to themselves, for example, after a suicide attempt or other self-destructive behavior. A special legal basis regulating hospitalization on psychiatric wards within the penal system does not exist; the penal detention code or criminal laws, which are federal law, neither stipulate nor forbid a psychiatric prison ward.

There are diverse problems in cases where an inpatient psychiatric ward exists in prison:

- The lack of mandatory legal criteria for admission to or release from a psychiatric prison ward can lead to the drive for acceptance, for example, by dissocial behavior – "inmates disrupting prison life". A dissociation from ethically questionable psychiatrisation tendencies is possible to the extent that a psychiatric prison ward is assumed to be responsible for the inpatient care of psychically ill prisoners, if and as long as those prisoners seriously endanger their lives, their health or especially important rights of others according to the German law concerning psychiatric practice (Gesetz über Hilfen und Schutzmaßnahmen bei psychischen Krankheiten, PsychKG).
- Prison subcultures and therapeutically counterproductive hierarchization among patients is promoted, if patients, instead of external personnel, must be used to a certain extent as ward aides for cleaning tasks, in which the standard of hospital hygiene depends on their unlimited utilizability.
- Moreover, in connection with the professional code for works and nursing services in Berlin, nursing personnel not only have to take part in gun training but also may have to carry a weapon, for example, during excursions; the role of a potential injuring party impedes the formation of a trusting, empathetic relationship, leads to a confusion of roles and harms the therapeutic interaction with the patient.
- Although inmates must receive the same quality of medical care as the general population according to the penal law, psychiatric care is subject to the ever-present risk, especially in times of tight budget constraints, that psychiatric patients in prison do not experience equivalent treatment standards of general psychiatry with regard to personnel, spatial and organizational aspects, if the Psychiatric Personnel Code – which is not legally binding for the penal system – is not accepted as the orientational criterion for the approximation of healthcare standards or if the inclusion times of closed prisons have to compete under organizational aspects with treatment offers and the milieu-therapeutic structure of a hospital.

### ***Psychiatric facilities in Berlin***

In the State of Berlin, there were 10 penal institutions holding 5,318 prisoners as of August 31<sup>st</sup>, 2003. 1,039 were remand prisoners, 377 juvenile prisoners, 15 in preventive detention and 186 not paying a fine. In 2002, we had 14,485 admissions.

The Department of Psychiatry and Psychotherapy in the hospital of the Berlin correctional facilities has over 40 inpatient beds in three units with various treatment options: a unit focusing on "psychoses" cares primarily for schizophrenic patients, who often concomitantly (Linaker, 2000) suffer from a (mainly polysubstance) dependence and thus has a multidisciplinary orientation. The

unit deals with patients in a supportive, encouraging, nonconfrontational and nonaffect/nonemotion-laden manner, which includes winning over patients who have thus far had either negative psychiatric experience or none at all. The other two units care for patients with the primary diagnoses of personality disorders and adjustment disorders. The treatment concept of the latter concentrates on implementing activating measures or suppressing regressive tendencies and limiting hospitalization time.

Clarity of roles is crucial for practitioners. Cooperation between the different occupational groups in the penal system is certainly necessary and benefits the patients. If, however, confidentiality is not respected, the patient-physician relationship will be even more endangered than it is in the therapy-hostile prison environment.

The department is run by

- 2 psychiatrists, 4 doctors
- 1 occupational therapist
- 27 nurses

We offer additionally per fee contract

- 16 hours per week occupational therapy
- 18 hours per week art therapy
- 6 hours per week music therapy
- 6 hours per week sports therapy

Germany has one facility resembling complementary inpatient psychiatric care units: The Berlin penal system offers a kind of semi-hospitalization in the form of a follow-up unit in closed prisons for those no longer requiring full inpatient care. The unit is spatially integrated into a building of the normal prison, i.e. patients live under the same spatial conditions as the other inmates. The specially protected atmosphere is ensured by easier access to psychiatrists and nursing staff and to occupational and art therapy performed as in a day hospital (Konrad, 2004b).

Patients requiring out-of-hospital care should be treated in an outpatient department with a psychiatric-psychotherapeutic spectrum that ensures continuity and adequate time (Kallert, 1996). Such an outpatient clinic exists in the Berlin penal system, which offers psychiatric outpatient treatment (with about 3,000 contacts per year) and psychotherapeutic outpatient treatment called the "Psychotherapeutic Counseling and Treatment Center" (PTB). PTB is run by 3 half-day psychologists and is based on the model of an extramural outpatient psychotherapeutic treatment facility: Therapy is voluntary and basically open to all prisoners, and treatment is provided with the strictest confidentiality. The therapist is not involved in prison planning but gives prognostic opinions on mitigating prison conditions. In addition to counselling and arranging other measures, the therapists offer individual behavioral therapy and deep-psychological sessions in 14-day intervals at the most. Even if the prisoners' psychic disorders and individual suffering are the reasons for taking up contact and starting therapy, it was found in a quasi experimental design that treatment also led to an improved legal prognosis: After a mean of 4 years, the recidivity (repeat offenses) of offenders with at least 20 therapeutic sessions was recognizably lower with 35.9 % than that of an untreated control group in regular prison with 47.4 % (Dahle et al., 2003).

It should be mentioned when comparing general and prison psychiatric facilities in Germany that general psychiatry is better staffed with more highly trained personnel and offers more up-to-date therapy (Konrad & Missoni, 2001).

### **Epidemiology of mental disorders**

In Germany, there are only a few method-based studies on the prevalence of mental disorders in prison that examine a large, representative sample of a prison population with standardized diagnostic instruments and provide a diagnosis oriented on international classification systems. One

study (Konrad, 2004a) examines the prevalence of mental disorders within a group of German male prisoners sentenced for not paying their fines (table 2). Impressive is the large percentage of persons (10 %) with psychotic symptoms in lifetime prevalence. Another study (Missoni et al., 2003) examines the prevalence of mental disorders within a group of German male remand prisoners (table 2). Notable is the large percentage of persons (40 %) with single or recurrent depressive episodes in lifetime prevalence. Most of these depressive episodes classified as adjustment disorders would not have arisen without imprisonment as psychosocial stress or, to be more precise, a critical life event.

**Table 2: Important DIA-X (Wittchen & Pfister 1997) Diagnoses**

Prisoners not paying their fine		Remand Prisoners	
Alcohol Use Disorder	77 %	Alcohol Use Disorder	43 %
Nicotine Dependence	64 %	(Recurrent) depressive Episode(s)	40 %
Substance Use Dependence (without Alcohol)	20 %	Substance Use Dependence (without Alcohol)	14 %
Specific Phobia	39 %	Nicotine Dependence	36 %
Dysthymic Disorder	21 %	Specific Phobia	14 %
(Recurrent) depressive Episode(s)	20 %	Dysthymic Disorder	6 %
Psychotic Disorders	10 %	Psychotic Disorders	6 %

Due to this research deficit, current data are not available, which would enable appropriate treatment planning with regard to the needs of mentally disturbed prisoners. Thus, an empirical basis does not exist for determining whether prisoners in Germany – as elsewhere (e.g. Lamb, 2001) - have an increase in mental disorders attributable to inadequate dehospitalization programs.

In most European countries, the suicide rate of males aged 15 to 44 years in the general population increased between 1983/86 and 1991/94, the greatest increase being in Latvia, Russia and Scotland (Konrad 2001). Germany shows a decline but not for inmates. There are discrepancies if one compares the development of suicide rates of inmates and the general population.

Inmates in Germany have a clearly higher suicide rate, if the mean ratio of inmate suicide rates is compared to males aged 15 to 44 years in the general population (Konrad 2001).

**Quality Standards and ethical aspects**

There are no standardized psychiatric diagnostics for all prisoners upon entering prison. Most mentally disordered prisoners in Germany are assessed and treated by prison physicians, who are usually specialists in general medicine and do not have any obligatory vocational training in psychiatry. Standardized instruments for the assessment/treatment of mentally disordered prisoners are not generally applied.

Medical confidentiality is regulated by the penal laws. In practice, a separate "health file" is kept on each inmate, which contains medical documentation and advisory psychiatric results and recommendations for the prison physician. This file is only available to medical personnel bound to professional confidentiality.

Mental health problems are overlooked especially in prisoners who are quietly psychotic. The more behaviorally disturbed are often viewed as a disciplinary problem rather than as individuals with mental health needs (Birmingham, 2004). Some of them are placed in disciplinary segregation instead of immediately receiving appropriate psychiatric care.

A generally accepted concept for inpatient psychiatric care in prisons has not yet been reported in German literature (Konrad, 2004b), although a number of studies on forensic psychiatric inpatient facilities can be found in the literature, which offer basic contextual and conceptual structures (e.g. Müller-Isberner et al., 2000). Classic psychiatric text books and standard works rarely deal with practical care and completely disregard psychiatry in prison. Even the current standard works on forensic psychiatry provide no information about structuring inpatient and/or outpatient care of mentally ill prisoners that goes beyond a description of clinical pictures and main treatment options.

An analysis of patients in a neurological-psychiatric admissions unit in the central prison hospital Baden-Württemberg "auf dem Hohenasperg", the largest German psychiatric department in the prison system with about 100 beds (Schulte, 1985), did not yield any information about their concept other than the fact that hospitalized patients are only differentiated according to treatment duration (acute and admissions wards, mid- and long-term wards). The department has recently been separated into an admission or acute unit, an evaluation and treatment of psychoses unit as well as an addiction therapy and rehabilitation unit under psychological direction (application of psychodynamic, psychoanalytical or interview and behavioral therapy-oriented programs) (Frießem & Stierner, 1996). In addition to standard medical care, there is psychopharmacologic therapy and psychologist-run crisis intervention as well as work and occupational therapy.

The European Prison Rules are widely unknown in Germany. However, it must be noted that the German penal law agrees with these rules on many points.

There are a few lobby groups in Germany that only (Friends of Prison Psychiatry) or also (Federal Association of Prison Physicians and Psychologists) address the needs of mentally disordered prisoners, but they have virtually no political influence.

Major deficits in German inpatient psychiatric care of prisoners are the lack of facilities for treating those with chronic mental illnesses and the inadequate management of acutely psychotic or delirious prisoners, which in many places leads to temporary "parking" in isolated cells (Missoni & Rex, 1997). Moreover, there are too little data on the incidence of mental illnesses to even perform quality assurance of medical services. Compared to psychiatric care outside of prison, the equivalence principle has failed as a fundamental guide in many places.

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## Greece

### Giorgos Alevizopoulos, Markos Skondras, and Antonios Papadourakis

The increased prevalence of individuals suffering from mental illness entering the criminal justice system has been referred to as the criminalization of the mentally ill. There are many reasons for that increase, such as the deinstitutionalization, the lack of adequate community mental health system, more restrictive civil commitment criteria, and finally the attitude of many prosecutors to underestimate the mental illness in respect to the criminal actions. All of us who are working on forensic settings in Greece, we have witnessed the phenomenon of the “criminalization” of persons with mental illness. Within the next pages of this chapter we hope that we shall have the opportunity to pin point some problem-areas which contribute to this inappropriate, inhumane and wasteful incarceration of persons with severe mental disorders, provide them with cost-effective care and treatment, and advance public safety.

#### Structure of Prison System

Correction in the structure of the prison system includes those agencies and programs at any level, that interface with individuals who have been either accused for crimes or they are convicted for them. The Greek correctional system is complex and includes three types of facilities: lockups, jails, and prisons. Lockups are incorporated organizational, administratively and financially to the Ministry of Public Order. All other correctional facilities in Greece are under the organizational scheme of the Ministry of Justice.

The lockups (Greek term Aftofora) are local temporary facilities that constitute the initial phase of the criminal justice system in a significant number of jurisdictions. The lockups are located in the local police stations that have relevant facilities, the Polydynama Astynomica Tmimata (Multi Functional Police Stations), where only temporary detainment is required. The lockup is the most common type of correctional facility, with an average stay usually lasting less than 48 hours. Arrestees detained in a lockup are obliged to present in the Court within a 48 hour period. The Courts are composed either by a Judge and a Secretary (Monomeles Aftoforo) or by three Judges and a Secretary (Trimeles Aftoforo), in respect to the criminal act.

There are also two other special facilities for the detention of inmates for transfer or deportation of illegal immigrants, called “Tmima Metagogon” and “Tmima Allodapon” respectively. The Transportation Station is located in Athens area. The station is under the authority of the Department of Public Order. Until September 2005 there were two such police stations located in Athens and Piraeus respectively but the services were incorporated to the one of Athens. Transfers that serve are:

1. Transfers of detainees between Greek correctional settings.
2. Transfers of detainees from Hospitals or Courts and backwards.
3. Transfers to Attorneys.

At any time, the department serves an average of 50 detainees although in cases the total number can be 3-4 fold higher. The station has no medical facilities and since a significant portion of the detainees is drug addicts, there are regular itineraries to the Psychiatric Hospital of Korydallos.

The department for the deportation of illegal immigrants or foreigners who are to be extradited (Tmima allodapon) is separate. There are five stations in the area of Athens, and they are extremely overcrowded due to the large numbers of illegal immigrants from Balkans, Eastern Europe, and Asia.

Jails are locally operated correctional facilities that confine persons before or after adjudication. Individuals who are convicted of a misdemeanor complete their sentence in a jail. Jails serve a variety of functions, including holding persons awaiting trial, detaining violators of probation, parole or bail, serving as temporary destinations for transfer of inmates. Nevertheless, the largest jail in Greece, the one located in Korydallos area was constructed in 1963, has become a regular and overcrowded prison.

Prisons are confinement facilities that maintain custodial authority over individuals who have been convicted of delinquencies (plimmelima) and felonies (kakourgima). In a total of 22 prisons in Greece there are four farming prisons in rural areas namely Agia, Kassandria, Kassavetia, and Tiryntha. There is only one prison, in Eleon area, providing specific services for addicts. However, the prison does not work under its full capacity and to date is rather an experimental institution than a specialized prison. Beyond that, the remaining 18 are regular prisons and they are widely spread in Greece. Five of them are located on islands, two in Crete, and one in Chios and Kos respectively.

There is also one prison for female offenders, in Korydallos area that serves every function concerning female prisoners. There are also two special prisons, the first in Attica, near Avlonas village and the second one, an institution in Volos area that serve as facilities for adolescent and very young adults inmates.

All Greek correctional facilities are overcrowded and understaffed. The constructions are rather old and far away from the current needs of the incarcerated population (table 1). To our knowledge, there is only one new prison under construction in Central Greece.

**Table 1: Total capacities of the Greek correctional facilities and the number of incarcerated persons.**

Correctional facilities in Greece	Total capacity	Detainees by 16-5-2006
30	5584	10051
<b>Major prisons and forensic medical facilities in Greece</b>		
Psychiatric Hospital of Korydallos	160	258
General Hospital of Korydallos	60	
Korydallos Prison	640	2190
Korydallos Prison for Females	270	554
Prison of Patras	343	718
Prison of Salonica	370	615
Eleon Prison for Addicts	300	51

Regarding financial issues of the correctional facilities in Greece, the authors were unable to determine the budget for them. The distribution in the Budget of Justice for 2006 is expressed per category of expense and it was impossible to determine the budget for the correctional settings. In any case, the unique explicit registration was that for the treatment and the rehabilitation of convicts who are drug abusers and it is roughly 100,000 Euros, which represents the 0.02 % of the total estimated expenses of the 2006 Budget for the Department of Justice.

## Medical Services and Mental Health Care Provision in Prison

As of December 2004 Greece incarcerated in its jails and prisons more than 10,000 people. The only national study, by one of the authors clearly establishes that at least 15 % of local jail population nationally comprise persons who are severely mentally ill. Anecdotal evidence further reported that the numbers of seriously mentally ill offenders receiving treatment in prison have also dramatically escalated over the last decade. The sad truth, to our knowledge, is that our prisons have replaced some of the mental institutions closed as a result of de-institutionalization in the late 1980s. Most of our mentally disordered offenders, whether in local or territorial custody, are non-violent and are imprisoned largely as a result of the lack of appropriate and consistent community based mental health care and individualized social services. These services promised by the proponents of de-institutionalization, have never work properly and never replaced the institutions. In the communities to which such offenders are released, mental health care is inconsistent, if available at all. Thus, these ill offenders are doomed to recycle through, involuntary admission and the criminal justice system, a costly and wasteful outcome of using the criminal justice system as it is currently constituted. Many of these offenders are the recipients of harsh mandatory sentences which punish recidivism without regard to the causes of the person's criminal behaviour. While in jails and prisons offenders with severe mental illness are frequently victimized by custodial staff and other inmates, because of their disorganized behaviour. Untrained prison guards frequently target these ill inmates for punitive treatment, simply because they are manifesting behaviours which are symptomatic of their mental disorders and because these inmates are unable to understand or adhere to custodial rules and regulations. Exacerbation of the mental disorders, serious physical injury and even death result in these inappropriate custodial environments. In most correctional settings of Greece, adequate, consistent and appropriate mental health treatment is largely nonexistent. Official reports establish that a major reason why jail and prison services are so poor is because of a lack of adequate screening of jail and prison admittees to determine whether they have a major mental disorder.

Most screening, if it exists at all, is conducted by custodial staff, not mental health professionals. Furthermore, screening is based upon the prisoner's reporting whether he or she has ever been diagnosed or hospitalized for a mental disorder. Because of embarrassment, stigma, and fear of being identified by staff and inmates as "crazy" because they fear being medicated or are simply poor historians, many persons with mental disorders, if simply asked, will deny any mental health history and hope to "pass" as normal. The practice, at least in the largest prison in Greece, namely the Korydallos prison, is that the admittee drops in a box a piece of paper with his name, asking for an appointment with a psychiatrist. If the prisoner does not ask it, or the custodial staff is not bothered by the prisoner's behaviour on mental grounds, the psychiatrist will never be aware of the existence of the mentally ill prisoner.

Since the system depends upon self-reporting it is going to overlook many persons who do not display positive symptoms of illness, who do not talk or act bizarrely, while responding to internal stimuli. It is common knowledge that those suffering extremely serious illness, but who are withdrawn, isolated, and non-communicative, are routinely overlooked by custodial authorities as well as mental health screeners.

Mentally ill patients have reported an indifferent attitude by staff to the patients' needs. Moreover, most mental health departments refuse to provide services to incarcerated persons. Local mental health departments simply refuse to serve persons with mental illness who have been "criminalized". Although the agencies will argue that they have been poorly resourced and that this lack of funding has caused them to deny services to some in preference for others, nonetheless there exists an underlying antipathy to working with mentally ill offenders. There exists little acknowledgment that those who have been caught up in the criminal justice system are among those most in need of consistent and appropriate care!

Regarding the proportion of the specialized staff in Greek prisons, the evidence is extremely disappointing. There are only two psychiatric nurses, both in Korydallos facilities. However, every prison in Greek territory, appoints at least one general psychiatrist, mainly as a visiting doctor to cover the needs of the inmates. It is obvious that it is impossible, for one person, to examine,

diagnose and treat those inmates in need, resulting to a disproportional flow from the regional prisons to the Mental Hospital of Korydallos. Recently, the Ministry of Justice moved forward to take on staff of the various professional disciplines to work with mentally disordered offenders. It also considered the specialized and more general training needs of staff at basic and post-qualifying levels. However, since the process has not finished yet, it would be precarious to evaluate the outcome.

In summary the correctional institutions in Greece usually do not appoint permanent medical personnel and the medical needs of the inmates are served either by the local hospitals or by first rank rural doctors. Prisons with medical personnel are those of Patra, Larissa, Ioannina, Salonica, Komotini, and Eleon. The only institution with psychiatric staff is the Psychiatric Hospital of Korydallos. The medical personnel are constituted by one appointed psychiatrist and four part time psychiatrists, while all other medical specialists are part timers. The nursing personnel is constituted by eight nurses. Nevertheless, there is at least one general practitioner at any time.

### Epidemiology

Epidemiological data concerning mental health in Greek prisons are minimal. There is only one study, by one of the authors, in Korydallos prison and it is the only available evidence about the mentally ill detained in Greek prisons. The inmates participating the study were 495, representing 5.33 % of the entire adult male incarcerated population in Greece. The mean age of the sample was 26.95 years (range 20-72 yrs). 32.93 % was married and 51.72 % had a rather stable occupation prior the incarceration. 58.38 % had no history of prison sentence, while 18.79 % had a history of more than four prison sentences. The sample was found to be similar to the total Greek prison population in respect to the demographic characteristics of age, social class, basic education and number of previous prison sentences.

Psychiatric disorders were diagnosed in 223 (45.06) of the subjects. Table 2 shows the prevalence of the different diagnoses made. Substance misuse involved the misuse of controlled substances, alcohol or both.

**Table 2: Estimated prevalence of mental illness among prisoners in Greek prisons**

Diagnosis	Number of subjects (%)
No psychiatric disorder	272 (54.94)
Personality disorder	79 (15.96)
Substance misuse	72 (14.54)
Depression	22 (4.44)
Neurosis	18 (3.64)
Psychosis	13 (2.63)
Organic mental disorder	7 (1.41)
Mania	5 (1.01)
Dual diagnosis	7 (1.41)

The prevalence of the most common mental disorders (personality disorder, substance misuse, depression, neurosis and psychosis) was analyzed separately in relation to the criminal history. Offenders were classified according to the type of offence with which they were charged, in three major crime categories: non-violent, violent, and drug related crimes.

Offences involving violence, ranged from violence against the person (assault, attempted murder, murder etc.) to violence against property (malicious and criminal damage and arson), according to the Greek criminal definition. Drug related crimes manifested with violence were recorded as violent crimes.

Non-violent crimes (theft, financial crimes, etc) were clearly the most prevalent reason for imprisonment. It was found for 40.7 % of all investigated criminal records. Drug related crimes were found in 30.3 % of the sample. The prevalence of violent crimes was followed with 28.0 % of the investigated population. The prevalence of personality disorders was significantly related to violent crimes. There was also significant relation between substance misuse and drug related crimes. Finally depression was correlated to drug related crimes. No other mental disorder related significantly to any crime category. Beyond that study, the research in this area is extremely limited. Furthermore, the Statistics of Justice are insufficient to provide quantitative evidence on issues such as annual suicide rates, epidemiological characteristics of the incarcerated population etc.

### **Quality Standards and Ethical Aspects**

Greece has adopted the recommendation of "The Council of Europe, Committee of Ministers. Recommendation No. R (98) 7 Concerning the Ethical and Organisational Aspects of Health Care in Prison (Apr. 8, 1998)" and there is a strong effort by all involved parts to comply with the recommendation. However, medical practitioners in prison face, by far, difficult problems which stem from conflicting expectations from the prison administration and prisoners try to guarantee minimum standards of humanity and dignity in prisons. Hereinafter we shall present a brief review and commentary of the major issues on quality standards of care provided in Greek prisons.

On admission to prison, each person receives information on rights and obligations, the internal regulations of the establishment as well as guidelines as to how and where to get help and advice. Special instructions are given to the illiterate and those who are not fluent in Greek language.

### ***Access to a doctor***

Access to a doctor when entering a prison and later on while in custody, is relatively feasible for prisoners, irrespectively of their detention regime. Unfortunately, there is no screening process for mental disorders, or psychological adaptation to prison, even withdrawal symptoms resulting from use of drugs, medication or alcohol, and of contagious and chronic conditions, usually must be declared by the detainee himself, in order to be referred to the medical staff. This results due to lack of qualified staff, particularly nurses, on a full-time basis in the large penal institutions. The prison's health care service is not able to provide out-patient consultations. Nevertheless, emergency treatment is offered mainly in liaison to the local hospitals and treatment is given, in health establishments outside the prison. There is no special treatment for sex offenders in Greece.

The access to psychiatric consultation and counselling is generally difficult. Since there is no psychiatric team in the majority of our penal institutions, the only available, consultations are by a psychiatrist of the private sector who is appointed to prison a few hours per week. Inmates addicted to drugs, alcohol or medication, are treated within the prison setting, without any provision for any special department or facilities.

### ***Equivalence of care***

Health policy in custody is not integrated into the national health policy. The prison health care service, to our view, is not able to provide medical, psychiatric and dental treatment and to implement programmes of hygiene and preventive medicine comparable to those enjoyed by the general public. The prison health care services have not sufficient number of qualified medical, nursing and technical staff and although, the efforts are grate the results are limited. We suggest that since the health care facilities of the penal system are under the Department of Justice and not under the Department of Health, the harmonization and integration of the health policy in prison settings, to the general health policy is impossible.

### ***Patient's consent and confidentiality***

There are no considerable problems regarding patients' confidentiality. Informed consent is obtained in the case of mentally ill patients as well as in situations when medical duties and security requirements may not coincide, for example refusal of treatment or refusal of food. Sentenced prisoners are able to seek a second medical opinion and the prison doctor considers the requests sympathetically. Information, prevention and education for health are rarely, if at all, provided in prisons. Circumstantially such programmes are developed by individual initiative and they are of limited duration.

Prisoners suffering from transmitted diseases, in particular: HIV infection AIDS, tuberculosis, and hepatitis are treated within the prison health care department. In cases of serious illnesses, treatment is provided in general hospitals.

The care of prisoners with alcohol and drug-related problems is supported by two independent programmes for drug abuse, namely "18ano" and "KETHEA". Both are represented and operate in Greek prisons with qualified external staff for social or psychotherapeutic assistance in order to prevent the risks of abuse of drugs, medication and alcohol.

Prisoners suffering from serious mental illness are kept and cared in the psychiatric hospital of Korydallos which is the only facility adequately equipped and possesses appropriately with trained staff. However, it is overcrowded (table 1) and the most disturbed patients are transferred to special mental hospitals of the public sector. The decision to admit an inmate to a public hospital is made by the psychiatrist, responsible for the patient.

### ***Refusal of treatment and hunger strike***

In the case of refusal of treatment, the doctor requests a written statement signed by the patient in the presence of a witness. The doctor gives the patient full information as to the likely benefits of medication, possible therapeutic alternatives, and warn him/her about risks associated with his/her refusal. It is ensured that the patient has a full understanding of his/her situation. If there are difficulties of comprehension due to the language used by the patient, the service of an experienced interpreter is sought.

The clinical assessment of a hunger striker is carried out only with the express permission of the patient, unless he or she suffers from serious mental disorders which require the transfer to a psychiatric service. Hunger strikers are given an objective explanation of the harmful effects of their action upon their physical well-being, so that they understand the dangers of prolonged hunger striking. If, in the opinion of the doctor, the hunger striker's condition is becoming significantly worse, the doctor reports this fact to the appropriate authority and takes action in accordance with national legislation.

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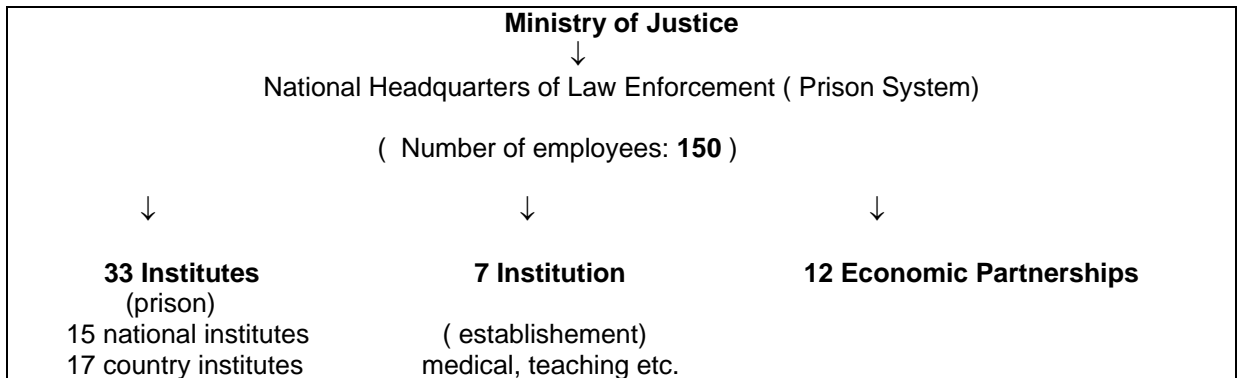
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# Hungary

László Lajtavári

**Structure of Prison System:**

**Figure 1:**



The total number of employees in Prison System: 7,973 persons (1,018 civil servants, 83 part time civil servants, 6,772 professionals; 2005.)

**Table 1:**

Total capacity of Prisons:	<b>11.263</b>	(2005)
Remanded people in custody:	3981	↓
Prisoner:	11469	
Severity: Severe	3550	
Average	6782	↓
Mild	477	
Adult	10809	
Young	660	↓
Male	10779	
Female	690	
Compulsory treated:	198	↓
(Mentally Disordered Offenders)		
Person in short term custody:	72	
Total:	<b>15.720</b>	↓
Average saturation:	<b>146%</b>	

In Hungary there are 3 degrees of penalty in prison and according to it 3 types of prisons. Severe, Average, Mild.

## Budget

**Total:** 37,764 million HUF (Phare financing: 319 million HUF)

**Public financing:** 35,164 million HUF (93.11%)

**Own income:** 2,600 million HUF (6.88 %)

Hungarian prison system belongs to the Ministry of Justice, the National Headquarters is responsible to operate the system. To maintain the Prison System is the task of the State.

52 several organisations belongs to the Prison System, including 33 prisons nationwide.

People committed criminal act or suspected with it belong to the Prison System since they are remand in custody.

The number of prison employees is approximately half those of the prisoners. (8,000 versus 16,000)

There are several types of prisons but only the Young Persons Prison and the Prison for Women Offenders are totally separate institution, generally the Hungarian prisons are „multifunctional”, different prison population are in the same prison, but they are placed on different prison department.

The main problem is the crowdedness and the generally poor physical environment. The cause of it is the lack of financial resources.

Since 1990 several reform initiatives were begun as a consequence of the new laws and regulations.

The most important act was the repeal of death penalty in 1990 and the humanisation process that began in the late period of the Kádár regime (since the 80s) continued.

In 2005 the CPT (Committee against torture, humiliation, inhumanity) examination found only minor problems in the Prison System. (see later)

## Medical Services and Mental Health Care Provision in Hungarian Prison System

The Health Department of the National Headquarters of Prison System is responsible to organize direct the health and mental health provision of prisoners.

The supply is free of charge, this is the prisoner's fundamental right.

The health/mental health provision is regulated by Laws, ministerial and common ministerial Regulations.

There are three Medical Prison Wards with 668 beds. The Central Hospital of the Prison System has 277 beds, The Hospital for chronic patients has 80 beds, and the Forensic Institution of Psychiatry (IMEI) has 94 beds for mentally disordered prisoners and 217 beds for psychiatric observation or compulsory treatment of Mentally Disordered Offenders.

(In Hungary we do not call them medical or psychiatric prison wards, but subsequently I shall use this term.)

Medical prisons also has out-patient services.

Every prison has its own medical service, the leader is the „GP of the prison”, in major Institution full time professional GP ,in smaller Institution part time civil servant GP is present with other health professionals.(GP= General Practitioner)

The health/mental health care system is available for the prisoners, my personal opinion is that the prison population is in better position than the average civil population. (but it doesn't concern the quality standards!)



The total number of employees in the Prison Health Service is 661 persons. 93 medical doctors, 12 psychologist, 470 health professionals employed in full time, and 86 health professionals employed in part time.

The health/mental health provision is has to be given according to the Health Law (1997), and it is possible to send prisoners to general health/mental health inpatient, and out-patients services.

Health/mental health professionals need to take part on a course dealing with knowledge about the Prison System, but they do not need any further health/mental health professional qualification.

The practice is that probably 90 % of the health problems are treated in prison health services and this ratio is higher in mental health provision.

The prison system has to guard the prisoners in general medical services, the security question is very important and there is an obvious fear from prisoners in the general health/mental health care system.

The prison health care budget is 1,910 million HUF (5 % of the total prison budget, 2005) and it contains more than 1,000 million HUF from the National Health Insurance.

The budget of the mental health services is not separated from the total health care budget (the same situation as in the general health system).

### **Mental Health Care Provision in the Hungarian Prison System.**

The central Institution of the psychiatric in an out-patient provision is the Forensic Psychiatric Institute (referred to as National Psychiatric Prison) which has specific legal rights to control, supervise and organise the psychiatric and Mental Health supply of Mentally Disordered Prisoners – including young prisoners - (and Mentally Disordered Offenders –forensic psychiatric observation and compulsory psychiatric treatment.)

The Psychiatric Prison is located in a 100 years old prison building, separated organizationally and territorially from the „normal” prison.

But this „living together” is insupportable in the future, so one of the most important task in the nearly future to find an independent building, naturally with better physical environment.

The total number of beds are 311, 94 beds for mentally disordered prisoners and 217 for mentally disordered offenders.

The number of inpatient episodes of prisoners are about 700 yearly (90 % men, 10 % women),

The number of out-patients is about 4,000 yearly.

The number of compulsory treated Mentally Disordered Offenders is about 190 yearly.

The number of psychiatric observations due to supposed mental disorder among remanded persons in custody is about **160** yearly.

The three types of Mentally Disordered population is totally separated concerned with men, but they often mixed concerned with women.

The staff consist of 12 psychiatrists, 4 psychologists and 150 other mental health professionals.

To be a „prison psychiatrist” is not popular among psychiatrist, especially among the young generation, and the majority of prison psychiatrists are over middle age, or retired from general psychiatry.

The function and situation of the National Psychiatric Prison is very similar to the function and situation of the National Institute of Neurology and Psychiatry in general neuro-psychiatry.

Both of these Central Institutions are representing the old fashioned traditional neuro-psychiatric care. (more than 100 years old buildings, neurology and psychiatry are not separated unanimously, and the domination of medical approach. .

About 5-6 % of the prison population has mental health problems, and there are several ways to find the proper solution to treat them.

The Mental Health Provision in prison doesn't basically differ those in civil life, the regulations are the same from the professional point of view.

Prisoners have the basic right to get psychiatric treatment free of charge.

More than 90% of mentally disordered prisoners are treated in the Prison Mental Health System, in the Psychiatric Prison Ward, or its Out-Patient Services, or in the prison, in the „ Medical-Educational Group”, „Prevention department for drug addicts”, or drug addict prisoners voluntarily can take part in the Alternative Programs for drug addicts.

In the cases of serious mental disorders the Psychiatric Prison has the right to qualify the prisoner from the „normal” prisoner status to mentally disordered prisoner status and place him in the psychiatric prison ward till the end of his penalty.

### **Epidemiology of mental disorders**

The mentally disordered prison population is basically different from the general mentally disordered population from the epidemiological (diagnostic) point of view.

Very difficult to obtain the valid epidemiological data, according to estimations 80 % of mentally disordered prison population belong to the diagnostic category of personopathy. There are sporadic epidemiological researches, but no key national papers and publications.

It seems to me that collection epidemiological data has no priorities. (similar situation in general mental health care – „psychiatrist are not in friendship with numbers” )

Apart from this fact there is significant research activity toward other professional questions,( non fatal suicide attempts, drug addiction, social psychiatry), and more then 100 presentations were done since 1999 by the prison mental health professionals on different psychiatric forums.

Forensic psychiatry is another priority, the Psychiatric Prison is an accredited place of postgraduate training from forensic psychiatry,

### **Quality standards and ethical aspects.**

The Psychiatric Prison is responsible to assure quality standards, according to ministerial regulation.

The aim is to assure the same mental health quality provision as in general mental health care.

The general mental health professional protocols (edited by the College of Hungarian Psychiatry) are also valid in the prison mental health care system.

Another duty is to assure the training of professionals working in the prison mental health care.

For psychiatrist is obligatory to collect at least 250 CME points in every five year to validate their medical license.

In general health/mental health system there is a growing tendency to develop internationally accepted quality control system, with regular internal and external quality control audit.

This quality control system is not developed in the prison mental health system, the main reason of it is the lack of financial resources.

The ethical standards are also the same as in general mental health care.

In 2004-2005 several EU agencies (CPT, Helsinki Committee, MDAC) examined the Psychiatric Prison, and recommended that the Psychiatric Prison should be moved to a new place, far from the „ normal” prison, with better physical environment, increasing the number of mental health professionals, and provide more time spend on fresh air for the most dangerous group of prisoners.

### **Conclusions:**

Some important differences between general and prison mental health care system.

### **At present:**

The Health Law (1997) unambiguously ordains that in every case of the compulsory psychiatric treatment the court has to determine in a 72 hours time period that the treatment is necessary, or not.

Theoretically that would be the case in the prison system too, but in the prison system there is no court inspection. The main cause of it, that according to the Codex of the Prison System the prisoner has no right to refuse the medical (and psychiatric) treatment.

Maybe this question has further regulation!

The main problem, that the prison first aim is to separate people from the community, and the imprisonment itself is a stress even for mentally healthy persons.

Approximately 80 % of the mentally disordered prisoners belong to the diagnostic category of the personopathies, and this is the most problematic psychiatric population from the point of view of good quality treatment.

In general psychiatry, persons have more human rights (especially that they can refuse the treatment), more access to alternative psychiatric treatments, more possibility to get atypical antipsychotics, get more support from the community (family, friends etc.).

The physical environment is worse than in the average general psychiatric wards in Hungary. The prisons are very crowded and this is a very serious problem.

In the prison psychiatric system the psychiatrist are highly educated, but their work conditions are poor.

### ***And the Future (?)***

The general health/mental health system is in a very serious crisis since the political changes in 1989, the health care reform delayed mostly because of political reasons.. It seems that at present the government began to make the first steps toward a real and deep health care system reform and this reform will make a major impact of the mental health care.

Drastically reduction of hospital beds and increasing importance of the community care, developing a new integrative system based on multidisciplinary approach, strengthen the role of mental health case managers, reducing the drug cost and increasing the importance of psycho, and sociotherapy, increasing the importance of mental health promotion and prevention, rather than psychiatric care, involving the civil sphere in the decision making process, put the emphasis on the quality of life rather than on simply treatment, reducing the number of people living on disability pension, all this questions will be in the focus of mental health care reform, fundamentally changing the whole mental health care system.

It is a big question, if the reform will be able to move forward, how it will influence the prison health/mental health care provision, how will face the new challenges the prison mental health care system, which more suitable to exist in the framework of a more traditional, hospital centered (based rather on social exclusion than inclusion) psychiatric approach.

## Iceland

**Jon Fridrik Sigurdsson**

### Introduction

This chapter about mentally disordered prison inmates in Iceland is a part of a research project commissioned by the European Union. The purpose of the project is to analyse and describe the situation of assessment, treatment and management of mentally disordered prison inmates in 25 European countries. The chapter begins with a short description of the Icelandic criminal justice system, followed by a description of the prison system and some recent prison statistics, to provide a conceptual framework for understanding the context in which the mental health care of prison inmates in Iceland occurs.

Iceland is a volcanic island of 103,000 square kilometres situated in the North-Atlantic Ocean, north-west of the Faeroe Islands and east of Greenland. It is sparsely populated by only about 300,000 inhabitants (on average about three inhabitants per square km), of whom more than half (60 %) live on the south-west corner in and around the capital Reykjavik. The population is rather homogeneous with only 6 % of foreign origin, low unemployment rate (2.1 %), a high standard of living and a high level of technology and education. Literacy is universal (99 %) and the level of education is very high, which is also the case amongst Icelandic prison inmates (Sigurdsson, 1998). These facts may be important in order to provide a reasonable background of prisoners' health care for the reader.

### The courts and the sentencing process

Iceland has been a republic since 1944, when it became independent of Denmark. Prior to that, or from about 1800, the Court System in Iceland could be divided into three divisions, District Courts (Héraðsdómur), the Country's High Court (Landsyfirréttur) and the High Court of Denmark. Iceland has a strong relationship with the Nordic countries and Icelandic legislation has largely been influenced by Scandinavian law and particularly that of Denmark (Gudjonsson, 1975). The main Criminal Law was created in 1940 (Criminal Law (Almenn Hegningarlög), 1995), although there have been a large number of revisions since then. The major and the most recent legislation concerning Criminal Law were published in 1989 (Law No. 92/1989), when new laws concerning the separation of the jurisdiction from the legislative power were implemented.

The Icelandic Criminal Law may be divided into two main parts, the general part, that is, the penal code, and a special law, which is for minor offences and offences concerning the various areas of society which are subject to frequent changes, such as, law concerning the use and distribution of alcohol, illicit drugs, traffic violations, customs, and taxes (Sigurdsson, 1998).

Today the legal system in Iceland is inquisitorial in nature, as in most other European countries. The court (judicial) system may be divided into two groups, District Courts and the High Court (Supreme Court, Court of Appeal). The District Courts are independent courts that can be found in the eight districts of Iceland (Regulation No. 58/1992). Before that, both the police and the courts in each district were governed by the sheriff (judge and revenue officer of the district).

The High Court (Supreme Court), which was founded in 1919 by the National Law of 1918, in which Iceland was given sovereignty from Denmark, is the highest court in Iceland. The Court acts mostly as a Court of Appeal in cases sentenced by the District Courts. The High Court consists of eight judges of which three to five (seven in very serious or important cases) are assigned to each case.

The sentencing process in Iceland may be divided into three main levels, the District Police, the District Courts and the High Court. The Public Prosecutor has the main responsibility for criminal investigations and prosecutions. Cases are investigated by either the District Police or the National Commissioner of the Icelandic Police. When the investigation is finished, the case is either sent to the Prosecutor's office or in minor cases it is dealt with by the District Police. According to law (Law No. 108/76, Section 6) the District Police investigates all criminal cases which can be dealt with by a fine and the District Police also have the power to prosecute in minor criminal cases (Law concerning the procedure of criminal cases No. 19/1991, Section 5). New law concerning the organisation of the police and prosecution in criminal cases will come into effect on 1st of January 2007.

Compulsory treatment of mentally disordered prisoners is regulated by civil law (Law concerning the deprivation of legal competence (Lögræðislög) No. 71/1997) as for other Icelandic citizens and no specific law or regulations apply to prison inmates. A medical doctor can by law (Law concerning the deprivation of legal competence No. 71/1997, Section 19) decide that a person shall be hospitalised against his will in case of serious mental disorder or mental state (i.e. suicide risk, serious substance dependence disorder) for up to 48 hours and with the agreement of the Ministry of Justice up to 21 days. If a longer period is needed according to medical assessment the case has to go to a District Court.

### **Detention and remand in Iceland**

In Iceland, the police are allowed to arrest and interrogate a person, without a warrant, if he is suspected of having committed a criminal offence. When a suspect has confessed to the police during an interrogation, he is usually set free, except in very serious criminal cases. The police can also detain a suspect in custody if there is credible evidence that he has committed a crime and that his detention is necessary in order to (1) prevent re-offending, (2) ensure his or her presence or security, and (3) to prevent the suspect from destroying evidence (Law concerning the procedure of criminal cases, Sections 97 to 102). In practice suspects are not detained for more than 24 hours without a court decision, although the law does not specify the exact time, in hours or days, before which the police must produce the suspect in court. The police are supposed to ask for a decision "without delay" or preferably within 24 hours from the arrest.

According to Icelandic Criminal Law (Law concerning the procedure of criminal cases, Section 103) there are stringent conditions for remanding suspects in custody for more than 24 hours. These are: (1) the suspect must be at least 15 years old, (2) there must be substantiated evidence that he or she has committed the offence, and (3) the offence must carry a prison sentence. In addition one of the following conditions must be met:

- There is a possibility that the suspect will interfere with the investigation, e.g. destroy evidence, or influence witnesses or co-defendants.
- There is a possibility that the suspect will try to leave the country or fail to appear in court.
- There is a risk of re-offending if the person is out on bail.
- Remand is necessary in order to protect others from the defendant or to protect the defendant from being attacked or influenced by others.
- There is substantiated evidence that the defendant is guilty of a serious offence for which the penalty is at least ten years in prison.

In cases where one or more of the above criteria are not fulfilled there will be a full hearing to establish all the necessary facts of the case.

According to recent data, fewer offenders are remanded in custody (pre-trial detention) in Iceland than in nearly any other European country (i.e. 5.2 per 100,000 inhabitants in 2005) (see table 1 and International Centre for Prison Studies, 2006). In cases where one or more of the above criteria are not fulfilled there will be a full hearing to establish all the necessary facts in the case.

## Prisons in Iceland

Prison sentences were first legalised in Iceland in the 17<sup>th</sup> century. Before that offenders were whipped, branded, or executed. Offenders who were sentenced to imprisonment were at first sent to Copenhagen, where they served their prison sentence in hard labour. This arrangement was considered too expensive and in the 18<sup>th</sup> century (1765-71) a prison was built in Reykjavik. This prison was only in use for about fifty years and is now the prime minister's office. About fifty years later another prison was built in Reykjavik, Hegningarhúsið (1874), which is still in use as the main admittance prison in Iceland. During the years in between, sentenced offenders were again sent to Denmark for hard labour (Sigurdsson, 1998).

The prison system in Iceland is run by the Prison and Probation Administration (PPA), a governmental institution controlled by the Ministry of Justice (Law concerning the completion of punishment (Lög um fullnustu refsinga) No. 49/2005). It's four main functions according to law are: 1) to be responsible for the completion of punishment according to law and regulations, 2) to run the Icelandic prisons, which presently are five, in four different parts of the country, 3) to supervise young and/or "first offenders", who have been given a conditional discharge for a period of at least one year (range 1 – 5 years) after pleading guilty to a criminal offence (one of the conditions of their discharge is that they attended supervision sessions with a probation officer during the period of their discharge), and 4) to provide specialised services in prisons, e.g. medical and psychological services. Presently, the medical service, including the psychiatric service, is operated by the Ministry of Health and Social Security (MHSS), but the psychological service by the PPA. Psychologists have been employed in the Icelandic prison service for more than thirty years or since 1974, during the first few years on a part-time basis only, but from the foundation of the PPA in 1989 to 1996 one psychologist was employed on a full-time basis. Since 1996 two psychologists have been employed full-time by the prison service, serving all the five prisons.

The five prisons in Iceland have the total capacity of 138 inmate places, including 11 remand places in two of them, and there is no special remand prison in Iceland. None of the prisons is privately run as happens in some countries (Christie, 2000). The five prisons are of different sizes and have somewhat different functions. Two of them, including the oldest one, Hegningarhúsið, are situated in the capital area and the other three in different parts of the country.

The largest prison, Litla-Hraun, has the capacity of 87 cells, including 9 remand/security cells. It is situated about 65 kilometres south-east of Reykjavik and was established in 1929, when a hospital building was converted into a prison for 21 inmates (Thormundsson, 1992). During the years new buildings have been added to the prison increasing its capacity and function and in 1995 a new modern prison building for 55 inmates was built. Relatively good working, educational and leisure opportunities are provided in the prison and long term inmates, disruptive, escape prone and difficult inmates are imprisoned there, because the prison has the highest security of all the prisons in Iceland. Litla-Hraun serves as the main remand prison in Iceland, with its nine security cells and double fencing all around it.

The two prisons in the capital area are situated in Reykjavik and Kopavogur, a nearby town. The prison in Reykjavik, Hegningarhúsið, the oldest of the five prisons built in 1874, has 16 places including two remand cells. This prison serves as the main prison in Iceland, having the function of an admittance prison where nearly all convicts, except women, are admitted, assessed and transferred to one of the other four prisons.

The prison in Kopavogur is a former juvenile delinquency institution, which was converted into a prison in 1989. It serves primarily as a women's prison, with places for 12 inmates (11 in the winter time when one cell is used as a class room). The number of female prisoners in Iceland is very low

and there are often only between four and five women in prison at each time. Because of this low number of female inmates, males are also imprisoned in Kopavogur prison, primarily serving short sentences.

In 1963 a farm, Kviabryggja, in the west part of Iceland about 250 km from Reykjavik, was converted into a small prison, which now has 14 cells. It is in fact a “half-open” prison in the sense that there are no security fences around the prison land, which is about 35 hectares in size. Usually only able-bodied men with short criminal records and young first offenders are imprisoned there, because inmates must be able to work there and to be trusted to serve their sentence at an open prison. Between 1954 and 1963 Kviabryggja had the only function of punishing men who did not pay their child support.

Since 1978 a part of the police station in Akureyri, the largest town in the north part of Iceland about 400 km from Reykjavik, has been used as a prison for up to nine inmates. It is rather small with limited facilities and no work opportunities and is mainly used for inmates who are serving short sentences. In exceptional circumstances longer term inmates from the north-east of the country are imprisoned there for a longer period of time if they wish it themselves, but it is not considered appropriate for long-term or difficult inmates.

As this summation of the prisons in Iceland shows, prisoners are selected on different premises for imprisonment in different prisons as in other countries (Andersen, 2004). Women are almost exclusively imprisoned in Kopavogur prison, although in rare cases female inmates have been imprisoned on the security wing at Litla-Hraun prison and female remand prisoners have been imprisoned both at Litla-Hraun and Hegningarhus in Reykjavik. As mentioned above, long-term inmates are imprisoned at the highest security prison in Iceland, the prison at Litla-Hraun, as well as nearly all of the most difficult, disruptive, dangerous, or escape prone inmates. Most of the mentally ill inmates are also imprisoned there as well, because it is the only prison in Iceland which has a regular psychiatric service. Short-term prisoners are imprisoned at Akureyri prison and mostly short-term, able-bodied men with short criminal records are imprisoned at Kviabryggja. There is no young offenders’ institution in Iceland and young prisoners are in fact imprisoned at all of the prisons, although able-bodied first offenders and young offenders, who are not considered escape-prone, are imprisoned at Kviabryggja.

It is also important to mention here the two alternatives of imprisonment available in Iceland, both of which depend on the decision and responsibility of the PPA. These are community service, which is not allowed by a court decision in Iceland as in many other countries, and serving a sentence at a half-way house in Reykjavik. The PPA can by law (Law concerning the completion of punishment nr. 49/2005, Section 27) allow sentenced offenders to serve their prison sentence in community service providing certain conditions are fulfilled. The sentence must be no more than six months and the offender must be considered fit and capable to serve community service according to rules and regulations of the PPA. In the past five years the number of sentenced offenders serving community service has been ranging from 142 to 289 (see table 1).

The other alternative is serving the last weeks or months (maximum eight months) of a prison sentence at a half-way house in Reykjavik, which is run by the Icelandic Prisoners Welfare Association, providing that the inmate has behaved properly in prison, or has shown improvement in behaviour during his or her incarceration. Many long term inmates finish their imprisonment at the half-way house and during the years between 2001 and 2005 from 6.9 to 10.5 per cent of the daily average prison population was serving a sentence at the house (see table 1) and the drop-out rate ranged between 8.8 and 16.3 per cent during these five years.

The Icelandic prison system has a total of about 100 employees (25 % females), thereof about 80 are prison officers. Half of the employees work at Litla-Hraun and about a quarter at the prisons in the capital area. The PPA, which is placed in Reykjavik, has 15 employees, including the Director General and a finance director. The total budget of the prison system for 2006 is 847,900,000 Icelandic kronur (9,056,825 Euros (Central Bank of Iceland Exchange rate (93.62) on the 21<sup>st</sup> July 2006)). Salaries comprise the largest part or about 70 % of the total cost and food for the prison inmates 12 %. The cost of the PPA is about 12 % of the total cost of the prison system.

There is no direct institutional quality control of the Icelandic prison system apart from the control of the Ministry of Justice, the Icelandic Parliamentary Ombudsman and the European Committee for the Prevention of Torture and Inhumane or Degrading Punishment (CPT), which has visited Iceland twice during the last ten years, in 1998 and 2004. The CPT reports as well as the responses from the Icelandic Government have been disseminated and are available on the PPA's and European Council's websites ([www.coe.int](http://www.coe.int); [www.fangelsi.is](http://www.fangelsi.is)).

The Icelandic Government has repeatedly during recent decades made plans for building a new prison in Reykjavik. About fifteen years ago the plan was to build a 90 cell prison, a remand and admittance prison just outside Reykjavik, but this has changed. Now the plan is to build a smaller prison (48 to 54 cells), which will take over the function of the prisons in the capital area as well as being the main remand prison in Iceland. It will be designed as a high security prison for both male and female inmates, with good health care facilities and prisoners work and leisure activities. Also, according to latest plans, this prison will have two small medical wards, one for detoxification and substance abuse treatment and one for mentally disordered prison inmates. No decision has yet been made about when it will be built.

### **Icelandic prison statistics**

The prison population in Iceland is among the lowest per capita in Europe and has been between 35.8 and 40.9 per 100,000 inhabitants the last five years, i.e. only counting imprisoned inmates (see table 1). The average daily number of all prison inmates in Iceland has also been rather stable in recent years at between 119.2 and 137.9 inmates, including inmates serving their sentence outside the prisons. As table 1 describes, between 13.0 and 15.3 of prisoners on average are placed outside the prison system (at health institutions, in substance abuse treatment or at a half-way house), on average 0.4 % to 4.0 % of the inmates are serving their sentence at health institutions, between 2.0 and 4.4 % at substance abuse treatment facilities and between 6.9 % and 10.5 % at a half-way house in Reykjavik. In addition to this a number of offenders have been serving their prison sentence in community service during these five years (see table 1).



**Table 1: The number of prison inmates and offenders serving community service in Iceland during the years between 2001 and 2005**

Prison statistics	2001 N (%)	2002 N (%)	2003 N (%)	2004 N (%)	2005 N (%)
Daily average number of all prisoners in Iceland	123.7	119.2	132.8	137.9	136.8
... thereof in prisons each day	107.2 (86.7)	103.1 (86.5)	115.7 (87.1)	119.9 (86.9)	115.9 (84.7)
... thereof serving unconditional prison sentences	87.2	85.0	97.9	100.1	96.8
... thereof on remand	14.5	14.7	11.4	12.0	15.6
... thereof serving terms as an alternative to fines	5.5	3.4	6.4	7.8	3.5
... thereof at health institutions	4.9 (4.0)	3.3 (2.8)	1.8 (1.4)	1.9 (1.4)	0.6 (0.4)
... thereof in substance abuse treatment	3.1 (2.5)	3.8 (3.2)	2.6 (2.0)	3.6 (2.6)	6.0 (4.4)
... thereof at the half-way house in Reykjavik	8.5 (6.9)	8.9 (7.5)	12.7 (9.6)	12.5 (9.1)	14.4 (10.5)
Daily average number of prisoners pr. 100.000 inhabitants	43.2	41.3	45.9	47.0	45.7
... thereof in prisons	37.4	35.8	39.8	40.9	38.7
... thereof serving unconditional prison sentences	30.5	29.7	33.7	34.1	32.3
... thereof on remand	5.1	5.1	3.9	4.1	5.2
... thereof serving terms as an alternative to fines	1.9	1.2	2.2	2.7	1.3
Number of prisoners who finished serving prison sentence*	157	163	208	214	187
... thereof first offenders	69 (43.9)	93 (57.1)	122 (58.7)	123 (57.4)	112 (59.9)
... thereof recidivists	88 (56.1)	70 (42.9)	86 (41.3)	91 (42.5)	75 (40.1)
... thereof prisoners with foreign citizenship	21 (13.3)	25 (15.3)	30 (14.4)	38 (17.8)	37 (19.8)
... number and proportion of males	146 (93.0)	147 (90.2)	198 (95.2)	198 (91.7)	169 (90.9)
... number and proportion of females	11 (7.0)	16 (9.8)	10 (4.8)	18 (8.3)	17 (9.1)
Number of convicted offenders serving community service	142	206	289	255	211
... thereof serving unconditional prison sentences	82 (58)	88 (43)	83 (29)	59 (23)	73 (35)
... thereof serving terms as an alternative to fines	60 (42)	118 (57)	206 (71)	196 (77)	138 (65)

\*Between 60 and 70 per cent on probation each year.

Table 1 also shows the number of inmates, according to gender, who finished imprisonment each year between 2001 and 2005. During this period on average 185.8 inmates finished their imprisonment each year in Iceland, the proportion of females ranging between 4.8 and 9.9 per cent during these five years. As the table shows the proportion of recidivists in the Icelandic prisons has decreased slightly the last few years and during the years between 1996 and 2000 their average proportion was 49.8 %.

Criminal responsibility in Iceland commences at the age of 15, but during the last five years only three of the inmates who began serving their sentence in Icelandic prisons were under the age of 18 years. The age distribution of inmates in 2005 was similar to the previous four years, 17 (5.6 %) were between 18 and 20 years, 76 (24.9 %) between 21 and 25 years, 71 (23.2 %) between 26 and 30 years, 46 (15.0 %) between 31 and 35 years, and 95 (31.2 %) older than 35 years.

Table 2 describes the types of offence leading to imprisonment during the years between 2001 and 2005. The classification of the offences corresponds with the Icelandic legal classification. Between a quarter and one third of the inmates (26.3 % to 34.47 %) were serving prison sentences for some kind of property offences and between 10.8 and 21.9 per cent for serious traffic violations. During these five years about a quarter (16.4 % to 25.3 %) of the prison population were serving prison sentences for offences against persons (homicide and sexual and violent offences) and about a third part (23.7 % to 31.5 %) for drug related offences. These four types of offenders comprise in total about half (47.9 % to 54.4 %) of the prison population, of which a substantial proportion is in need of psychological and psychiatric treatment.

**Table 2: The type of offence leading to imprisonment in Icelandic during the years between 2001 and 2005.**

Type of offence	2001 N (%)	2002 N (%)	2003 N (%)	2004 N (%)	2005 N (%)
Homicide/attempted homicide	16 (6.3)	13 (5.2)	15 (4.6)	13 (4.1)	15 (4.9)
Property offences	83 (32.7)	66 (26.3)	86 (26.5)	109 (34.4)	83 (27.2)
Serious traffic violations	39 (15.4)	55 (21.9)	53 (16.3)	39 (12.3)	33 (10.8)
Drug offences	75 (29.5)	79 (31.5)	91 (28.0)	75 (23.7)	96 (31.4)
Sexual offences	14 (5.5)	14 (5.6)	30 (9.2)	36 (11.4)	27 (8.9)
Violent offences	22 (8.7)	14 (5.6)	32 (9.8)	31 (9.8)	28 (9.2)
Arson	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	3 (1.0)
Other offences	5 (2.0)	10 (4.0)	18 (5.5)	14 (4.4)	20 (6.6)
<b>Total</b>	<b>254 (100)</b>	<b>251 (100)</b>	<b>325 (100)</b>	<b>317 (100)</b>	<b>305 (100)</b>

The number of foreign citizens in the Icelandic prisons has increased substantially the last few years. During the years between 1996 and 2000 their number ranged from 5 to 12 (on average 7.8 foreign inmates a year; 3.2 % to 5.3 % of the prison population) but between 2001 and 2005 from 21 to 38 (on average 30.2 foreign inmates a year; 13.3 % to 19.8 % of the prison population, see table 1). In 2005 these inmates were from 27 countries (citizenships) and about half of them were serving a prison sentence for property offences (19; 51 %), followed by drug related offences (14; 39 %), sexual offences (2; 5 %) and violent offences (2; 5 %). This increase of foreign citizens in the Icelandic prisons may affect the prison population considerably and complicate the medical and psychological services due to cultural differences, language problems and even medical problems.

### Medical services and mental health care provision in prisons

The medical service in the Icelandic prisons is the responsibility of the Ministry of Health and Social Security (MHSS) (Law concerning the completion of punishment No. 49/2005, Section 22). The health service is provided for by local primary health care services (in Reykjavik, Grundarfjordur, Akureyri and Selfoss) by contract with the MHSS. The service is different between the five prisons in accordance to their function and inmate population.

According to information from the MHSS the total budget for the health care service in the Icelandic prisons in 2006 will be 56,500,000 Icelandic kronur (603,503 Euros). In the contracts between local

primary health care services and the MHSS no requirements are made for a certain amount of psychiatric service, except at Litla-Hraun. However, the service provider is supposed to provide, in addition to a general health care service, a specialised medical service, including psychiatric service and regarding Litla-Hraun, there is a claim of 75 % of a full-time psychiatrist post by the end of 2006.

All the prisons have regular visits by general practitioners (GPs) and the two prisons in the capital area have regular visits from nurses. Litla-Hraun prison provides full-time nursing service five days a week (one full-time post), 75 % of a full-time GP post and it is the only prison which has a regular psychiatric service. Presently a psychiatrist visits the prison one day a week (25 % of one full-time post) but from next autumn (2006) the service will be increased to four days presence a week (75 % of one full-time post).

Prisoners' access to psychiatric care at the other prisons is inconsiderable and irregular, partly because the majority of mentally ill prisoners are imprisoned at Litla-Hraun. Despite that the prisons in the capital area should be provided with a regular psychiatric service. Kopavogur prison is the only female prison in Iceland, housing both short-term and long-term inmates and able-bodied and mentally ill women.

According to law (Law concerning the completion of punishment No. 49/2005, Section 16) all newly admitted prison inmates shall be medically examined at the beginning of their imprisonment. Nearly all prisoners admitted to prisons in Iceland, except female prisoners, start serving their sentence at the Hegningarhusid in Reykjavik, where they are medically examined by a GP and a nurse.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) visited Iceland in June 2004 and made various positive and negative comments about the Icelandic Prison Service. The CPT (CPT, 2006) regarded medical screening of prison inmates on admission performed systematically in all prisons except for Kvíabryggja, which nearly exclusively receives able-bodied inmates who have been medically examined at another prison, most often at Litla-Hraun or Hegningarhusid. According to the Committee's investigation "... the initial medical examination - usually carried out by a nurse, who referred the prisoner to the doctor in case of need - took place a few days after arrival. It is noteworthy that this situation was the least favourable at Skólavörðustígur Prison [Hegningarhusid] - the main point of entry to the prison system - where newly arrived inmates might not be seen by a member of the health-care service until the fifth day." (CPT, 2006; p. 24). The CPT recommended that medical screening should be carried out on the day of admission, especially as far as remand prisoners were concerned.

In addition to the medical screening performed at admission, every newly admitted inmate is interviewed by a PPA's staff member, when his or her imprisonment or treatment plan is made (Law concerning the completion of punishment No. 49/2005, Section 17). A personal report is written, which is one of the bases of decision made about the inmate's transfer to another prison. In case of mental or behavioural problems, serious substance abuse problems or suicide risk, or when the main reason for imprisonment is violent or sexual offending, the case is referred to one of the PPA's psychologists who attend to it within a reasonable time (preferably within two weeks and immediately in cases of suicide risk) and to the GPs, who in some cases call in a psychiatrist. Regular consultations with the medical staff as well as visits by or consultations with a psychiatrist would be a valuable addition to the admission process in the prisons system. In cases of mentally ill, suicide risk or seriously behaviourally disturbed inmates, psychiatric and psychological assessment should be carried out immediately after admission in order to ensure proper medical and psychological treatment during imprisonment. The PPA has planned that later in 2006 the prisoner's imprisonment report will be based on assessment of risk (to self and others), treatment needs (psychiatric and psychological), educational and/or working skills and need for social support.

There are no medical wards within the prisons in Iceland, no manual based treatment programs for mentally disordered inmates, and no figures are available about the number of prison inmates having received psychiatric or psychological service each year. Presently the two psychologists are based at the PPA in Reykjavik and visit the prisons regularly, Litla-Hraun prison four days per week, Kópavogur prison and Hegningarhusid once a week each prison and Kvíabryggja and Akureyri only once a month each prison. Apart from providing psychological service in the prisons the

psychologists provide service for other clients of the PPA, i.e. offenders who have been released on probation, prisoners' families in some cases and juveniles who have been given conditional discharge and are under the supervision of the PPA. According to the PPA'S website the psychologists have about 30 client interviews every week.

The psychological service offered is mainly individual cognitive behavioural therapy, but group treatment of anger and violence problems has been run at Litla-Hraun. Either the inmates themselves ask for psychological service, which is received on a voluntary basis only, or inmates who are considered in need or at risk by health care staff, prison officers or inmates relatives, are offered service. Also, violent offenders, sex offenders and mentally disturbed offenders are offered treatment at the intake interview on admission. Apart from therapeutic work the psychologists provide consultation and teaching for the prison service employees as well as conducting research. According to information from the PPA the total cost of the psychological service will be 11,000,000 Icelandic kronur (117,496 Euros) in 2006.

The PPA can by law (Law concerning the completion of punishment No. 49/2005, Section 15) allow admission of a prisoner at a health or a therapeutic institution during a part or the whole of the imprisonment. This can be a physical or mental health institution or a substance abuse treatment institution. Since 1990 the PPA and the Government Agency for Child Protection have a contract, which makes it possible to admit young offenders to one of the Child Protection's therapeutic facilities (Treatment Homes) in Iceland. This possibility has though not been used much except in rare cases where the young inmate is willing to accept treatment instead of imprisonment. Also, in recent years the number of prison inmates between 15 and 17 years of age has been very low. The total number of young offenders in this age group who were given unconditional prison sentences by the Courts between 2001 and 2005 was 7, of whom only three were admitted to prison (started serving their sentence) during this period, or 0.4 % to 0.6 % of all admissions.

As table 1 shows, only 0.4 % of the daily prison population on average in 2005 served prison sentences at health institutions and 4.4 % in substance abuse treatment outside the prison system. Inmates with physical complaints who need short-term hospital care are usually referred to the nearest hospital for treatment. In some cases medical staff asks that the prisoner is accompanied by prison officers during hospitalisation.

Inmates with substance abuse problems at intake are given detoxification treatment by the prisons' health care staff immediately after admission. In practice this happens mainly at the prisons in the capital area where nearly all inmates are admitted. In cases of serious psychiatric problems (e.g. delirium, depression, suicidal state) inmates are sometimes referred to the detoxification treatment ward at the Landspítali-University Hospital where they receive proper psychiatric care, otherwise they are taken care of by the prison health care staff and prison officers.

As mentioned earlier, prison inmates with substance abuse problems have had the opportunity to finish their imprisonment in substance abuse treatment at independent treatment facilities outside the prison system since 1990 (Sigurdsson and Baldursson, 1998; PPA's Website: [www.fangelsi.is](http://www.fangelsi.is)). In 2005, 33 inmates or 18 % of those who finished imprisonment that year served the last weeks in substance abuse therapy before they were released and between 2001 and 2005 the proportion varied between 7 and 18 % and drop-out rate varied between 21 and 40 %. The substance abuse treatment programmes that are available to Icelandic prisoners are primarily based on the 12-step programme modelled after the Alcoholic Anonymous (AA) tradition (Olafsdottir, 2000) and mainly involve education and psychotherapy groups.

Fortunately, there have been relatively few suicides in the Icelandic prisons during the last two decades, especially if compared with the suicide rate in the Icelandic population, which is on average 12.8 per 100,000 inhabitants a year (Directorate of Health, 2006). In 1998 there were three suicides in the Icelandic prisons, all at Litla-Hraun prison, but before that none in 17 years and after 1998 only two suicides have occurred. Following the three suicides in 1998, the Ministry of Justice set up a committee consisting of three eminent Professors of psychiatry, psychology and law, to investigate the matter. Subsequent to the investigation the PPA implemented guidelines for suicide prevention within the Icelandic prison system as well as training courses for prison officers. In the CPT visit in

2004 the committee noted that the prison authorities had made a considerable improvement in this respect from 1998 (CPT, 2006).

In Iceland there is a small seven bed forensic psychiatric institution, Sogn, which was established in 1992 not far from Litla-Hraun prison. Its main purpose is to admit mentally ill offenders who are given a hospital order by the Courts because they are not considered responsible for their own actions because of mental illness (Criminal Law No. 19/1940, Section 15). Sogn is also meant for mentally ill offenders who have been remanded or are serving a prison sentence, but because of its small size that is very rarely possible. During recent years one or two mentally ill prison inmates have however been hospitalised there.

In its last visit in 2004 the CPT commented on the difficulties in transferring prison inmates who require hospitalisation to psychiatric institutions. In the committee's report it is stated that "All the prisons visited (except Kvíabryggja Prison) accommodated certain prisoners who were clearly in need of specialist psychiatric care, which they did not receive inside the prison." (CPT, 2006; p. 25), but Sogn failed to meet the demand because of its limited capacity. As can be read in the Icelandic Governments reply to the CPT report (Response to CPT, 2006), the PPA has recommended that when a new prison is built in the capital area, it must include a medical ward where mentally ill inmates can be treated and the Psychiatric Division of the Landspítali-University Hospital shall be responsible for their care.

In the last CPT report (CPT, 2006) the main problems of the prisoners' health care service in Iceland are described very well:

"Although the delegation was impressed by the professional competence and commitment of the health-care staff with whom it spoke, it also became aware of the shortcomings of the solution chosen by the Icelandic authorities. There seemed to be no clear management, no coordination of work of different health-care professionals and no proper needs analysis addressing the specificities of health care in a prison setting (e.g. as regards transmissible diseases or drug issues). Moreover, the health-care staff concerned did not receive any specialised training for performing their duties in a prison environment, other than courses in which they participated at their own initiative and in their free time. The CPT invites the Icelandic authorities to review the organisation of health care for prisoners and develop the training of health-care staff working with inmates, in the light of the above remarks." (CPT, 2006; p. 24).

There are three main important criticisms in the CPT report, 1) lack of coordination of health care service in the prison system, 2) no needs analysis has been performed in order to guide the health care staff and 3) the health care staff receives no special training to perform their duties. There are undoubtedly a number of reasons for this lack of co-ordination of prisoners' health care service, the main reason probably being the fact that the service is provided for by different local health care services in four different parts of the country, which makes co-ordination complicated. However, it should not have to be like this. As has already been explained, Iceland is a small nation with a population of about only 300,000 inhabitants and an average daily prison population of between 119 and 138 inmates (see table 1). This low number could make both co-ordination of the health service as well as training of health care staff realistic and easily put into operation. The same can be said about needs analysis or treatment needs assessment, which could easily be achieved because of the small number of prison inmates.

No research has been carried out specifically into the mental health of Icelandic prison inmates, but presently studies are being conducted into screening of ADHD and co-morbid symptoms among Icelandic prison inmates. The results will be disseminated to the prison and health authorities in Iceland and also hopefully in an international peer reviewed scientific journal. However, a number of psychological and psychiatric studies have been carried out on various different psychological and psychiatric characteristics of the Icelandic prison population during the last 25 years, studies of homicide (Petursson and Gudjonsson, 1981; Gudjonsson and Petursson, 1981, 1982, 1986 and 1990), over-controlled hostility (Gudjonsson, Petursson, Sigurdardottir, and Skulason, 1991a), personality characteristics (Gudjonsson, Petursson, Sigurdardottir, and Skulason, 1991b; Sigurdsson and Gudjonsson, 1996a), confessions to during police interrogations (Gudjonsson and Petursson, 1991a; Gudjonsson and Sigurdsson, 1994; Sigurdsson and Gudjonsson, 1994, 1996a,d), alcohol

and drug intoxication during police interrogation and drug dependency and personality characteristics (Sigurdsson and Gudjonsson, 1994, 1995, 1996b,c), attribution of blame (Gudjonsson and Petursson, 1991b; Peersen, Gudjonsson and Sigurdsson, 2000; Wood and Newton, 2003), intelligence and suggestibility (Gudjonsson and Sigurdsson, 1996; Sigurdsson, Gudjonsson and Peersen, 2001), amnesia (Gudjonsson, Hannesdottir, and Petursson, 1999), criminal history (Sigurdsson and Gudjonsson, 1997), violent and sexual offenders (Gudjonsson and Sigurdsson, 2000), and recidivism (Peersen, Sigurdsson, Gudjonsson and Gretarsson, 2004).

Although there are no statistics available on the number of mentally ill prison inmates in Iceland there is reason to believe that their number or proportion has increased in recent years. There are several reasons for this conclusion. Firstly, Iceland is not dramatically different from other countries in the western world and there is an indication of an increased number of prisoners with both moderate and severe psychiatric morbidity in prison populations in many countries (Andersen, 2004). Secondly, the proportion of longer-term offenders and more disturbed offenders in prisons in Iceland has increased in recent years. A substantial proportion of convicted offenders are serving prison sentences in community service, provided certain conditions are fulfilled, one of which is being capable of following the strict rules of the community service. These offenders, who comprise the less difficult sentenced offenders, never enter the prisons, which leaves them with a higher proportion of disturbed and longer-term inmates. Also, the most disturbed and difficult offenders are usually not allowed to finish their imprisonment in substance abuse treatment and at the half-way house in Reykjavik, because they are too behaviourally disturbed or antisocial in behaviour and therefore not considered capable of following strict rules and conditions. Thirdly, the proportion of offenders serving sentences for drug related offences has more than doubled since 1995 or from 13.8 % to 31.5 % in 2005, which certainly indicates a higher number of inmates with substance abuse problems. All this increases the need for identification of mental disorders and assessment of treatment needs among prison inmates in Iceland as elsewhere (Andersen, 2004) and most importantly on admission.

## Conclusions

Iceland is a small but modern European country, which has changed rapidly since World War II from being a rather poor farming and fishing society. Today it is known for an excellent health and welfare system, low unemployment, literacy, longevity and social cohesion. This should also apply to health care in the prison service.

The Icelandic prison service is rather small in comparison with other European countries, but it is in accordance with the small population. In general, prisoners' primary health care service is good and is provided for by qualified health care employees, but mental health care service is limited and seems to be insufficient. The Icelandic prison population has changed over the last years with increasing proportion of difficult and mentally disordered inmates. There is a need for immediate actions. Improvements can not wait for the building of a new prison in Reykjavik, it has been postponed again and again during the last decades and no implementation is in sight when this is written.

According to what has been written above it seems that the following improvements are the most important at this moment: 1) Increase prisoners access to psychiatric and psychological services in all of the five prisons in order to provide inmates with realistic opportunities of treatment and rehabilitation during imprisonment. 2) Set up a medical ward (wing) at one of the prisons (or at a hospital) for seriously ill inmates, inmates in suicide risk and those who need detoxification. 3) Investigate, as soon as possible, the mental status of Icelandic prison inmates in order to implement guidelines for the medical staff. 4) Put routine assessment of prisoners' mental illness and treatment needs into practice at admission at the main prison in Reykjavik in order to plan their imprisonment with treatment and rehabilitation in mind.

## Note

This chapter is mainly based on information available on the websites listed below, on some of which English summaries can be found, but also on personal information from the Ministry of Health and Social Security and the Prison and Probation Administration and published works as the reference list indicates. The author was employed by the Prison and Probation Administration during the years between 1988 and 2001 and therefore some of the opinions expressed in the chapter are based on his own experience.

Ministry of Justice:	<a href="http://www.domsmalaraduneyti.is">http://www.domsmalaraduneyti.is</a>
The Supreme Court:	<a href="http://www.haestirettur.is">http://www.haestirettur.is</a>
The State Prosecutor:	<a href="http://www.saksoknari.is">http://www.saksoknari.is</a>
The National Commissioner of the Icelandic Police:	<a href="http://www.logreglan.is">http://www.logreglan.is</a>
The Prison and Probation Administration:	<a href="http://www.fangelsi.is">http://www.fangelsi.is</a>
Ministry of Health and social Security:	<a href="http://www.heilbrigdisraduneyti.is">http://www.heilbrigdisraduneyti.is</a>
The Directorate of Health:	<a href="http://www.landlaeknir.is">http://www.landlaeknir.is</a>

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## Ireland

**Enda Dooley**

### **Structure of the Irish Prison System**

The Irish Prison Service (IPS) currently operates 14 separate custodial locations of which half are located in the greater Dublin area and the remainder scattered throughout the country. The average daily population (Irish Prison Service, 2004) was 3,199 and over 8,800 persons were committed to prison (90 % male). A number of prison locations functions at over 100 % capacity and the overall percentage of bed capacity in use is 95 %. Most prison establishments are closed, medium security prisons. There is one high security prison (Portlaoise) and two prisons are designated as open centres. One prison (Cloverhill) is designated as a male remand prison. A number of other prisons hold both remand and sentenced prisoners. Female prisoners are held in two separate locations, a specific women's prison in Dublin (the Dochas Centre) and a wing of a male prison (Limerick). At any particular time approximately 80–85 % of those in custody will be serving sentences and the remainder will be on remand.

Each prison is under the direct management of a designated Governor. Overall administration and organisation of the Irish Prison Service resides with a number of management directorates under the overall direction of a Director General. Overall prison expenditure in 2004 was €290.6 m which represents an average cost per offender of €83,800. The vast bulk (over 70 %) of expenditure was on pay and related costs while capital expenditure was approximately 12 % of overall budget.

The organisation and structure of prison based health services is the responsibility of Healthcare Directorate which is one of the IPS management directorates mentioned above. This Directorate is responsible for the development of prison health policy and for the development and implementation of adequate professional structures so as to ensure that prisoners are provided with health services that are at least equivalent to what is available to persons of similar income and background in the general community. While initial steps have been taken to involve the national health authorities more directly in the organisation and provision of prison health services as yet they have no direct management responsibility for prison health care.

### **Medical Services and Mental Health Care Provision in Prison**

Historically, mental healthcare in prison has been provided by visiting psychiatrists who provide input to prisons on a sessional or ad hoc basis. Until recent years there was no cohort of professionally qualified nurses working in prison and support to visiting professionals was provided by prison officers with basic first aid training (medical orderlies). In recent years nurses have been recruited in a number of prisons but significant deficiencies still remain in both the management structures required to adequately organise this resource and, more particularly in the context of mental health, in ensuring that an appropriate skill mix is present to meet needs.

In the Dublin area specialist mental health input is provided by in-reach teams based in the Central Mental Hospital, Dundrum, which is the national forensic psychiatry resource. Elsewhere services are provided by either local community based psychiatrists or by retired psychiatrists. There is no linkage between prison based mental health provision and that based in surrounding communities. A government white paper (Department of Health, 1995) considering the provision of new civil mental health legislation (eventually passed into legislation as the Mental Health Act, 2001) considered the incorporation of legal support for both the diversion of mentally disordered persons charged with offences and the admission of mentally ill persons in prisons to local mental health facilities. Unfortunately, these recommendations were not incorporated in legislation and the historic situation whereby prisoners deemed to require in-patient mental health must be admitted to the Central Mental Hospital (a high security forensic psychiatry hospital) remain in force. This necessity is not based on legislative requirements but has developed over time as an operational expediency. It should be noted that this practice (whereby prisoners requiring psychiatric admission are referred to a single forensic resource) is quite different to that pertaining to admission for medical or surgical purposes where prisoners are referred and admitted to local community hospitals, either under escort or otherwise.

A recent review of the Structure and Organisation of Prison Health Care Services (Dublin Stationery Office, 1995) recommended that prison based mental health services should be organised in conjunction with local community based services both in relation to the provision of in-reach services operated within a prison and also in relation to access to in-patient facilities within the community. This recommendation has been re-iterated in a recent discussion paper published by the Mental Health Commission (2006).

The broad standards of professional mental health organisation and provision in the prison system are outlined within the IPS Healthcare Standards (2004). While these Standards are in the form of recommendation they remain advisory as there is currently no legislative provision pertaining to the precise provision of healthcare within the custodial setting. While current Prison Rules outline that health provision should be made to meet the needs of prisoners there is no specification of where responsibility should lie, the involvement of inspectorial mechanisms, inclusion of prison based mental health provision within overall community structures, etc.

Within the Irish Prison System there are no prison based hospital units or wings. As outlined above prisoners requiring in-patient care are transferred to community hospitals (for general healthcare) or to the Central Mental Hospital (for in-patient mental health needs). With the development of increased health service demand and expectation, including within the custodial setting, within recent years there has been a failure to provide the healthcare resources necessary to ensure the adequacy and safety of such provision within the custodial environment. Notwithstanding certain developments the availability of appropriately trained and skilled staff within the custodial environment remains deficient to ensure that mental health needs are addressed on the same basis as in the general community. This is particularly the case in relation to addressing the problems associated with chronic substance abuse among the prison population.

There is no structured mental health assessment or screening process routinely carried on prisoners. Where, in the course of routine medical or nursing assessment, it is considered that particular mental health needs may need to be addressed arrangements are made to undertake such assessment within prison. Access to specialist mental health services is usually through the general primary health service within the prison.

Protocols exist within the Healthcare Standards for the management of drug or alcohol withdrawal features and for the provision of drug treatment (usually in collaboration with community agencies). The provision of active drug treatment, particularly through substitution treatment, is inconsistent across the prison estate and this reflects overall community inconsistency in access to suitable treatment.

While there is mental health involvement in screening for suicidal behaviour within the prison population this is considered an overall corporate responsibility (rather than a specific mental health issue) and significant focus has been devoted over a number of years towards addressing the factors

associated with such behaviour within the custodial setting. In particular, improved access to drug treatment, improved communication with families through increased access to telephone contact, and provision of televisions within cells in recent years have, in conjunction with some improvement in availability of mental health services, helped to significantly lessen suicidal behaviour among this vulnerable population. In overall terms in spite of a ca. 50 % increase in the average daily prison population over the last ten year or so with corresponding increase in yearly turnover the annual number of self-inflicted deaths has remained more or less static (ca. 4 per year) and the number of self-injury incidents has decreased markedly.

Specific treatment programmes for the increasing numbers of sex-offenders incarcerated are offered under the aegis of the prison Psychology and Probation and Welfare services. These programmes do not have specific mental health service input. To date participation in these programmes by sex-offenders has been, at best, variable. This is attributed to factors unrelated to the therapeutic design (which is based on cognitive behavioural principles) of the programme.

There is no legal provision for the compulsory treatment of mentally ill prisoners within the prison environment. Prisoners who are deemed to require in-patient treatment may be transferred to a 'designated centre' (currently the Central Mental Hospital is the only such designated centre) under the provisions of the newly enacted Criminal Law (Insanity) Act 2006. This new legislation replaces outdated legislation (in some cases going back over 150 years) covering various matters pertinent to the management of mentally disordered prisoners and persons coming before the courts. Section 15 of this new legislation which, at the time of writing (May 2006), was due to come into force in June 2006 makes provision for the transfer, either on a voluntary basis with the consent of the prisoner or on a compulsory basis. Due to the failure of current community mental health legislation (the Mental Health Act 2001) to incorporate specific provision dealing with the management of mentally ill persons before the courts or in custody the legislative oversight for such matters (including relating to review of detention, treatment, etc.) is separate to the provisions dealing with the overview of civil treatment situations.

As outlined above notwithstanding various improvements in recent years the overall quality of psychiatric care in prison is, arguably, not as good as that available in the general community. This relates to the availability of suitably trained staff in the prison environment, the structural and management impediments inherent in a custodial situation, and the diminished range of treatment and rehabilitative options available in a prison situation. An opportunity to integrate both civil and custodial treatment structures together with the legislative controls to safeguard human rights was raised in the context of preparing recent civil mental health legislation (Mental Health Act 2001). Unfortunately, this opportunity was not utilised.

### **Epidemiology of mental disorders in prison**

As is the case in other jurisdictions the prevalence of mental illness among the prison population is significantly higher than among people of similar age and gender in the general population. This excess is partly accounted for by the increased risk of vulnerable people being charged with minor offences, the lack of court diversion procedures, along with the increased prevalence of substance misuse among the prison population.

A recent study (Kennedy et al., 2005) undertaken in 2003 which reviewed rates of mental illness among the prison population surveyed a large sample of both committals to prison and sentenced prisoners (male and female). Drug and alcohol dependence were by far the most common problems, being present in between 61 % to 79 % of prisoners. Typically prisoners had a history of using multiple intoxicants. 16 % of male committals and 27 % of sentenced men had some form of mental illness while the corresponding figures for female prisoners were 41 % and 60 % respectively.

For the more serious mental illnesses rates of psychosis were 3.7 % among men committed to prison, 7.6 % amongst men on remand, and 2.0 % among sentenced men. 5.4 % of female prisoners had some form of psychosis. Depressive disorder was present in 10 % of male prisoners and 20 %

of female prisoners. The overall recommendation of this study was that there was a need for greater diversion to psychiatric services and greater levels of psychiatric intervention with the prison population.

Suicide rates among the prison population have remained numerically relative static over the last 10 years at ca. 4 per year. When taken in terms of both the increased prison population and number of committals per year, which have both increased by 30–40 % over the last ten years, the rate of prison suicide has decreased significantly. This decrease is attributed to a number of factors, particularly a major increase in the availability of appropriate drug treatment, improved communication thorough access to telephones, in-cell television, etc., and to some degree improved access to psychiatric services. There has been significant organisational focus at both central and at local prison level in reviewing both prison self-injury and deaths.

### **Quality Standards and ethical aspects**

The provision of healthcare, including mental healthcare, in prisons is governed by the Prison Rules. Guidance in relation to the application of appropriate and necessary professional standards to the prison situation is contained in the IPS Healthcare Standards. There is no specified health monitoring or audit mechanism operative within the prison system.

Due to the inability to ensure an appropriate skill mix in each prison establishment, particularly in relation to nursing staff in those establishments where professional nurses are currently employed, it remains the situation that in a number of prisons the staff responsible for ongoing care and monitoring of mentally ill prisoners may not have any specific mental health training or qualification. While the IPS has a policy of promoting staff training and education various resource and operational constraints lead to a situation where structured vocations training of healthcare staff is difficult to ensure. External staff involved in in-reach services (including assessment and treatment) would be trained in line with relevant professional norms.

The process of clinical assessment and treatment should be in line with pertaining professional norms.

The European Prison Rules would provide an overriding guidance towards the standard of healthcare practice and professionalism to be observed and implemented in the custodial situation. These Rules together with the more extensive IPS Healthcare Standards provide guidance to both prison management and to clinical staff in relation to the quality of practice required in the prison situation. There is, however, currently no formal process or specifically designated available resource to audit and monitor observance of such standards.

Various NGOs and lobby groups such as the Irish Penal Reform Trust, Amnesty International, etc., would comment and seek to address the perceived needs of mentally disordered prisoners. Legitimate concerns raised by such bodies will, invariable, be taken seriously by the management of the Prison System. In addition, each prison has a statutorily appointed Visiting Committee which will, if deemed necessary, communicate with the Minister in relation to matters pertinent to safeguarding the mental health of prisoners.

Recent studies have indicated that, as in other jurisdictions, the proportion of prisoners with significant mental disorder is greater than in the general population. Notwithstanding improvements in recent years it cannot be said that the resource applied towards addressing these issues within the prison situation is proportional to the level of the problem presenting. While there is a stated policy of providing services on an equivalent basis to general community provision this remains aspirational. Part of the difficulty in this regard is that prisons by their very nature (with priority on custody and security) present an environment which is in conflict with modern mental health structures. Allied with this difficulty is the problem in providing a work environment which will prove acceptable to mental health staff.

In the Irish situation a number of reports have recommended that prison based mental health services should be organised in cooperation with local community mental health services. This should include not only the provision of in-reach services by staff with a direct involvement in community services but also access to in-patient services based in local communities and with no greater security than is required in terms of both the mental health needs of the individual and the circumstances of the underlying offence. If mental health services within prisons are to be provided on an equivalent basis to those on the general community it is considered that integration on the lines proposed is the only way to achieve this.

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## Italy

### Angelo Fioritti & Federico Boaron

#### Introduction

Italy has a complex system of institutions, some run nationally and some devoluted to Regional Councils and administrations. During the '90s the process of devolution saw a rapid acceleration and many institutions passed completely under regional autonomy, as in the case of the National Health Service. The national Ministry of Health has power only in defining the Basic Standards of Care to be met locally (Livelli Essenziali di Assistenza – LEA) and in redistributing to each region the resources dragged by the fiscal system. Each region has full autonomy about how to provide and organize care for its population, about imposing additional taxes in case of shortage of funding, about if and how to provide more services in addition to those required by the LEA. Actually the National Health Service (Servizio Sanitario Nazionale – SSN) is composed by 20 Regional Health Services (Servizio Sanitario Regionale – SSR)

On the contrary the prison system is still centralized and run nationally by the Ministry of Justice, by its specialized Department for Prison Administration (Dipartimento Amministrazione Penitenziaria, DAP). This Department has regional offices (Provveditorati regionali dell'amministrazione penitenziaria – PRAP), but policies, regulations, staff management, careers, budgets etc.. are completely centralized at the national level.

How mental health care is provided in prisons is affected by this relationship between a centralized national institution and twenty devoluted regional ones. Since the 1970's DAP has had its own health system in prisons, managed centrally and constituted by facilities located in prisons or special facilities (e.g.: the forensic psychiatric hospitals) and by directly employed medical and nursing staff (about 6,000 staff are currently employed by DAP). During the '90s, under the influence of the steadily growing prison population (from 25,000 in 1989 to more than 60,000 in 2005) and the emergence of serious health problems in prisons (viz. drug addiction, HIV infection, mental health problems) it became clear that running a completely separate system would have brought to duplication of services, inefficacy, no cost-effectiveness and ultimately to inequalities between free citizens and prisoners in basic right to health.

Law 230 of 1999 shifted responsibility for drug addiction care and preventive medicine in prisons from DAP to RHSs: staff and funding were diverted from DAP to Health Care budget accordingly. The same law also required all aspects of health care to be managed jointly between DAP and Regional Health Systems, though not specifying how and when this collaboration had to be put into practice. This has caused many conflicts arising from different interpretation of the Law. DAP has always claimed autonomy in drawing and managing health services in prison, according to the principle of security. Despite the increase in prison population DAP has suffered a substantial lack of resources and major difficulties in ensuring health services: therefore DAP interpreted law 230/99 as the normative basis for claiming regional services to contribute financially to its system. Regions refuse to consider the collaboration merely financial but seem to be available to deliver services directly within the prisons.

This has led to a scattered landscape in which only drug addiction treatment and preventive medicine are uniformly run by general health services across the nation prisons. In most regions

nothing more than that happened. In others medications were provided by regional administrations but administered by prison medical staff. In a few others experiments of integration between prison and NHS staff have been led, notably in the area of infectious diseases and in psychiatry. These differences pose a serious problem of equality between citizens and the problem of health in prison has still to find its way to become a priority in the political agenda. Mental health and HIV infection care are the two public health issues which cause more concerns. Rates of suicide, self-harm, growing population with depression or psychotic symptoms are all aspects which have raised much debate also in the media and are gaining momentum.

This presentation tries to document how the general health and mental health in prison system is conceived and run, without trying to describe analytically the few exceptions and experimental projects which so far have left substantially unaffected its processes.

### Structure of Prison System

The Italian prison system is regulated by the law n.354/1975 and D.P.R.n.431/1976; law n.663/1986 and D.P.R. n.230/2000. It is a centralized institution run by the Ministry of Justice through DAP and encompasses facilities with different aims, size and population.

**Table 1: The different institutions in Italian prison system**

Casa Mandamentale (CM)	Prisons for short-sentenced (shorter than 1 year) inmates and defendants remanded for minor crimes. Nowadays almost all closed, their functions now held by <i>Casa Circondariale</i> and <i>Casa di Reclusione</i>
Casa Circondariale (CC)	Detention centers functioning as general and remand prison for inmates with less of 5 sentence years left; they have always an infirmary and may have special sections for longer sentenced inmates (" <i>sezione penale</i> "), high-security (" <i>alta sicurezza</i> "), medical ward (CDT), Psychiatric Observation ward.
Casa di Reclusione (CR)	Similar to CCs, CRs are general prisons for inmates serving longer than 5 years sentences. As CCs, they may have a remand-section and special sections.
Ospedale Psichiatrico Giudiziario (OPG)	Six forensic psychiatric hospitals for defendants deemed "not guilty by reason of insanity and socially dangerous" and for inmates become mentally ill during incarceration. Always include a Psychiatric Observation ward. Only one has a female section.
Centro Diagnostico Terapeutico (CDT)	Medical ward for ill inmates who need medical care more intensive than provided by prison infirmaries.
Istituto di custodia attenuata per il trattamento dei tossicodipendenti (ICATT)	Facilities for drug-addiction rehabilitation working in cooperation with external therapeutic communities
Istituto penale minorile (IPM)	Juvenile prisons for remanded defendant and sentenced inmates between 14 and 18 years old.
Casa di lavoro (very few units left)	Small scale manufacturing workhouses hosting inmates declared "habitual, professional or tendency delinquent", once the sentence is over but dangerousness persist. Inmate's life is very similar to general imprisonment, often lacking of working possibilities.
Colonia Agricola (very few units left)	Small scale farming workhouses hosting the same typology of inmates as in <i>Casa di Lavoro</i> .

Today general prisons (CC and CR) host 95 % of prison population, work as detention center and often comprise separate units for remanded prisoners, women's unit and high-security units, medical wards (CDT), psychiatric observation ward. Only Juvenile Prisons (IPM) and psychiatric forensic hospitals (OPG) are always discrete institutes with their own staff and location. Since the Ministry does not provide data organized for units, but only for facilities, it is mostly impossible to provide separate data about exact number of places for remand prisons and detention centers.

In all prisons the organization of care is under responsibility of a medical officer (*Medico incaricato*) who manages nursing and medical staff enrolled in the prison administration and a few professionals (mainly medical specialists) working under an allowance scheme. As stated before the problems with implementing bill 230/1999 and subsequent D.lgs 433/2000 were such that the current landscape of the relationship between DAP and RHSs is today very patchy with a mixture of clinical competences provided by Prison Staff and RHSs Staff very difficult to describe on unitary bases. In a few regions, where shortage of funding put at risk basic services (e.g. drug provision or basic medical services) agreements were made that allowed RHSs to supply goods and services directly.

### Medical Services and Mental Health Care Provision in Prison

According to Bill 354/1975, every prison has its own health care service comprising staff of different professions. The medical component of it is constituted by the following medical professionals:

- Health Care Director (*Direttore Sanitario*) who leads, organizes and coordinates programs of all general and specialized health services in the prison;
- Medical Officer (*Medico Incaricato*), employed by the Ministry of Justice, who organizes general health care and coordinates the nursing staff;
- Primary care physicians (*medici SIAS*) who ensure 24hr medical care, and carry out medical evaluation of the newly admitted prisoners.
- Specialist consultants, who are usually independent or NHS professionals employed part time by DAP.

A Drug Addiction Service (*Presidio SerT*) is present inside every prison, it is organized and managed by NHS, and has its own medical and nursing team.

Small facilities, with less than 225 inmates, provide day-time medical care, whereas larger prisons warrant a 24hr medical care. Most institutions have an infirmary section. Furthermore there are 23 medical wards, mostly in sizable facilities, for diagnosis and treatment of more severe illness. A few prisons have medical wards specialized in treatment of HIV related problems. Ten facilities (76 beds in all) have a psychiatric ward.

Overall the number of health professionals employed by DAP is the following: 3,097 medical doctors (including 235 psychiatrists), 456 psychologists and 2,401 nurses. Most of them work part time, so full time equivalents are estimated to be around 40 % of general figures.

Health care staff is generally proportional to prison's nominal capacity, disregarding problems of overpopulation in Italian jails. The prison system, designed to hold about 35,000 prisoners, exceeded 60,000 inmates in 2005, resulting in an understaffed health care, and in an obvious additional discomfort for prisoners.

Recently a "pardon decree" was approved (Bill 241/July 31<sup>st</sup>, 2006) cutting away 3 years from all sentences for offences committed before May 2<sup>nd</sup> 2006 (except for extremely blameworthy crimes as terrorism, sexual offence, child pornography, ransom etc...). The pardon released about 12,000 inmates, reducing the huge jail overpopulation, but leaving unaltered the lasting of punishment required by the current criminal law it is very likely to witness a rapid resurgence of prison population.

There are no available data on which percentage of the 129,080,000 € prison medical service budget is for mental health care. The collaboration between NHS Mental Health Departments and prison



mental health care staff is difficult to summarize. There are no collaboration protocols at the national level; the handover of clinical information between prison psychiatrists and their community colleagues is up to each doctor's good will, both during the incarceration as well as upon release. A few experimental projects of integration have been carried out in Turin, Genoa and Florence. They are too preliminary and bound to local opportunities to try to generalize their experience to the national level. What follows is a description of how mental health care is delivered in prisons throughout the nation, on an average basis.

Screening mental health of new inmates is mandatory and consists in a check-up by a physician and one or more sessions with a psychologist from the Service for Newly Admitted Inmates (SNG - Servizio Nuovi Giunti). SNG was created in the '90s after big public opinion concern about an epidemic of suicide in prison and demonstration that 60 % of them happened during the very first days after incarceration. These evaluations are done in order to offer a first support and to evaluate the presence of a mental illness, aggressive behaviors, suicidal risk and compatibility with other prisoners. If the physician or the psychologist suspects any current or past mental disorder, they generally require a formal psychiatric assessment by a psychiatrist. Drug Addiction assessment is mandatory whenever the inmate declares a recent drug use/abuse. Dissimulation of drug abuse is unlikely because of treatment and regimen benefits provided by current legislation in order to stress rehabilitation vs. punishment for people affected by such medical condition. Simulation is screened by specialist examination that inquires the medical history and evaluates abstinence signs, indirect signs of use of narcotics (i.e., signs of recent i.v. injections), and toxicological test. Third parties information can be obtained by contacting, whenever useful, the NHS Drug Addiction Service (SerT) that may have treated the patient before admission. Withdrawal symptoms are treated with substitutive and/or symptomatic drugs. In order to exclude the occurrence of infectious epidemic pathologies and improve the psychological evaluation, the prisoners usually spend the first few days of incarceration in an infirmary.

During incarceration prison medical staff, prison director, magistrates or the prisoner himself can request further psychiatric evaluation at anytime. Any medical doctor is allowed to prescribe psychiatric drugs. Emergency care is provided by the medical officer, or by the primary care physician on duty. The physician can administer drugs, and require specialist's consultation. In addition, in order to avoid aggressive or self-harming behavior, he can put the inmate under high surveillance (checked by a prison guard every 15 minutes), or uninterrupted direct surveillance, and/or allocate him to a self-harm prevention cell waiting for urgent psychiatric consultation. The psychiatrist can confirm or stop such preventing measures. Inmates allocated in self-harm prevention cell should be assessed on daily basis.

For a deeper assessment magistrates can order a 30-days psychiatric observation, usually on suggestion of prison or health staff. This is carried out in specific sections (reparto di osservazione psichiatrica) or in Forensic Psychiatric Hospitals. On the basis of the observation report, the judge decides the appropriate allocation. Questions may arise from the reported use of psychiatric observations in order to move prisoners with troubling behaviors from their prison sections at least temporarily.

Law 833/78 regulates compulsory treatment (Trattamento Sanitario Obbligatorio - TSO) of mental disorders, and it applies equally to inmates and free citizens. TSO is decreed by the city mayor when two medical doctors (at least one of them must be NHS officer) agree that somebody is in urgent need of psychiatric treatment but refuses it, and it is impossible to treat him outside the hospital. Compulsory psychiatric treatment can be effected only in general hospitals psychiatric inpatients divisions, and the inmate has to be transferred to such facilities. This requires an ad hoc 24/24 hours security service, provided on site by prison staff, which may be difficult to ensure rapidly due to shortage of security staff. If the prisoner becomes mentally ill during incarceration, he can also be held in forensic hospitals (OPG) for "voluntary" clinical evaluation and treatment.

Standards of mental health care in prisons vary a lot between regions, primarily for financial reasons. The use of atypical antipsychotic drugs is discouraged for budget reasons, and even where such drugs are supplied by RHSs procedures for obtaining them are complicated and reduce in practice their use. Psychotherapeutic treatments, sometimes available in general mental health services, are

virtually absent in prisons, with exception for very limited projects for some inmates' categories. Specific programs for sex-offenders are absent in practice, despite the attention that Italian mass-media give to these type of offences.

Treatment of drug addiction is supposed to be more homogeneous, since SerT provides care in and outside prisons as a branch of NHS and because law provides benefits meant to encourage detoxification and rehabilitation programs in therapeutic environments and other community services.

### **Epidemiology of mental disorders within the prison system**

One remarkable aspect of the Italian situation is the shortage of official data about commission of crimes by the mentally ill and about their management. Although the Ministry of Internal Affairs and the Ministry of Justice publish periodical reports monitoring criminality rates and prison population, psychiatric forensic institutions and psychiatric care in prisons are not covered by such reports. Only a few ad hoc studies from the Ministry of Justice are available (Andreoli, 2002) and there is not a national register linking tribunals, prisons, forensic psychiatric sector and NHS files.

Most available data indirectly support the view that there has not been an increase of severe crimes committed by the mentally ill during the deinstitutionalization process. The actual number of people placed in OPGs has not increased since 1978. In 1980 the population of OPGs comprised 1.424 people and then a trend of decrease took place until 1998 when it reached its lowest number (977). Since 1999 a slight opposite trend appeared and the last census available counted 1,040 people on Dec 31<sup>st</sup> 2004. Prison population increased dramatically at the beginning of the '90s, mainly due to a change in provisions about drug crimes and immigration. In 1990 at a census day there were 25,573 people in Italian prisons. In 1994 they reached the number of 50,723, which remained stable throughout the '90s. Since 1999 a new increasing trend appeared bringing this figure to more than 60,000 in December 2005. However the degree in which the mentally ill are represented within the prison population remains absolutely unknown.

Only one cross-sectional study has tried to define the prevalence of mental disorders within an Italian prison (Carrà, et al. 2004). It examined a sample of consecutive male prisoners referred, over a twenty-month period, for a clinical psychiatric assessment, among the population (N = 990 with 22 % of foreigners) of prison "Torre del Gallo", Pavia. One-hundred-ninety-one men over 990 consecutively admitted male prisoners (19.3 %) had one or more DSM-IV Axis I current mental disorders (excluding substance misuse), including 13 (1.3 %) psychosis; 53 (5.4 %) mood disorder; 24 (2.4 %) anxiety disorder; 26 (2.6 %) adjustment disorder. Prevalence of mental disorder in this population seems to be higher than US and EU averages, and for particular diagnostic subgroups it could be underestimated.

In 2005 the national scientific association of psychiatrists (Società Italiana di Psichiatria – SIP) launched a three year project called "Consensus conference over psychiatric practice in prisons" which among other things implies a research on prevalence and treatment on mental disorders in prisons. More detailed description of the interaction between general psychiatric and judicial services can be found elsewhere (Fioritti & Melega, 2000; Fioritti et al. 2001; Fioritti et al. 2003).

### **Quality standards and ethical aspects**

The 1990's have promoted a culture of standardization and quality assurance throughout all health services, public and private. From the deliverance of LEA to be met across the nation by the Ministry of Health, to a systematic policy of authorization and accreditation, to the development of certification procedures, all sectors of the health system passed through the era of "quality" and changed accordingly.

This cannot be said for health in prisons. As stated before this sector remained excluded from mainstream developments in health services, centrally managed and with little definition of standards to be ensured locally.

Periodically DAP requires each prison to be involved in special action plans (Piano Esecutivo di Azione – PEA) which implies some form of education, training and quality improvement, but these are bound to single projects and do not constitute mandatory standards to be met and regularly maintained. As a consequence there is neither obligatory nor voluntary specific vocational training for staff responsible for the assessment and treatment of mentally disordered prisoners and no standardized instruments are used for their assessment or treatment. There are no specific regulations for confidentiality and those used in general medical practice are considered valid, though not always applied consistently.

The strong Italian tradition of non governmental organizations (mainly of religious affiliation) taking care of people in sufferance has allowed a substantial and factual access of their volunteers to prisons. Despite the many remarks made by EU to Italy for several aspects of the Penal and the prison system (excessive length of trials and remand imprisonment, lack of quality standards in prison management, lack of monitoring of outcome of correctional treatment methods) NGOs have done much in keeping high the attention of public opinion over the problems of this sector. They have access (under allowance of magistrates) to prisons both for human rights control purposes and as helping volunteers agencies. Some of them have reached national level of fame (e.g. Nessuno Tocchi Caino, Antigone) and have connected the political class with the problems of this area.

### **Acknowledgement**

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### **Legenda**

- DAP – Dipartimento dell'Amministrazione Penitenziaria, Prison Administration Department, an agency of Ministry of Justice
- LEA - Livelli Essenziali di Assistenza, Basic Standards of Care
- PRAP – Provveditorato regionale dell'Amministrazione Penitenziaria, Regional Office of DAP
- SerT – Servizio Tossicodipendenze, Drug addiction Service, a NHS unit providing care for free and imprisoned citizens
- SIP - Società Italiana di Psichiatria, Italian Society for Psychiatry
- SNG – Servizio Nuovi Giunti, Recently Admitted Service, appointed to assess thoroughly physical and mental health of the recently incarcerated population
- SSN – Servizio Sanitario Nazionale, National Health Service
- SSR – Servizio Sanitario Regionale, Regional Health Service
- TSO – Trattamento Sanitario Obbligatorio, Compulsory Civil Commitment

### **Abbreviation for prison types (see table in the text)**

- CM - Casa Mandamentale
- CC - Casa Circondariale
- CR - Casa di Reclusione
- OPG - Ospedale Psichiatrico Giudiziario
- CDT - Centro Diagnostico Terapeutico
- ICATT - Istituto di custodia attenuata per il trattamento dei tossicodipendenti
- IPM - Istituto penale minorile

## Lithuania

### Dovile Juodkaite & Virginija Klimukiene

Since 1990 in Lithuania there were a number of researches carried out and reports published on the situation within the “confinement institutions”– imprisonment establishments, psychiatric hospitals and social care homes (pensionats). For a list of surveys and reports see references. Nevertheless those researches do not mention (or make only passing reference) on the situation of people with mental health problems and level of mental health care services at places of imprisonment. Because of the lack of particular attention to the problem, there were no specific steps taken by the government authorities and responsible officers in the area of mental health care services.

#### **Structure of Prison System**

##### ***Overall structure of the correctional system***

Implementing legal system reform, in 2000 the responsibility for the prison system was transferred from the Ministry of the Interior to the Ministry of Justice. Previous Department of Correctional affairs was renamed to the Prison Department under the Ministry of Justice (hereinafter – Prison Department). Prison department is responsible for organising and controlling activities of places of imprisonment in dealing with the questions of inmates’ correction, rehabilitation, protection and supervision; organising and controlling selection and training of personnel, providing refresher courses and qualification; implementing other tasks of commitment. Prison Department is managed by the Director, who is appointed and dismissed by the Minister of Justice. Director of Department has 3 deputies, responsible for activities of separate sectors (see figure 1). It should be mentioned that Health care sector unlike the Social rehabilitation sector is directly subordinate to the Director of Prison Department, and not to one of his deputies.

Institutions subordinate to the Prison Department:

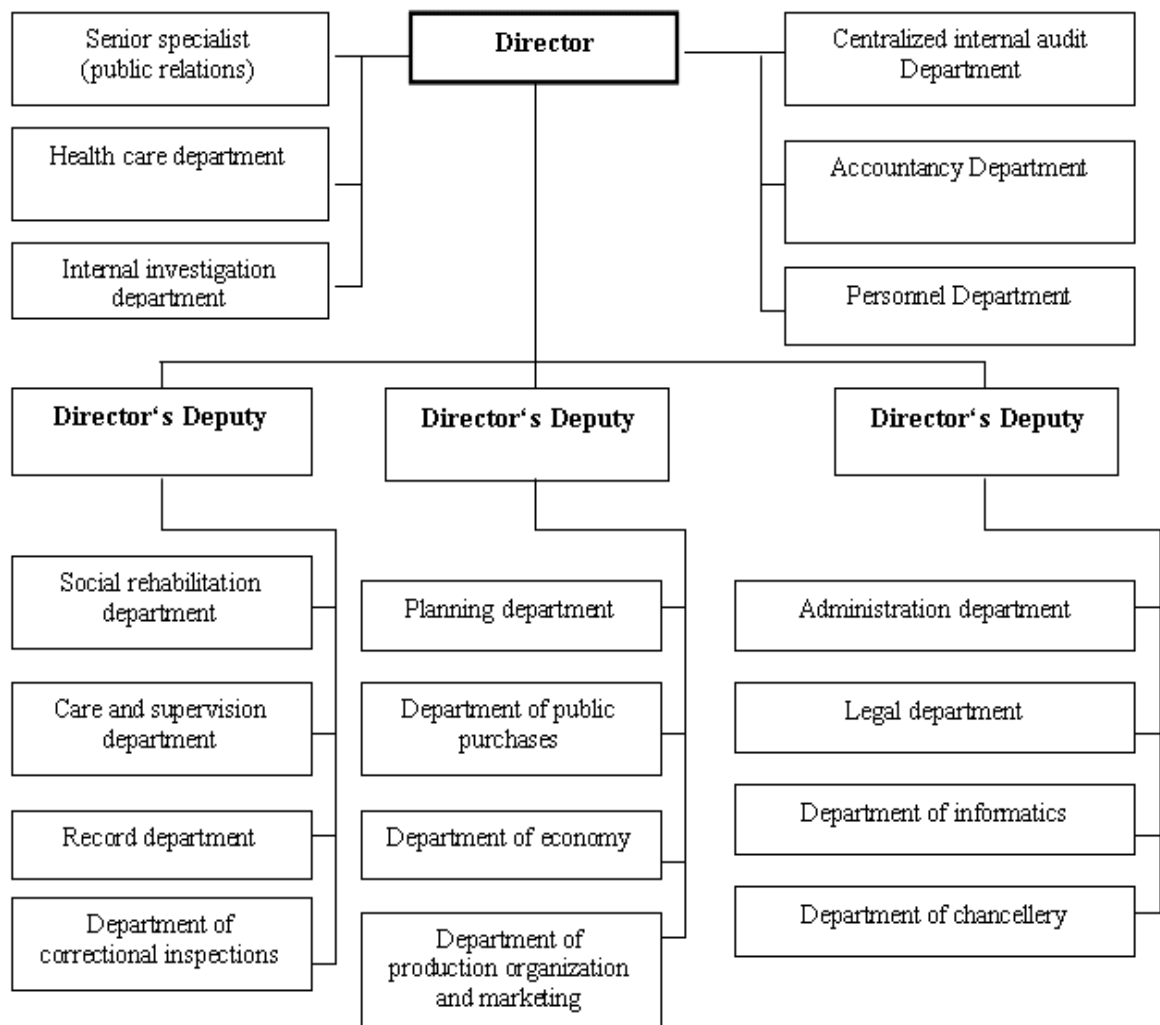
- 15 correctional establishments, that carry out custody and imprisonment: 8 correctional homes; 1 correctional home-open settlement, 1 treatment and correctional home, 1 juvenile remand prison and correction home, 1 Prison Hospital, 1 remand prison - prison and 2 remand prisons;
- 48 territorial correctional inspections, that are responsible for implementing non-custodial sentences, and supervision of persons released from the places of imprisonment;
- Training centre that provides initial trainings to the new employers admitted to an office in the establishments subordinated to the department, also refresher courses for other personnel.

In Lithuania there is a special Rokiškis psychiatric hospital established, where mental patients having committed the crimes with the imposed coercive medical measures are treated. Under the Lithuanian Government Resolution of 17 December 1991 a special psychiatric unit was established within the Rokiškis psychiatric hospital where by the court decision coercive medical measures are invoked to the citizens of Lithuanian Republic who committed a dangerous offence and were referred for to the

special department to be treated under the reinforced and strict observation conditions. Until 2002 patients under general observation conditions were treated in ordinary mental hospitals of general nature according to the place of residence. Such division of patients did not provide the conditions for the formation of individual treatment programmes, there was no specially trained personnel and conditions for the resocialisation and reintegration into the public of these persons (Law Institute, 2005). 2002 it was decided to concentrate all patients with an imposed coercive medical measures within Rokiškis psychiatric hospitals. For this purpose hospital reconstruction project was prepared, planning to equip modern institution for patients undergoing compulsory treatment with 270 places. The project is not yet implemented – at present reconstruction works are still carried out, because of that part of such patients are still in other hospitals.

Forensic psychiatry is of interdisciplinary nature. In Lithuania it belongs not to justice or penitentiary system but to health care system and is under the competence of the Ministry of Health care, because of that it will not be analysed in the current work.

**Figure 1: Structure of the prison department under the Ministry of Justice**



### ***Provision with specific prison services***

Lithuanian penitential system and peculiarities of individual sentences execution are regulated by the Lithuanian Penal Enforcement Code, 2002 (hereinafter – PEC). In accordance with the Article 21 of PEC custodial sentence and life imprisonment are executed by the correctional establishments:

- Correctional homes,
- Juvenile correctional homes,
- prisons,
- open settlements.

Treatment establishments of the places of imprisonment are equated to imprisonment places:

- treatment – correctional homes and
- prison hospital.

The court determines the type of imprisonment establishment, where the person is sent to execute his custodial sentence, depending on the offender's personality, character and dangerousness of crime committed. The Internal Order Regulations of Correctional Establishments, 2003 (hereinafter – IRCE) determined the procedure of referring and accepting convicts to the places of imprisonment (Minister of Justice). The laws determine in details the persons to be sent to each type of correctional establishments for executing their custodial sentence. The Code requires keeping in separate correctional establishment females and males, adults and juveniles. Separately and isolated from each other those persons should be kept also in Prison Hospital. There can be various purposes of separate or isolated retention of other convicts in the places of imprisonment: to separate convicts, who because of the character of the crime or personal features may have a negative influence on other inmates; to facilitate inmates' social rehabilitation; to help guarantee the supervision and security of inmates; to safeguard compliance with the safety and management requirements of correctional establishments. Administration of the establishment also have a right to keep isolated from other inmates persons with medium or severe disability, convicts with AIDS, persons with diminished responsibility, if because of their behaviour such persons endanger others and agree to execute their sentence separately.

### ***Capacity***

According to the data provided by the Prison Department, on 1 April 2006 there were 7,109 persons in Lithuanian correctional establishments, 1,088 of those under detention. IRCE indicates the highest capacity numbers of correctional establishments, although these numbers in most of the establishments are signally higher. For instance, on 1 January 2004 the total number of persons both remand prisoners and inmates in the places of imprisonment was 9578, though there were only 6,430 places foreseen. On 1 January 2006 the total number of places in all penal institutions was increased up to 9,476 (Kalėjimų departamentas prie LR teisingumo ministerijos, 2006). Analyzing the data of 1 April 2006 it is noted, that the real number of prisoners in different establishments is still higher then the number of places, although it has decreased within two years. The fact on the overcrowding of places of imprisonment is significant, taking into account that the staff needed is calculated upon the theoretical and not upon the actual number of convicts.

### ***Prison and jail population***

On 1 January 2006 there were 8,137 persons in Lithuanian correctional establishments (239 prisoners for 100,000 inhabitants) (see also figure 2):

- 1,127 persons under detention, waiting for the court decision;
- 7,010 prisoners (92 of them with life sentence);
- 179 juveniles;
- 310 women;
- 73 foreigners.

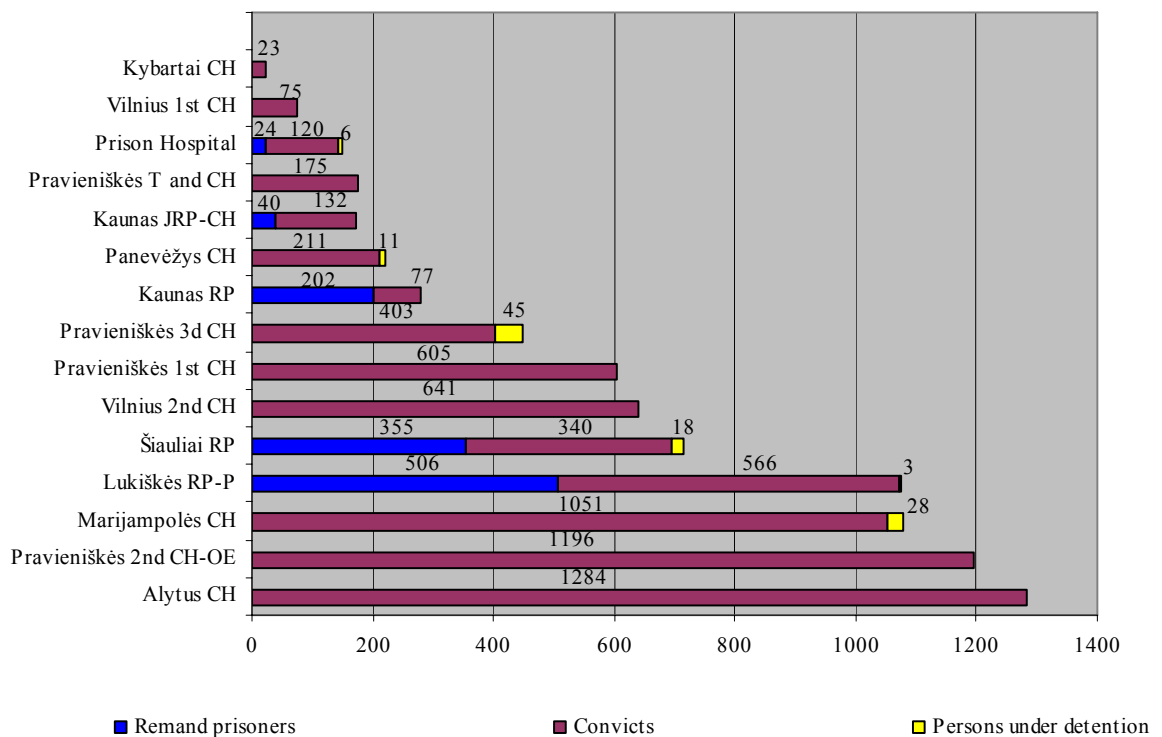
In year 2005 on average there were 8,020 persons in the correctional establishments. The number of prisoners varied from 6,809 to 7,012. Though recently the number of imprisoned persons is quite stable, still remand prisons for adults and prison hospital are overcrowded (see figure 3).

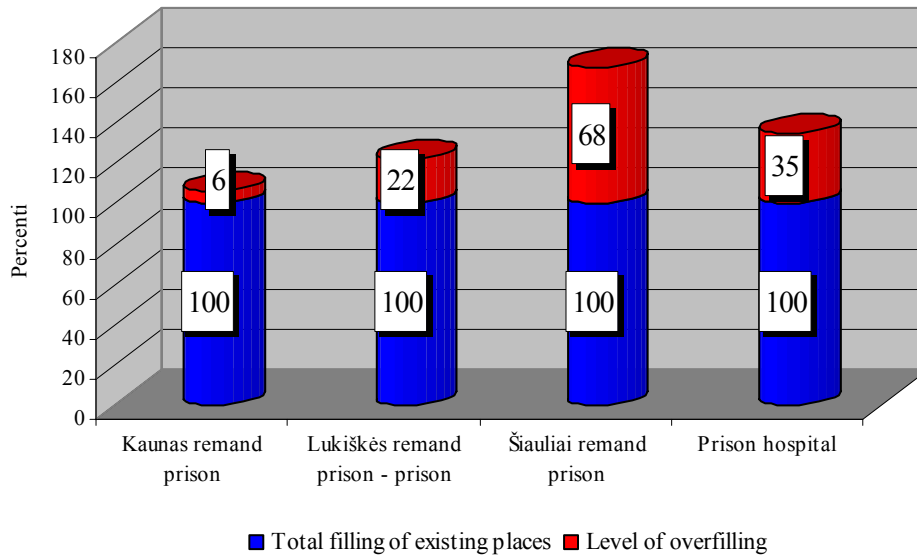
The number of prisoners in correctional establishments is very much related to the whole policy of sentence imposing and implementation. Analysing the situation of the latter years with regard to the actual imprisonment sentence, it decreased from 36.7 percent in 2003 to 29.7 in 2004 from all the punishments imposed (Law Institute, 2005). The average duration of custodial sentence imposed by the court decisions in 2005 was 4 years and 11 month. An average duration of real sentence execution is 2 years.

**Regional variability**

Places of imprisonment are not evenly distributed within the regions. Most of the biggest correctional establishments are located in the Central and Southern parts of the Lithuanian territory. The only Prison Hospital is situated in Vilnius - the capital of Lithuania, and is located in the same territory as the biggest Lukiškės remand prison – prison.

**Figure 2: Distribution of convicts within places of imprisonment (1 January 2006)**



**Figure 3: Overcrowded places of imprisonment (1 January 2006)**

### **Administrative structure**

Seeking to standardize an internal structure of both the Prison Department and establishments subordinated to it, there is an Order of the Director of Prison Department establishing the typical structure of places of imprisonment subordinated to the Prison Department, (Kalėjimų departamentas prie LR teisingumo ministerijos, 2004), which are analogues to the internal structure of the Prison Department. [see also figure 1]

### **Prison budget**

Prison Department and its subordinated establishments are financed from the state budget, with annual funds for maintenance of the establishments. There is no separate line within the budget for financing the health care services provided. After receiving financial requests from the imprisonment establishment Department gives resources only for paying to the staff and purchasing medicaments needed, and do not plan to finance concrete health care services and programs for the inmates. Money received by the establishments is dispensed by them. In year 2004 the total budget given for the penal execution was 122,169,000 Lt (35,382,588 EUR), in 2005 – 146,373,000 Lt (42,392,550 EUR), in 2006 – 157,992,000 Lt (45,757,645 EUR). This is the total sum which was divided between correctional establishments and correctional inspections. The budget distribution between different fields of Department's activities is shown in table 1. Two things should be mentioned: firstly, that the budget foreseen is not sufficient (the biggest part of it goes for guaranteeing activities of penal execution system, i.e. security and supervision, meanwhile separate line for financing various rehabilitation programs is not indicated), and secondly, general public opinion does not allow this problems to become a topicality since it is supposed that the criminal offenders may not be in a better position than others. Such attitude gives an understanding and explains low quality and numbers of health care services and programs – since such services and programs are considered to be unnecessary luxury.



**Table 1: Finances allocated for different activities:**

No.	Name of activity	2004 (thousand Lt)	2005 (thousand Lt)
1	Guaranteeing activities of penal execution system	114,645	124,427
2	Construction, planning works and purchase of long-term property	12,377	13,622
3	Professional training of the personnel	1,086	1,104
4	Organization of execution of custody and criminal sentences	4,102	4,263
5	Retiring allowance	1,935	2,820
6	Special program for provision of paid services	159	137

## Medical Services and Mental Health Care Provision in Prison

### *General principles and regulations*

Lithuanian legislation provides that all prisoners are equal despite their origin, social situation, genetically features, disability and other grounds. "Prisoners should be treated in the way to preserve their health and dignity" (Minister of Justice, 2003). Health care of the prisoners is organized following the principle that convicted persons should receive health care services of the same quality as other Lithuanian citizens.

Health care of convicts is organized in accordance with the general health care regulations and special provisions on health care of the prisoners. At present, the provision of health care in Lithuanian prisons falls under the responsibility of the Ministry of Justice. A limited involvement of the Ministry of Health in the prison health-care services, mainly through inspections and the handling of prisoners' complaints about health-care matters is observed (CPT, 2006). In its report on 2004 visit CPT recommended that a greater participation of the Ministry of Health in this area would help to ensure optimum health care for prisoners, as well as implementation of the general principle of the equivalence of health care in prison with that in the outside community.

### *Availability of medical wards and staff in prison*

There is an Order of the activities, structure and staff of the person's health care centers established within the penal institutions adopted in 2003 (hereinafter – The Order) (Minister of Justice and Minister of Health Care, 2003). In accordance with the Order, for guaranteeing health care of prisoners health care offices are established within the penal institutions (hereinafter – Health care offices) which provide ambulatory – first level person's health care services. Second level health care services – in-patient examination and treatment is provided in the Prison Hospital. Person's health care services of tertial level are provided in the public health care institutions, guaranteeing security prisoners.

Persons executing the imprisonment sentence should be guaranteed with the ambulatory services of the general practitioner or internist, psychiatrists, stomatologist. In 2003 there was an approval of the structure, principles and forms of activities of psychological offices within penitentiary institutions (Minister of Justice, 2003). Main forms of activities of the psychological offices are: psychological evaluation of the convict's personality; work with the newly arrived prisoners to the institutions – psychological diagnostic, training of the adaptations skills; stimulations of the prisoners to participate in social rehabilitation and social skills trainings; survey of the psychological microclimate of different

groups of prisoners; general surveys of the needs, risk factors and psychosocial situation of prisoners personality; prevention of psychological crisis, suicides and intentional auto-aggression; personal psychological therapy; performance of the role of mediator in cases of interpersonal conflicts between the prisoners and the prisoner and the staff; organization and implementation of the programs for target groups of prisoners; organization of the professional consideration of individual cases, cooperation with specialists from psychological offices of other penitentiary institutions; provision of recommendations for the administration in estimating the needs of prisoners to provide individual means of correction and social rehabilitation; provision of recommendations to the administration in dividing prisoners into the groups, sections, transferring into other penitentiary institutions; preparation of the characteristic of prisoners; educating of staff and prisoners on the questions of mental health.

Psychological offices are subordinated to the Director's deputy responsible for the social rehabilitation, meanwhile health care offices – directly to the Director. Cooperation of those two offices is based only on the mutual goodwill principle.

In those establishments where access to the health care office is limited, persons willing to see the health care specialist and also the psychologist have to register in advance. Such order for registering to the medical specialist is regulated by the Regulations of registering prisoners for ambulatory admission. Prisoners to the medical specialists are registered daily. Supervision officers authorised by the establishment's director fill in the register for the ambulatory admission and also are responsible for registered patients to meet with the medical specialists. Every person upon arrival to the correctional establishments is familiarized with the order of health care services provision.

Prison Hospital (hereinafter Hospital) – is a specific institution within the penitential system, which executes person's health care and detention, arrest and imprisonment punishment, and is meant for inpatient health care of convicts and arrestees. IRCE regulates an order of persons' delivery to the Hospital. Escort officers bring prisoners to the Hospital, where they are accepted by the hospital director's assistant on duty and doctor on duty. Upon arrival to the hospital prisoners are examined by the doctor and after giving a diagnose is send to the corresponding hospital unit. There are 25 beds in the Hospital's psychiatric unit, 20 of which are for patients with psychiatric problems and 5 for persons having substance abuse problems. In 2004 there were 450 patients treated in this unit, average treatment time is 21.5 days (average treatment time for patients with psychiatric problems is 25.5 days and for those with substance abuse problems – 13.2 days). It should be noted that the personnel working in Hospital's psychiatric unit is oriented to use and psychiatric care is limited to pharmacotherapy. There are no psychosocial rehabilitation provided, do not work occupational, educational, skills training programs adapted for individual needs of the patients.

According to Order No.1-1 issued on 6 January 2005 by the Director of the Central Prison Hospital several new specifications were included into the job description of a social worker and a senior specialist of the psychiatric group that are entitled to take care of the patients at the Psychiatric Division of the Central Prison Hospital. A social worker has been assigned to examine the relationship of a patient with his (her) family members, to define which one of them is capable of making a positive influence upon the patient and assisting him (her) best in maintaining this positive relationship. The functions delegated to a psychologist include both the treatment and the correction of the behavior of the patients, their consultations on the subject of the dependence diseases, also the involvement in the religious ceremonies of those patients who are willing to do so (CPT, 2006).

Addicted persons upon their written request can be treated in correctional establishments during execution of their punishment. By the joint Order of the Minister of Justice and Minister of Health care an Order of the treatment of addicted persons in the places of imprisonment (2003) is approved. The Order establishes the treatment of persons having alcohol, drugs or psychotropic substance dependencies and executing their imprisonment punishments in the places of imprisonment. Specialists of the health care offices are obligated to carry the supervision of the health care of addicted persons. Rehabilitation center should be established for treating addicted patients within the places of imprisonment. General standards for substance abuse treatment and rehabilitation are applied in the activity of the center (Minister of health Care, 2002). Nevertheless there is no center established in none of the Lithuanian penal institutions, except of some correctional homes, where

psychologists and social workers (but not health care specialists as requested in the laws) provide ambulatory or inpatient rehabilitation services for the addicts on their own initiative (Kalėjimų departamentas prie LR teisingumo ministerijos, 2005):

- In 21 January 2004 there was a rehabilitation group for prisoners having substance abuse problems established in Vilnius 2<sup>nd</sup> correctional home. Everybody who wanted to understand himself, name its weaknesses and was determined to banish them was accepted. After two years of working, the results show that both the establishment of such a group and working with prisoners in it served its purpose. In total there were 28 prisoners treated in the group, 13 of them already left the establishment.
- In year 2005 there was a project on Drugs and HIV/AIDS prevention carried out in Pravieniškės 1st correctional home, which was supported by Canadian embassy. While implementing the project cooperation agreement with Lithuanian AIDS centre was signed regarding 14 lectures for inmate groups on the drug and HIV/AIDS prevention.
- Since 2003 there is an Alternative rehabilitation centre established in Pravieniškės 2<sup>nd</sup> correctional home. The purpose of the centre – to help prisoners' to cure the dependency from the alcohol and drugs. There are 31 prisoners treated in the centre.
- Two groups of addiction diseases treatment and psychological rehabilitation are effectively functioning at the Panevėžys correctional home. At the moment there are approximately 40 inmates undergoing the treatment under the Minnesota program and attending the lectures.

By the joint Order of the Minister of Justice and Minister of Health care of 2003 typical staff normatives of health care offices are approved. In accordance with those normatives in correctional homes with more than 1,000 inmates, there should be 1.0 doctor psychiatrist; with more than 1,000 inmates – 1.5. For each 1.0 doctor psychiatrist there should be 0.5 of psychotherapist and 0.5 of clinical psychologist established. Irrespective of the number of inmates there should be at least one doctor psychiatrist working all day long in the establishment. It should be noted, that the current situation does not reflect those normatives. In reality "from 15 doctor psychiatrist staff established in the places of imprisonment even one third of them are vacant, besides, only in few institutions psychiatrists are working full time. There should be 8 doctors psychotherapist working in the establishments, but they are also missing (Steering Group, 2005). In total there are 28 posts of psychologists foreseen in penal institutions. In reality there are 26 posts filled in, 22 of which occupied by the specialists and 4 – by persons having university education and having completed courses of psychology. By the opinion of Prison Department, the number of psychologist in these establishments should be double in order to provide proper assistance to the inmates. The CPT (2006) is also seriously concerned by the inadequate psychiatric/psychological care offered to prisoners. The low number of psychologists is also a matter of concern, bearing in mind, inter alia, that a number of the establishment's inmates were isolated for risk of suicide.

### ***Prison mental health care budget***

There is no data what part of the budget of correctional establishments is allocated to the mental health care. Nevertheless in reality expenses for the mental health care include only salaries and expenses for the medicaments.

### ***Collaboration of prison services with general mental health care***

Legal acts regulate specialized necessary medical services provided for the prisoners in public state or municipal person's health care establishments (Minister of Justice and Minister of Health Care, 2003). In case the prisoner needs necessary medical services, which can not be provided by the Health care office of the correctional establishment, such services should be provided in Prison Hospital or public person's health care institution.

### ***Mental health assessment and screening***

Upon arrival of a new person to the correctional establishment, health care office fills in the person's health history (form of medical record No. 025-1/ap), if it has not been filled in by the institution that executed detention, and within three days checks up person's health. The preventive checks up of prisoners kept in the correctional establishments and medical tests are performed as frequent as once per calendar year. In this sense, by the statement of the specialists of Prison Department's Health care office, health care and screening within the penal system is organized much more effectively than in society: prisoners receive health screening and treatment for free.

Evaluation of person's mental health is done by the psychiatrist or general practitioner (in case there is no psychiatrist) and included into the person's health history of newly arrived inmate. Generally the person's inclination to autoaggression, drug or alcohol addiction, brain trauma and Central Nervous System (CNS) injury is evaluated, and mental disorder diagnosed.

### ***Treatment programs for mentally disordered prisoners***

There are two national programs implemented in Lithuanian Correctional System: (1) Program of Drug Prevention and Drug Control in Penal Institutions and (2) National Suicide Prevention Program.

Currently the most attention in Lithuanian Correctional System is paid to Drug abuse and its Prevention. Organizing implementation of the provisions of the drug prevention and control in the places of imprisonment conception is one of the main trends of Prison Department's activities. According to the CPT recommendation (2006) it is important that the prison authorities make efforts to provide an environment in which prisoners without drug problems do not develop them and those who do have such problems are helped to overcome them. A high priority should be accorded to effective drug awareness training of staff, which would provide a basis for establishing constructive, supportive relationships with prisoners. Further, consideration should be given to the introduction of effective programmes of education, counselling and other forms of support for prisoners, as well as the setting-up of drug-free units. It is clear that any preventive measures must also be accompanied by a genuinely multidisciplinary therapeutic programmes to help drug-addicted prisoners.

On 30 January 2004 the Minister of Justice of the Republic of Lithuania by the Order No.1R-27 approved the Concept of Drug Prevention and Drug Control in Penal Institutions. The Prison Department implements the provisions of the Concept and once a year reports to the Minister of Justice and the Drug Control Department at the Government of Lithuania. A yearly action plan of drug prevention and drug control is prepared at every penal institution and is approved at the Prison Department. This document introduces the targeted programs and their implementation. The drug prevention and drug control program at the penal institutions is carried out in two directions:

- The prevention of drug
- Education and medical treatment of inmates (detoxication of the abstainers).

In 2005 one of the tasks of this Program was to provide inmates with the education in the field of drug prevention, social orientation and legal aspects. Therefore two seminars for the medical staff of correctional settings as well as representatives of the Service of Social Rehabilitation and officers of Security division were held with the purpose to train participants to diagnose intoxication, to recognize and differentiate drugs, and to introduce them with the main principles of drug effects. Furthermore the training course for the officers of appropriate services was held in order to train them how to properly and effectively carry out a search and how to train tracker dogs. Lectures for the inmates were provided (3,866 offenders have participated); leaflets and other information publications were distributed. Within the framework of the Program a Consulting-room for the prevention and treatment of HIV and AIDS was established in the Prison Hospital. According to the Report of the Prison Department, in 2005 the Consulting-room provided services for 311 inmates (Kalėjimų departamentas prie LR teisingumo ministerijos, 2005).

However Drug prevention is rather complex and long term process, which requires a comprehensive educational course rather than one lecture or several seminars. Besides, if during the implementation of the National program, one of the directions is to prevent the drug smuggling into the penal institutions, it means that drug abuse is a rampant phenomena, therefore the main focus should be on rehabilitation (rather than on prevention) – this kind of services in Lithuanian Correctional System is very deficient.

The Government of Lithuania approved the Suicide Prevention Program for 2003 – 2005. Following the provisions of this Program the Prison Department is obligated to prepare and implement the programs of adaptation, integration and re-socialization of prisoners. In 2004 the Standard Program of Prisoners' Adaptation was approved by the Prison Department Director. Prevention of suicide and self-aggression is one of the constituents of this Program. On 24 May 2004 the Director of the Prison Department by his order approved: 1) the typical adaptation program for the newcomers to the Correctional institution and 2) the typical program for the integration of the inmates to the society. The main goal of the first program is to help the inmate to integrate himself into new social environment and to create the background for the successful process of his correction. During the program, the personality assessment is made as well as the needs of the offender are identified; the offender is introduced with the conditions of penal enforcement, he gets all necessary help and support (psychological counselling and therapy, medical care, social support, etc.), and the individual correctional plan for the offender is developed.

In October – November 2004 a survey concerning the causes leading to suicides or self-aggression was carried out. More than 1,000 inmates in the eight penal institutions filled in the questionnaire. On the basis of the information collected, the Standard Program of Prevention of Suicide and Self-Harming is being finalized (Lithuanian Government, 2006).

In summary, it should be positively evaluated the fact that the Government called its attention to the tender for Lithuania subject not only by approving the necessity of the Suicide prevention program for the society (according to the statistical data, Lithuania has the highest rates of suicides in Europe) but also by involving the Correctional institutions into the implementation of this Program (it is well known, that offenders is a high risk group for committing suicides).

On the other hand it should be noted that both, quite low financing resources for the programme's implementation (Suicide Prevention Programme for 2003-2005 received 3,132,000 Lt and in order to implement this programme for the executable practice in the correctional institutions 50,000 Lt were assigned) and the lack of time (the programme was prepared for the year 2003 – 2005 and not prolonged for the next period) influenced the fact that the programme could not be stated to be an effective and useful for practical purposes.

### ***Regulations for emergency cases and compulsory treatment***

Provision of the necessary medical services in emergency cases for the prisoners is regulated by the legal acts (see section "collaboration of prison services with general mental health care"). This covers necessary first medical aid and immediate medical services in emergency cases provided within in-patient or out-patient institutions.

The first medical aid for the inmates of the imprisonment places is provided by the employees. Specialists of Health care offices within the imprisonment places are required to guarantee the necessary medical aid. In case necessary medical aid can not be provided by the Health care office, it should be provided in Prison Hospital or public person's health care institution.

The Law on Mental health care (1995) very concretely specifies cases of an involuntary hospitalization. A person who has a severe mental illness and refuses hospitalization may be admitted involuntarily to the custody of the hospital only if there is real danger that by his actions he is likely to commit serious harm: to his health or life; or to the health or lives of others.

Patient may be involuntary hospitalized and treated within the psychiatric institution not longer than two days without the permission from the court. After patient's involuntary hospitalization, administration of psychiatric institution is obligated to approach the court no later than within two days. The court, after considering recommendations provided by psychiatrists, is entitled to issue decision on involuntary hospitalization and treatment of the patient, but not longer than one month. Depending on the recommendations of treating psychiatrist, administration of psychiatric institutions is entitled to suspend involuntary hospitalization and treatment earlier. In case when patient's involuntary hospitalization and treatment must be prolonged further, administration of psychiatric institution has to approach the court due to the prolongation. According to the conclusion provided by the psychiatric institution the court may discontinue or prolong involuntary hospitalization and treatment, but no longer than for 6 month every time. Depending on the recommendations of treating psychiatrist, administration of psychiatric institutions is entitled to suspend involuntary hospitalization and treatment earlier.

This law is equally applicable to the persons with mental health problems within imprisonment places. Only involuntary hospitalisation and compulsory treatment for prisoners is provided in the Prison Hospital's psychiatric unit, and not in general psychiatric hospitals.

### ***Overall quality of psychiatric care***

The general provisions of mental health care in Lithuania are defined in the above mentioned Law on Mental Health Care in Lithuania. Considering the quality of psychiatric care at places of imprisonment it is important to note that there is no data (researches or surveys) that would allow an object evaluation of the situation. It could be stated that the quality is not of the highest rates due to: (1) the lack of staff; (2) the level of staff competence; (3) the failure to create a system of quality supervision. Generally, the psychiatric care and its quality gained more attention just couple of years ago. The noticeable improvement of the services in the society is not great in correctional institutions, however, still noticeable in terms of the establishment of various offices and staff (or at least the need of such organizations is approved by the administrative level), the fulfillment of the number of staff members, the growth of specialist qualifications, applicability of higher qualification requirements. Nevertheless, as the opinion of society does not claim the improvement of the correctional institutions to be one of the prior and major streamlines of the government, there is also no single-minded concern and attempt to better the quality of mental health care in the Prison System.

### ***Networking mechanisms and collaboration between institutions***

It is possible to claim that the cooperation mechanism does not function at all; there is no collaboration between the institutions governable by different ministries. In other words, there is a rigid separation in the fields of competence, so if a person is under responsibility of one institution; other institution does not feel any concerns about him despite the fact that eventually it will become the provider of the services and will become responsible for the quality of their accomplishment. Even such an inexpensive and effective means of communication as the sharing of information between different institutions is not fully developed in Lithuania.

## **Epidemiology of Mental Disorders**

### ***Availability and quality of data***

The Prison Department from dependable institutions collects quarterly, half-annual and annual reports that not only describe the activities of the institutions but also provide various data on the convicts. The Prison Department summarizes the received data and sends it to such institutions as Drug Control Department or State Mental Health Center and also places it in its website (<http://www.kalejimudepartamentas.lt>).

However, it is important to note that the information provided by Health services is not publicized and easily available. Usually, it is the information on what somatic and mental diseases or disorders were diagnosed for the prisoners during a particular period.

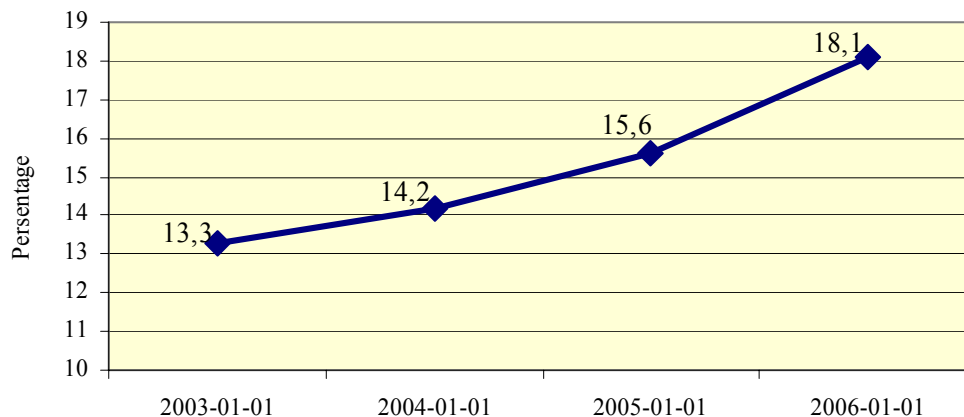
One of the most common diagnosis is an emotionally unstable personality disorder (according to ICD-10 used in Lithuania the code is F60.3); quite a large part of mental disorders belongs to alcohol (F10.2) and opiates (F11.2) abuse.

Unfortunately, the quality of these epidemiological data is quite doubtful because, as mentioned earlier, not all correctional institutions have a psychiatrist (in such institutions the psychiatric diagnosis is confirmed by a doctor of general practice). Other tendency that reduces the reliability of data is that for those people who face the repeated conviction, the earlier identified diagnosis is usually rewritten according to the diagnosis that was given during the previous imprisonment (this phenomenon is very common with the drug abuse). Finally, if a convict is caught to use drugs inside the institution, s/he is included into the list of drug addicts, even if it was a situational drug-taking and the person does not yet have the drug dependence. This, obviously, can also influence the quality of epidemiological data.

### **Epidemiological trends**

The Ministry of Health approved the statistical record form No 14 “Report on Mental and Behaviour Disorders Using Psychoactive Substances”, according to which the number of people being in a dispancer list for using drugs in correctional institutions constantly increases (from 8.8 % in 2001 to 18.2 % in the beginning of 2006, taking into account the total number of all convicts in all imprisonment institutions). In comparison with the year 2005, even though the number of convicts has decreased in 2006, the number of drug addicts has increased up to 2.5 % (Kalėjimų departamentas prie LR teisingumo ministerijos, 2006).

**Figure 4: Drug addicted offenders at correctional institutions**



In 2002 there were 4,405 drug addicts registered by Mental health care institutions in Lithuania. This made up around 0.13 % of all citizens of the country. Meanwhile, the concentration of drug addicts in the correctional institutions exceeded the state's average up to 100 times. The scale of drug addiction in the Prison system confirms the fact that convicts and arrestees are an enlarged risk group. In January, 2006 the largest part of convicts having an addiction to drugs and psychotropic substances served their sentences in Marijampolė Correctional House (458), Alytus Correctional House (242), Pravieniškės Correctional House No.3 (130) and Pravieniškės Correctional House No.1 (120).

The analysis of the data about people being on the dispensary list carried out that the most common drugs used in the correctional institutions are the opioids (74.4 %). The number of people using more than one type of drug has also increased (from 11.6 % in 2002 to 14.3 % in 2003). In the places of imprisonment, as well as in the rest part of the society, there is a noticeable tendency for young people to also use drugs. In 2001 out of all convicts having an addiction to drugs, 7.5 % (6.6 % in 2002) were people of the age of 15 – 19. In the year 2001 such people of the age of 20 – 24 made up 41.5 % (33.6 % in 2000) and people of the age of 25 – 34 composed 44.4 % (45.3 % in 2000).

Taking into account the rates of suicides at correctional institutions, there are no noticeable tendencies of increase or decrease, therefore, it is possible to claim that the situation is more or less stable (table 2). This could be due to the National Suicide Prevention Programme provided by Lithuania and due to the increased number of psychologists in the imprisonment institutions.

**Table 2: Number of suicides**

	2003	2004	2005
Committed a suicide	14	4	11

### ***National research and publications***

There are no specific national researches and publications on the mental health services within the Lithuanian prison system. Prison Department is overall responsible for organizing penal system, collecting statistical data and reporting on the situation of prison system in Lithuania. But it is more focused on the issues of sentences' execution, supervision and security within the places of imprisonment, and not particularly about the mental health care needs, rehabilitation, re-socialization of the prisoners. Prison Department provides statistical reports every month, and makes public its annual activity reports. Certain situational analysis and studies are carried out by several institutions in terms of various project frameworks, but those are more episodically (see references).

### **Quality Standards and Ethical Aspects**

#### ***Quality standards***

For a long time the quality standards of mental health care in Lithuania were based on Soviet ideology, however, in the recent decades noticeable changes with an attempt to apply modern methods, widely used in Europe and the rest of the world, has been observed. The Ministry of Health of the Republic of Lithuania on the basis of WHO annual announcement (2001) "Mental Health: New understanding, New hope" claims that mental health is an inherent part of an individual's and society's common health. There is no, and there cannot be, health without mental health, therefore it should be/is an area requiring certain resources and reforms. Currently the Parliament of the Republic of Lithuania is due to consider the Draft on the National Strategy of Mental Health Care for the year 2006 - 2010 which provides the provisions of the reorganization in the field of mental health care services by paying much attention to deinstitutionalization and development of the system of community based services. However, the project provides no references to the correctional institutions. This is a strictly hierarchical, closed and inflexible system in which the changes are in a very slow process. The non – governmental organizations that actively take part in defending the rights of people suffering from Mental disorders, their integration into society and destigmatization do not show any concerns about the correctional system, as if no mental patients were there.

The main principles of doctors working in Lithuanian correctional institutions practice are reglemented by the Code of Medical Ethics provided by the Lithuanian Doctor's Association, which was agreed at the 12<sup>th</sup> congress of the Association held on the 12<sup>th</sup> of November in 2004. The



psychologists working in the correctional institutions, as anywhere else in Lithuania, follow the Code of Ethics of Lithuanian Psychologist's Association that was confirmed at the Congress of the Association held on the 23<sup>rd</sup> of November in 1996. On the 1<sup>st</sup> of April, 2003 the Minister of Justice of the Republic of Lithuania issued the regulation No.86 by which approved the following common rules for the psychological offices in the correctional institutions:

- The principle of competence claiming that when working with convicts, psychologists shall use the methodologies based on scientific researches, constantly collect scientific and professional knowledge dealing with their work and apply methods concerning the personal and social needs of the convicts.
- The principle of professional and scientific responsibility. According to the code, the specialists of psychology office shall secure the rights of the convicts and their legal concerns, comply with moral standards and assure the confidentiality about his/her work with the convicts.
- The principle of the convicts' welfare concerns claims that in the case of a conflict between the professional responsibilities of a psychologist and convict's personal interests, one should attempt to reach a compromise avoiding to cause damage for the convicts. Apart from this, psychologists shall avoid inapt and possibly harmful relations with the convicts.
- The principle of positive and effective communication claims that psychologists shall motivate their relations with the convicts in terms of mutual trust and respect by encouraging the convicts to take part in social rehabilitation, providing them with proper assistance taking their personality and evaluation of risk and requirements into account.
- The principle of social responsibility. Psychologists shall apply and announce professional knowledge with an attempt to satisfy the interests of society and develop psychology by avoiding to misuse the working position and professional ability.

### ***Qualifications of staff***

The rules state what staff qualification requirements should be applied for people working as psychotherapists or psychologists in Lithuania. In order to be a psychiatrist, one must gain the professional qualification and have a special license issued by the Ministry of Health which must be renewed after each 5 years. However, a person having no diploma in psychology can still work as a psychologist. Lithuanian Psychologist's Association seeks to assure that the system of licenses was applied at least for clinical psychologists. This would guarantee that people working as psychologists would meet all the qualification requirements.

### ***Vocational training for staff***

Prison Department is responsible for the vocational training of the staff of correctional institutions. Training centre of the Prison department is a specialized institution that has its aim to train officers, state servants and other staff of the Prison Department and all institutions subordinated to it to professionally carry out their duties in accordance with the strategically tasks of penitential system and advanced experience of foreign countries. Trainings for the personnel are provided according to the programs developed taking into account special needs of different personnel group, changes in legislation, etc. In the year 2005 the Training centre prepared: training program for the managers of the Prison Department and institutions subordinated to it on development of the administrative skills; training program for persons responsible for staff qualification development within the Prison Department and institutions subordinated to it; training program for officers responsible for physical and special preparation and its development; training module on the basis of law. However, there are no training programs in the field of mental health care (excepting the vocational training organized in the process of implementing the national Drug Prevention and Suicide Prevention programmes). The attempts to gain higher qualification usually is the concern of a psychologist or psychiatrist himself, however the courses may be financed by the institution.

### ***Standardization of instruments***

At present, Lithuania lacks standardized instruments that could help to evaluate mental health care parameters; however, it is important to notice certain initiatives to prepare these instruments. For example, the Psychology Department at the Mykolas Romeris University runs a project which aims at preparing the methodology that would evaluate the criminogenic needs of a convict. The public institution “Global Initiative on Psychiatry” also runs a project whose one of the main goals is to adapt HCR-20 (Historical Clinical Risk – 20) to Lithuanian population. Apart from this, there is an attempt to adapt the British methodology OASys (Offender Assessment System).

### ***Regulation of medical confidentiality***

The Codes of Professional Ethics describes the principle of confidentiality. Articles 194 of the Internal Order Regulations of Correctional Establishments stipulates that a member of custodial staff of the same sex as the prisoner concerned could be present during the examination of the patient on his arrival only when the doctor requests that. This means that the decision whether a prison officer stays during the medical examination of a prisoner lies with the medical staff, and they are responsible for the confidentiality. Medical staff is additionally informed about the necessity to guarantee the confidentiality of the medical examination, evidences of the possible breach of the confidentiality and their liability for this. Nevertheless it should be noted that medical confidentiality is not fully respected in any of the correctional establishments.

- For example, medical examinations were systematically conducted in the presence of prison officers. The CPT had serious misgivings about this approach. It acknowledged that special security measures may be required during medical examinations in a particular case, when a threat in terms of security is perceived by the medical staff. However, there can be no justification for prison officers being systematically present during such examinations; their presence is detrimental for the establishment of a proper doctor-patient relationship and usually unnecessary from the security standpoint.
- Further, medical files are accessible to non-medical staff. This implies, inter alia, that all medical examinations of prisoners (whether on arrival or at a later stage) should be conducted out of the hearing and - unless the doctor concerned requests otherwise in a particular case - out of the sight of prison officers.

### ***Implementation of European Prison Rules***

European Prison Rules were broadly accepted by the states as providing the factual code for activity and supervision of correctional establishments' administration. Yet they do not have the legal status within the international law. Both Ministry of Justice, Prison Department and all correctional establishments are well informed about the Rules as formulating recommendations and promoting higher standards minimal standards and conditions in the correctional establishments, but they are rarely used as the actual guidance for daily activities in Lithuania.

### ***Role of NGOs and lobby groups***

There are NGO's in Lithuania that are concerned about people with mental disabilities (e.g., “Giedra”, “Viltis”, “Lithuanian People with Mental Disorders Care Association”) or (ex) offenders (e.g., LIAPO, Lithuanian Prisoners Aid Association, a part of “Kris” organization), however they do not cooperate between themselves and there are no NGO's whose target group would exactly be convicts suffering from mental disorders. The “Global Initiative on Psychiatry” is the only organization seeking to pay attention to this specific group of people requiring special assistance and initiating service development projects intended for the group, for instance, “Reorganizing forensic psychiatric services in Lithuania”. Moreover, the Lithuanian Psychologist's Association and the Lithuanian Association for Psychosocial Rehabilitation could contribute in guaranteeing the quality via controlling mechanisms of the mental health care specialists working in the correctional institutions.

### **Major research activities in the field**

No research has been made nationwide. Just several institutions are concerned about the needs, rehabilitation, re-socialization and crime prevention of the offenders. Certain situational analysis and studies are carried out in terms of various project frameworks, however, the changes are unsystematic and information and the received data are not publicized because the attention towards the criminals and the emphasis on the care and psychosocial services provided for such people causes quite a considerable hostility from society (positive attitude towards revenge is significant in Lithuania; quite a high percentage of people are for capital punishment). Due to the lack of academics that would critically consider these problems, no significant researches are made in this particular field in Lithuania. Worth mentioning are the students from higher education schools who carry out researches in this area; apart from this, the management of the imprisonment institutions cooperate with the students by providing them with an ability to communicate with the convicts and to collect information.

### **General Assessment and Outline for the Future Reforms**

In order to improve the quality of mental health care in the correctional institutions in Lithuania:

1. One should change the attitude and consider certain issues;
2. A closer collaboration is needed between the Ministry of Health and Prison Department;
3. It is necessary to finance the system, to establish more working places and social guarantees that would motivate specialists of higher qualification to work in this system;
4. It is important to involve academic community that would contribute in implementing the programmes of improving ones qualification by creating certain methodologies.
5. It would be also useful to attract non – governmental organizations, especially the ones working according to self-aid principles (former prisoners having mental disabilities, AA, AN etc. groups)

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## Luxembourg

### Georges Rodenbourg & Jean-Marie Spautz

#### The structure of the correctional system in Luxembourg

The overall structure of the correctional system can be viewed as a pyramid. The department of Justice bears the responsibility. The correctional system is under the direct authority of the attorney general's office, through one of the major magistrate of the general prosecutor's office (avocat général).

The attorney general accumulates four main tasks:

- general management office (direction générale);
- sentence execution;
- penal treatment;
- prison surveillance.

The budget for the correctional system lies around 30 million Euros per year. This includes all the expenses related to the detainees, but also the wages of every person working within the system. Of those 30 million, just under 1.4 million Euros is planned to be spent on prison mental health care for 2006.

Luxembourg has two prison facilities. These two facilities diverge in their concept.

1. **CPG (Centre Pénitentiaire de Givenich):**  
The CPG is a semi-open prison with the capacity to hold around 100 detainees. The current population is around 86 individually selected detainees. Certain detainees are free to leave the facility during the day; however, they must return at night. The security at CPG is low.
2. **CPL (Centre Pénitentiaire de Luxembourg):**  
The CPL is the only closed facility in Luxembourg with a capacity of 597 detainees. At today's date, the CPL holds 673 detainees: convicted, remand – male and female prisoners alike - as well as administrative detainees. The different groups of detainees (convicts, remands, juveniles and administrative detainees) are kept separately as best as possible. The CPL is a medium to high security facility with high outer security parameter.

#### The medical services and the mental care system in prison

##### *The Penitentiary Medico-Psychological Service (SMPP)*

To understand the organization of the offer of care in mental health at the CPL of Luxembourg, a little look back should be made. Indeed, it is necessary to keep in mind that before the Ministry of Justice requested the Centre Hospitalier Neuropsychiatrique (CHNP) to intervene in the psychiatric care at the CPL, there was only one free-lance psychiatrist to consult in the Penitentiary Centre of

Luxembourg. 1 to 2 times a week. In 1999-2000, several deaths in the prison, either by suicide or by overdose, led the Luxembourg authorities to reconsider the system of penitentiary care and ordered an audit, after which several recommendations were retained, and, in particular, the one which insisted on the creation of a permanent service of psychiatric medicine at the prison.

The Penitentiary Médico-Psychological Service (SMPP) was created only after the signature of a convention between the Ministry for Justice and the CHNP on April 22, 2002. The fourteen articles of this convention define the general framework of operation of the SMPP and guarantee a relative independence of the therapeutic orientation with respect to the legal authority.

Administratively, the SMPP is under the authority of the organization of the CHNP. The responsibility of the medical director concerning the actions, interventions and therapeutic activities is explicitly specified, the same as the responsibility of general management as an interface for any external interpellation.

Organisationally, it was possible during 2005 for the SMPP to clarify its working procedures by appointing a service coordinator (a person in charge for medical issues and a person in charge for the nursing team).

As to the infrastructures, the ground floor of the P2 block of the prison could be equipped correctly in 2003, same as the hospitalizations could be carried out on the 1<sup>st</sup> floor of our building (this is more general, since the local terms are not interesting in an international book).

The nursing team could also be staffed during 2003, starting with a full-time psychiatrist, one half-time psychologist, a psychiatric nurse with responsibilities for the team, 7 full-time psychiatric nurses and 1 half-time to and with 1 full-time psychiatrist, 1 full-time psychologist and 8 full-time psychiatric nurses. In 2004, the team once again saw itself getting reinforced and thus the team is currently composed of 2.5 full-time psychiatrists, 1 full-time psychologist, 9 full-time psychiatric nurses and of an administrative secretary. There no was no change in the SMPP personnel key in 2005.

The daily organization guarantees a presence of the team during working hours from 8.00 to 18.00 hours from Monday to Friday, same as for weekends and public holidays. As a matter of fact, after the taking of hostages in April 2005, it was decided to staff the team by 2 people to work on weekends and on public holidays from 8.00 to 18.00 for reasons of safety.

### ***The missions of the SMPP***

Three aspects should be taken into consideration, as specified by convention and/or imposed by reality:

1. the "preventive" part is devoted primarily to the tracking of the mental disorders:
  - Systematic admission consultation (between 70 and 119/month for a total of more or less 1,000 in 2005)
  - Crisis management
  - Consultation after description (examining magistrate, general infirmary, SPSE (psycho-socio-educational service), guards and sergeant majors or the patient himself).
  - To actively detect the potential situations of attempted suicide, with a special effort for the first-admission patients
2. the "nursing" part provides the entire psychiatric care to those patients whose state of health does not require the help of the external psychiatric hospital :
  - Hospitalisations in our unit (from 17 to 22/day)  
These patients participate in the proposed activities (mosaic workshop, games, relaxation and fitness activities) and the referent psychiatric nurses guarantee a privileged availability.
  - Besides the standard pharmacological treatment, we propose three levels of psychotherapies to our patients: The support psychotherapy is guaranteed by the nurses, the psychologist and the psychiatrist; the group psychotherapy is considered by

the psychologist or the psychiatrist with a designated psychiatric nurse, and the “real” psychotherapy are guaranteed by the psychologist, the psychiatrist, or by one of the external psychotherapists, according to the indication by the prosecutor, the committee of guidance of the sentence execution system or the patient himself.

- Ambulatory Consultations:

Currently on Friday afternoon we are consulting around 10 patients at the CHNP policlinic.

- Relationships with families

It happens that the parents of a prisoner or the authorities of his country of origin contact appear the examining magistrate of the CPL, the management or directly the infirmary. The logic of these talks is the same one as that of the hospital, it is necessary to reassure the family and to possibly integrate them into the care. These talks with families are done either at the visitors rooms of the prison, or at the CHNP policlinic, depending on the penal situation of the prisoner

3. The “administrative” part

- The cooperation with the actors of the legal world is done within the limits of the deontology and the professional secrecy, often in the form of written opinions or reports/ratios at the committee of guidance or the penitentiary commission, but generally in the form of informal meetings with the members of the psycho-socio-educational service (SPSE) and of the central social assistance service (SCAS) which accompanies the prisoner after his release from prison. Also it is necessary to note here our answers to the interpellations of the law firms, who worry for the mental health of their customers.

- We also took part regularly in university and international research studies.

### ***Prisoners suffering from mental disorders***

To access to the care by the psychiatrist and to the psychologist the prisoner can either send a letter to for a consultation, or it is done by prescription of a third person (somatic infirmary, guards, family, lawyer, judge, penal execution).

The evaluation of the mental state of the prisoner is mandatory, i.e. every new admittance (man, woman and minor) is seen by a psychiatric nurse (cf. 2.2. visits of entry).

As to the symptoms of need, both the general practitioners as well as the prison authorities’ doctors are brought to examine all new admission and to possibly prescribe a treatment of substitution there. Later on, the psychiatrists either adjust this treatment or, in case of symptoms of lack they prescribe new during the prison stay.

As to the evaluation of the suicidal behaviour, it is necessary to specify that any attempt, as well behavioural as verbal, is taken seriously. The person is hospitalized in the infirmary, supervised by a camera and seen by a psychiatrist before being re-transferred into regular detention.

With respect to the problems of the treatment of the sexual delinquents, we individually evaluate each case by confronting our diagnosis with those of the experts set by justice for the lawsuit. According to this analysis, and if necessary we offer an individual psychotherapeutic follow-up to the person, who then decides whether to benefit or not from the offer. Generally one can say that half of the sexual delinquents take advantage from an individual care taking.

Currently all persons involved are setting up rules and procedures which, amongst other things, should clarify the regulation and the routine practices in the event of urgency. It should also clearly establish the competences of the service of somatic medicine, the supervisory staff (guards) and from the SMPP in the event of emergency.

The difficult problem of the treatment under constraint of the prisoners suffering from mental disorders is regulated in the same way than in the civil society, i.e. according to the law of 1988 ruling the treatment under constraint of people suffering from mental disorders in establishments or

closed psychiatric services, with the only difference that it is the deputy of the Attorney General of State, charged with the penal execution, respectively the examining magistrate who must give its agreement for a transfer of the prisoner from the prison towards the CHNP.

With regard to the standards of quality applied to the SMPP, it should be noted that we are required to stick to all the procedures, regulations and directives enacted by our head office, the CHNP, which is why there are no major differences in the quality of the psychiatric care given in the civil society.

As to the network and collaboration with the legal services concerned with the penal execution, there are regular meetings to confirm the therapeutic work done with the patient, but the psychiatric evaluation of the lawsuits, requiring the rupture of the medical secrecy is entrusted to external expert-psychiatrists.

### **Organisational and legal aspects of the treatment and the evaluation of prisoner suffering from mental disorders**

Through what has been described earlier, one realizes that the needs in mental health care for prisoners are relatively important, especially if one considers the general reserve both outside and inside the prison to consult a psychiatrist or a psychologist.

This also makes it necessary to consider the psychiatric health care in penitentiary environment as a whole, i.e. to extend it well beyond the walls of the prison. Indeed many of the stays in prison are short, with the result that a prison stay is connected with a hospital stay and hence the question of return of the patients to normal life must be resolved, therefore ambulatory work. We had proposed to the Ministry for Justice to extend our service to a post-penal consultation, unfortunately this idea was rejected for lack of a legal frame and a current impossibility of budgeting.

A legal aspect currently very discussed by magistrates and politicians relates to the group of recidivist sexual delinquents and/or considered as potentially dangerous for the society. The problem is the future of these individuals after their stay in prison and gets to topics like the obligation of care or a possibility of keeping these persons in a closed environment after their purge. Currently, a specific work group composed by magistrates and experts explore the various possibilities while referring to the experiments and models of our neighbouring countries (France, Germany, Belgium).

### **Epidemiology of the mental disorders with the C.P.L.**

With regard to the availability and the quality of epidemiologic information on the prisoners, it must be noted that these are internal data to the SMPP which are part of the prisoner's medical file. Currently we do not reckon the number of prisoners presenting a specific diagnosis on a daily basis, mainly because of a lack of time and the absence of specific use of a collection of such data.

However, we dispose of gross statistics of the various pathologies and diagnoses, for the drug addicts for example, we know the exact number of people registered in the substitution program. Another diagnostic category, which is relatively easy to reckon because of their low number, is the group of psychotics. The most reliable data that we have are on the sexual delinquents, because we hold a rigorous register with the incoming and the outgoing ones (cf. 2.3.).

With respect to the epidemiological tendencies, we note a relatively similar number of admissions of prisoners with mental disorders every year, although the indicative percentage of the prisoners presenting an established psychiatric diagnosis (psychosis, drug-addiction) has had a tendency downwards for 3 years, because of a consequent increase in the penal population.

Concerning the suicide rate at the prison of Luxembourg, it should be noted that the last suicide dates from August 2002, and there was none in 2003, nor in 2004. It should be known however that the European Union calculates the suicide rate in prison for 10.000 inhabitants, which gives a suicide rate in prison of 26.3 suicides for 10,000 prisoners in Luxembourg for 2002. We think that such a



statistical presentation is not very "honest", as in 2002 the average number of prisoners was only 380 with one (1) person who committed suicide. So, to avoid misinformation, these details should be precised in case of publication of these statistical data.

### **Quality standards and ethical aspects**

With regards to the level of qualification of the S.M.P.P personnel, responsible for the evaluation and treatment of the prisoners suffering from mental disorders, our team is composed of 3 psychiatrists, 1 psychologist and 10 psychiatric nurses, who all have gotten a certain professional experience in a closed psychiatric environment, prior to their assignment at the SMPP.

As to the training of the SMPP staff, responsible for the evaluation and treatment of the prisoners suffering from mental disorders, it should be specified that it is optional. However every year a fixed budget is set for by the Ministry for Justice for the ongoing training of the SMPP personnel.

Besides the traditional psycho-diagnostic instruments, the SMPP team has familiarized with standardized evaluation tools such as the PCL-R, the SONAR, the VRAG or the HCR-20.

To respect the confidentiality during evaluation and the treatment of prisoners suffering from mental disorders, the therapists are liable to adhere to the respect of the professional and medical secrecy, except of course in the event of vital danger.

The SMPP unit was conceived as a unit or an appendix of the Neuropsychiatric Hospital complex and consequently refers to the standards of quality applied there. Of course we take note of the European Prison Rules, by trying to conform to them as much as possible, in particular for articles 12.1., 12.2., 15.1.f., 25.4., 34.1., 34.2., 40.1., 40.4., 40.5., 42.3., 43.1., 43.3., 46.1., 47, 48.2., 68, 81.3., 89.1., and 103 of the recommendation REC (2006) 2 from the Committee of Ministers from the Council of Europe.

In Luxembourg, the association "Information-Prison" was created specifically in order to make the prison world more human and to prepare the after-prison life and the re-socialisation of the prisoners. Recently the criticisms of this association with regards to the care including the psychiatric care, were taken into account by a study on the access to the care of the prisoners lead by the National Ethics Commission.

Because of the small size of our country, research activities in the field which is of interest here, would certainly not be very representative. However the SMPP regularly participates in university research and it is necessary to point here to the privileged partnership which we keep up with the Social Defense Research Center of Tournai.

Your last question relates to the reforms to improve the situation of the prisoners suffering from mental disorders. On this subject one can mention an ongoing discussion for years on the need for implementing a forensic unit in the Neuropsychiatric Hospital complex. The creation of such a unit would imply important budgetary investments to guarantee the required safety level and it would certainly be very discussed taking into consideration the limited number of persons declared penal irresponsible (Article 71) and the ideological consideration regarding the role of the psychiatric hospital.

## The Netherlands

Catharina H. (Katy) de Kogel <sup>1</sup>

### Structure of Prison System

The Dutch prison system resides under the Ministry of Justice and is run by the Agency of Correctional Institutions (Dienst Justitiële Inrichtingen, DJI<sup>2</sup>). The Minister of Justice has the ultimate responsibility, and the prison service division of DJI manages the execution of pre-trial custody, prison sentences, and detention measures imposed on adults.

The penitentiaries are organised in about 20 regional clusters, each with institutions at several locations (Nota Capaciteit & bestemmingen DJI, 2006). The main types of regimes (see below) are present in each cluster, although some of the provisions serve the whole country. There are about 66 institutions in total. The capacity of the prison system is 16,499 places (2005, excluding 1,258 places for illegal immigrants). Mean daily costs for a place are budgeted to be 185 euros (Budget Ministry of Justice for 2007). The total budget for 2007 is 1,095,000,000 euros (185 x 16,220 places). In 2003 circa 4,000 prison sentences of six months or shorter, and circa 10,000 sentences longer than six months were imposed (Verhagen, 2005).

Detention measures include the placement in an institution for repeat offenders (Instelling Stelselmatige daders, ISD) and detention of foreign nationals who are illegally present in the Netherlands. Foreign nationals without a residence permit, can be arrested and placed in a detention centre while waiting to be repatriated (art 59 Vreemdelingenwet). Because of capacity shortages in the forensic psychiatric sector, a number of persons who have been sentenced to TBS (Terbeschikkingstelling<sup>3</sup>) are waiting in (remand) prisons for their placement in a forensic psychiatric institution. In 2005 there were 225 of such so-called TBS-passanten. Since January 2006 148 beds for TBS-treatment have been created within the prison system, to help reduce the waiting lists for forensic psychiatric institutions. The subject of this chapter however, is mental health and care of those with a prison sentence, TBS-treatment in prison will therefore not be discussed any further.

The prison system includes jails and prisons (capacities of different regimes are presented in table 1). The jails or remand prisons host mainly adults suspected of a relatively serious offence while they await trial, and adults with short prison sentences. Persons who are sentenced with a longer ( $\geq 3$  months) penalty of imprisonment are subsequently placed in prison. There are a variety of security regimes: a high security prison (Extra Beveiligde Inrichting, EBI), secure institutions and institutions with limited or very limited security. In addition there are units with individualised regimes for inmates who behave disruptively or are otherwise difficult to manage (afdelingen voor beperkt gemeenschapsgeschikten, BGG) and for those who are extremely difficult to manage (Landelijke Afdeling

<sup>1</sup> I am thankful to Suzi Baitali, Ton Daans, Richard Geense, Nol van Gemmert, Gerda van 't Hof, John Houtman, Arie van den Hurk, Jan Cees Zwemstra for sharing their knowledge and data.

<sup>2</sup> The Agency of Correctional Institutions (DJI) consists of four divisions: 1) the prisons and remand prisons; 2) the forensic psychiatric institutions; 3) the juvenile institutions; 4) detention centres for foreign nationals.

<sup>3</sup> Terbeschikkingstelling (TBS, art 37 a, b of the Netherlands Criminal Code) is a hospital order that can be imposed when a serious crime has been committed and criminal responsibility is considered to be diminished or absent, and the risk of reoffending unacceptably high.

voor Extreem Beheersproblematische Gedetineerden, LABG). In case a crisis cannot be solved within the institution, a detainee can be placed in the national seclusion unit (Landelijke Afzonderingsafdeling, LAA). The system currently has several local, regional and national special units for inmates who have psychosocial problems or mental disorders and for TBS-patients (see next paragraph).

**Table 1: Formal capacity of regimes of prisons and remand prisons**

Capacity adults	Remand prisons		Prisons	
	Men	Women	Men	Women
Regular regime	8092	671	2664	109
IBA	125	16	68	
BIBA			60	
PSC			24	
Penitentiary hospital	56 (men and women)			
FSU	48			
FOBA	60	6		
VBA	195		111	
BGG			60	
LAA	29			
LABG			25	
EBI	6		12	
Limited security (half open places)		846		58
Very limited security (open places)		287		26
Mother & child				5
Foreign nationals			1958	

Census data week 17, 2006. Source: DJI

IBA: unit for individual care

BIBA: secure unit for individual care

FSU: forensic switch units

FOBA: forensic observation and treatment unit

PSC: penitentiary selection centre

VBA: addiction care and treatment unit

BGG: individualised regime for detainees with disruptive behaviour or otherwise difficult to manage

LAA: seclusion unit in case of crisis

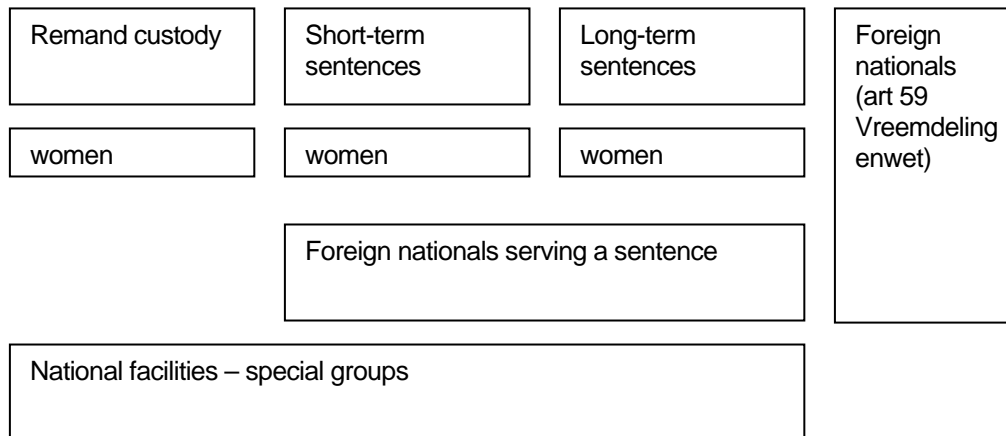
LABG: individualised regime for detainees who are extremely difficult to manage

EBI: High security institution

The prison system is currently going through a transformation. An ambitious operation has been planned, under the names of The New Institution (De Nieuwe Inrichting, DNI) and Customized Detention and Treatment of Adults (Detentie en Behandeling op Maat, DBM), aimed at dealing with capacity shortages, cutting back expenditures, and improving quality: make the execution more effective and efficient with respect to the different sub-populations or target groups of prisoners (Verhagen, 2005). Other important purposes of this proposed reorganization are a better cooperation with partners also involved in criminal proceedings such as the police and the prosecution service, and conformation to expectations of society at large. The new basic structure of the penitentiary system would fall apart into the following target groups of detainees: individuals remanded in custody, individuals in short-term detention (< 4 months), individuals in long-term detention (> 4 months), and foreign nationals serving a sentence (figure 1). The target group approach would apply to both men and women, but because women are few in number, they would be placed together in a few specific institutions. The fifth target group, the 'special groups', consists of detainees who need more care or treatment, more security, or more control measures than the basic service can offer. They would be placed in one of initially four national special care centers. Foreign nationals who do not serve a sentence and have no residence permit are considered a separate category, placed in

different detention centers than those who have to serve a prison sentence, because they are detained based on civil legislation (art 59 Vreemdelingenwet) while waiting for repatriation.

**Figure 1: Intended basic structure penitentiary system after transformation (Source: Verhagen, 2005)**



Apart from the target group approach, many more changes in prison climate were planned. The regimes in the remand custody and short-term detention would be more basic, and detainees would be expected to share cells unless there is a reason why they can't. The detention climate would emphasize responsibility of detainees for their behaviour and for the course of their detentions. Good behaviour would be rewarded with more privileges. Leave for instance, would be no longer standard, but individualised and must be earned.

Plans and developments for DNI and DBM started in 2003 and the reorganization was expected to take place in 2006-2008. In October 2006 however, the reorganization was postponed for two reasons (TK, 10 January 2007, 32-2076-77). One reason was a negative advice by the Group Works Council of employees because they were concerned about the far-reaching consequences the reorganization would have for the security and methods of working of the employees within the prison system. An additional motive for postponement was the urge to reconsider on a large scale, the fire safety measures and -procedures with respect to the correctional institutions. The immediate cause was a fire in a detention centre at Schiphol airport in the night of 26-27 October 2005, which cost the lives of eleven detainees, and led to a critical report by the Dutch Safety Board (2006). At present, March 2007, plans are being reconsidered. The Minister of Justice will inform Parliament about the modified reorganization plans in early summer 2007 (TK, 10 January 2007, 32-2076-77).

### **Medical Services and Mental Health Care Provision in Prison**

The legal position of detainees within the prison system is regulated by the Penitentiary Principles Act (Penitentiare Beginselenwet, PBW) and the Prison Regulations (Penitentiare Maatregel, PM). Although the prison system is a system of control, rather than a system of care, DJI must offer detainees the same (mental) health care facilities as are available outside the prison system (art 2 lid 4 PBW). The director of each of the penitentiaries is responsible for organising and facilitating medical care and mental health care (art 42 PBW). Civil legislation regarding the position of medical patients, such as the Act on Agreement to Medical Treatment (Wet op de Geneeskundige Behandelovereenkomst, WGB) and the Medical Professions Act (Wet Beroepen in de Gezondheidszorg, Wet BIG) applies also within the prisons. Basic health care within the prison system must meet the Kwaliteitswet Zorginstellingen (KWZ, Act on Quality of Health Care Institutions).

### **Mental health care services**

The costs of (mental) health care within the prison system are largely paid for by DJI. The prison system has a budget of about 20.3 million euros for operating the medical services which includes medication, costs for medical specialists, dentistry, and tuberculosis screening (year of reference 2006). There is an additional budget of 110 million euros for the treatment of substance abuse and addiction disorders, and a mental health care budget of 74 million euros (all budgets are include overhead costs).

DJI has a special division for health care in judicial institutions. The division focuses on developing and implementing health care policy. In 1995, a critical report appeared about the health care situation within the prison system ('Locked-in care': Zorg ingesloten, Commissie Van Dinter, 1995), and in 1997 improvement of medical care in prisons was high on the priority list of the Ministry of Justice. Several measures were taken: in order to provide basic health care, every institution had to install a medical service (medische dienst), and a psycho-medical team (psycho-medisch overleg, PMO). The latter team consists of a psychologist (coordinator), a physician, a forensic psychiatrist, and a nurse. Currently the psycho-medical team has a central role in the (mental) health care within the prisons. The health care policy for judicial institutions saw the light in 2003 (DJI, 2003, *Verantwoorde zorg in penitentiaire inrichtingen*). It divided the health care within prisons into basic health care and forensic care. Basic health care focuses on the needs of the patient and includes health care every Dutch citizen should be able to receive. In forensic care, in addition to improvement of health, reduction of the risk of criminal recidivism is a main aim. The health care policy further stipulates that in each institution the professions of penitentiary medical doctor, penitentiary nurse, head of the medical service, and administrative worker have to be fulfilled (DJI, 2003). Penitentiary medical doctors need to be general practitioners with extra training in psychiatry, infectious diseases, and care of addictions. Prison doctor is not a very popular job, therefore DJI in many cases purchases hours from communal GP practices (Verhagen, 2005). Psychiatrists working in the prison system are employed by the Forensic Psychiatric Service (FPD) which belongs to DJI. They employ about 85 psychiatrists, most of whom have part time contracts. The tasks of the FPD are twofold: provide (pre-trial) expert reports to the courts about mental state, and providing psychiatric care within the prison system<sup>4</sup>.

The prison system has its own medium care medical hospital with 56 beds, situated on the premises of the Penitentiary Institution Haaglanden in Scheveningen (Verhagen, 2005). If necessary inmates who need highly specialist medical care are transported to a hospital outside the prison system. The prison system provides security measures in such cases.

If an inmate needs more care or security that can be provided within the regular regime, (forensic) psychiatric care can be provided within special regimes (table 1). In the current system the following special regimes exist (but this may change during the transformation of the prison system). Most institutions have a special care unit (Bijzondere Zorg Afdeling, BZA). This is a first step in the care system for detainees who due to psychiatric, psychosocial, or personal problems cannot function well enough in the regular regime. The next step in the prison care system is the unit for individualised care (Individuele Begeleidingsafdelingen, IBA) or the secure regional unit for individualised care (Beveiligde Individuele Begeleidingsafdeling, BIBA). There are nine IBA's with a total of more than 200 beds, and two BIBA's with 48 and 12 beds respectively. The latter serve a national function. The last step in the system is the forensic observation and treatment unit (Forensische Observatie- en Begeleidingsafdeling, FOBA) a single national crisis intervention centre with 66 beds for detainees with very severe and acute psychiatric problems. The FOBA attempts to stabilize the detainee's behaviour using a treatment plan that may include compulsory medication. Finally, the penitentiary selection centre (Penitentiair Selectiecentrum, PSC) can be consulted for psychological advise about detainees with non-acute psychiatric disorders.

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<sup>4</sup> The FPD has fused in 2006 with the 'Pieter Baan Centrum', the psychiatric observation clinic of the Ministry of Justice. The new organisation is known as the 'Netherlands Institute for Forensic Psychiatry & Psychology' (NIFP).

DJI and the Ministry of Health have installed three 'forensic switch units' (Forensische Schakel Unit, FSU) in different regions, run by the FOBA, with a total of 48 places. The function of these units is to facilitate the possibility to move detainees with psychiatric problems via forensic psychiatric hospitals to the regular mental health care sector. In practice this has not made placement in mental health care easier (Zwemstra, pers. comm.). Detainees do not fit well within the general mental health care because they have antisocial traits, and have addiction problems in more cases than other patients.

Many detainees are dependant on or have abused alcohol or other drugs. The prison service employs a discouraging policy: e.g. regular checks of cells, urine checks, and disciplinary measures against trading. Detainees can receive treatment and care, if they choose, in a special unit VBA (verslavingsbegeleidingsafdeling). Not many choose to do so: in 2000 about a quarter of the 500 VBA-beds were not in use (Verhagen, 2005).

### ***Mental health care provision***

As mentioned earlier, the psycho-medical team (PMO) coordinates the care of the penitentiary psychologist, forensic psychiatrist, physician, and nurse. The PMO has a central role in the mental health care system within the prisons. Any professional within the penitentiary can present a detainee to the PMO if they think he may need more than basic care. The team is chaired by the penitentiary psychologist, who also acts as a coordinator of diagnostic, treatment, and aftercare activities. The PMO concentrates mainly on the detainees with the most severe psychosocial problems and psychiatric disorders (Bulten & Van Kordelaar, 2005). The psychologist also has legally defined (PBW) consultancy tasks regarding selection, placement of detainees, and isolation of inmates and supervision using cameras.

Persons sentenced to prison, are in principle subjected at entry to a general medical screening by a nurse. If the screening indicates there may be medical or mental health problems, the nurse will consult the doctor or the PMO for treatment or further diagnostics. If psychosocial, behavioral or psychiatric problems appear later in detention, the detainee will also be brought to the attention of the PMO. Selection and placement for some interventions is done by the national Penitentiary Selection Centre (PSC). For instance sex offenders can be referred by the local PMO to the PSC to be placed in one of the three penitentiaries that offers an intervention for sex offenders.

If care and treatment within the prison setting are not sufficient and a detainee with psychiatric problems is considered to be better off in a psychiatric hospital, he can be transferred to a more suitable facility (art 15 lid 5 PBW). A detainee can also be transferred for care and support/treatment, for in-stance if the treatment he needs is not available within the prison system (art 43 lid 3 PBW). Placement in a general psychiatric hospital during detention is rare, because the hospitals are reluctant to accept detainees for security reasons (Van't Hoff, pers. comm.).

In acute situations, like suicide risk or suicidal behaviour of a detainee, or an acute state of psychotic disorder or schizophrenia, the forensic psychiatrist will usually be consulted. The patient will be reported to the PMO, and in case of suicide risk, the psychologist will make a treatment plan and will coordinate with the other professionals. In case of acute psychoses and problematic behaviour, the patient may be placed in a special care unit like, BZA, (B)IBA or in case of a crisis the FOBA.

Compulsory treatment is legal only in case of severe danger to health or safety of the detainee or others (art 32 PBW). In the Netherlands 'compulsory treatment' is usually understood as short term forced medication. Compulsory treatment within the prison system is almost exclusively practised by the FOBA. Seclusion is in the Netherlands compared to other countries a relatively common alternative to forced medication, but there is discussion about what would be the most humane alternative. Depot medication is explicitly mentioned as an alternative (Vegter, 2004). Seclusion is permitted in the following cases (art 23, 24 PBW): a) if necessary for keeping order or safety in the institution or for undisturbed execution of the penalty; b) if necessary for protection of the detainee; c) in case of illness of the detainee; d) on request of the detainee, if the head of the institutions considers the request reasonable. Physical restraint during seclusion is allowed only to avoid severe danger for health or safety of the detainee or others. There are several possibilities for the detainee

to appeal against compulsory treatment, for instance with the supervisory committee of the institution and against the decision of this committee with the RSJ (Moerings, 2005).

Most detainees with psychiatric problems still need care and treatment after their sentence expires. An important task of the forensic psychiatrist is to try and find a possibility for care and treatment in a general psychiatric hospital or clinic (Zwemstra pers. comm.). For reasons mentioned earlier, this is usually difficult to achieve and it takes much networking with (the management of) psychiatric facilities.

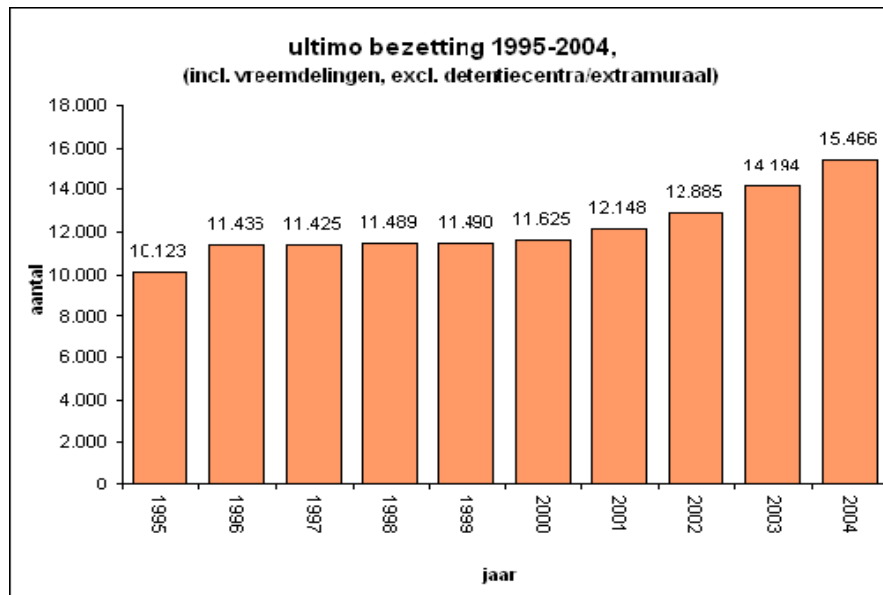
About a hundred cognitive or behavioural interventions for detainees are offered within the prison system. Mostly rather diverse local initiatives, which in many cases do not meet criteria employed by for instance accreditation committees in the United Kingdom or Canada (Tigges, 2005). There are a few well described and theoretically founded programs, for instance a reintegration program called 'Start inside, stay outside (Binnen beginnen, buiten blijven) of the penitentiary Limburg Zuid, or the program 'Nice story' (Mooi verhaal). There are interventions for sex offenders in the penitentiaries Breda, Eindhoven and Utrecht (DJI, 2003b). Although there are some comprehensive treatment programs, most interventions are very short, and aims and target groups are often not clearly indicated. The last five years several developments were started by the Ministry of Justice, DJI and the probation services to improve the overall situation regarding behavioral interventions within the prison and probation system, this initiative is called 'Pushing back criminal recidivism' ('Terugdringen Recidive', TR). Target groups of TR are detainees with a relatively high risk of criminal recidivism. Aims of TR were:

- to select and or develop a small set of standardised interventions that meet quality standards based on behavioural research, and form a coherent treatment program that aims at reducing the risk of criminal recidivism
- invest mainly in behavioural interventions for a medium and high risk group, interventions will also be offered only to those with long-term sentences (> 4 months)
- cognitive-behavioral interventions form the core of the program: a COVA intervention and an aggression-intervention
- develop a screening instrument (RISc, based on Oaysis used by the English probation service) for use by the probation service to assess criminogenic factors in order to determine the interventions needed
- the program within the institutions should be connected to aftercare by the probations service (project 'Aansluiting nazorg')

The screening instrument RISc, and interventions are being piloted at present, and in the beginning of 2005 an accreditation committee for behavioral interventions has been installed: the 'Commissie Gedragsinterventies Justitie'.

## **Epidemiology of mental disorders**

DJI records basic statistics of the prison population such as age, sex, length of sentence, type of offence, and cultural background. Furthermore the agency keeps record of the units and penitentiaries where detainees are placed, incidents, mortality and escapes. The Forensic Psychiatric Service (FPD) keeps track of the consultations of forensic psychiatrists within the prison system and records DSM-IV diagnoses. At present, not much data about diagnoses and treatment are recorded. In the future more data may become available from the FPD-database that is being developed, and via screening by the probation service. The probation service will in principle screen each person with a penalty of four months or more, using the RISc. The reliability and validity of the instrument are currently assessed by the Research and Documentation centre of the Ministry of Justice (WODC). The RISc aims at assessing risk factors of criminal recidivism, but is not specifically designed for recording data about mental health.

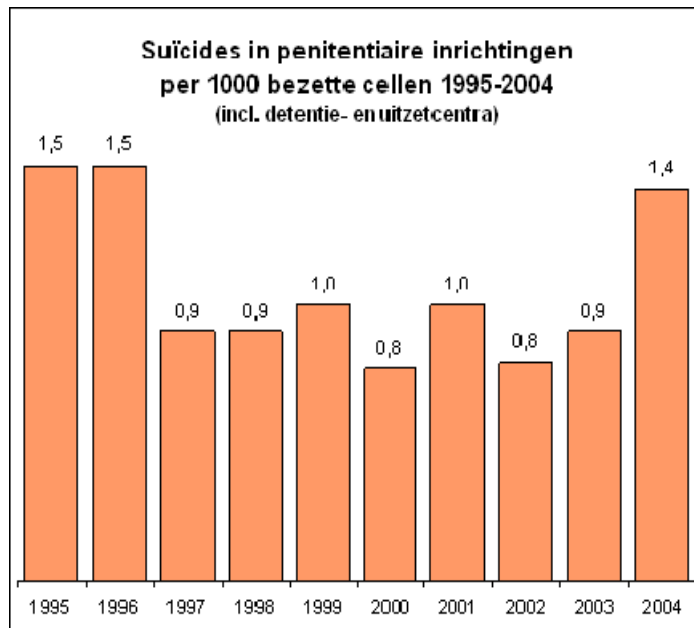
**Figure 2: Occupancy of prison system capacity**

The formal capacity of the prison system in 2004 was 16,255 beds, of which 15,845 functional (usable) capacity. Occupancy is depicted in figure 2. Six and a half percent of the population are females (DJI, 2005). There are no nationwide epidemiological studies of mental health in detainees, but some small-scale studies have been conducted. Schoemaker & Van Zessen (1997) studied 135 detainees in the Penitentiary of Scheveningen and found a prevalence of the antisocial personality disorder of 31.9%, anxiety disorders (26.7%), affective disorders (30.4%), but no psychoses. The authors attributed the latter finding to the large number of non-responders (66% of 310 detainees) of whom a relatively large proportion may have been psychotic. Bulten (1998) found in a population of 200 adolescent detainees with a short-term sentence, prevalences of 8% with a psychotic disorder in the past year, 4% with a chronic psychotic disorder, 25% with an anxiety disorder. In addition, 65.3% had addiction problems and 47.5% matched with criteria for an antisocial personality disorder.

About 10-20% of detainees come into contact with the psycho-medical team (PMO; Bulten & De Vrugt, 2003). In this specific population of detainees, 97% is diagnosed with a psychiatric disorder or severe personality disorder, and 10% has an IQ below 80. In a population of high security units (241 detainees in LAA and LABG), high prevalences of psychopathology have been found. In the LAA 34% was diagnosed with a personality disorder, and 17% with a psychotic disorder, in the LABG 44% was diagnosed with a psychotic disorder, and 78% with a personality disorder (Bulten, 2001). Between 500 and 600 detainees, about 4.7 percent of the population were sentenced because of a sex offence (DJI, 2002a).

The suicide rate of detainees within the prison system lies between 0.9 and 1.4 per 1,000 occupied cells (figure 3), the rate of natural deaths is about the same (Verhagen, 2005).



**Figure 3: Suicides per 1,000 occupied cells**

Criminal recidivism is monitored yearly by the WODC. Between 54 and 59 percent of ex-detainees whose sentence expired in 1996-2003 are prosecuted for another offence within two years (Wartna, Kalidien, Tollenaar & Essers, 2006). Between 40 and 45 percent of these are prosecuted for a serious offence (for which a maximum sentence of four years can be imposed), and about ten percent for a very serious offence (for which a maximum sentence of eight years can be imposed). The high rates of criminal recidivism are a source of concern. Terugdringen recidive (TR), described above is one of the initiatives that are being implemented to reduce the recidivism rate and improve effectiveness of the penalties imposed. It is still too early to see if any effects of TR or other operations will be reflected in the recidivism rates.

### Quality Standards and ethical aspects

Quality standards that have implications for mental health care within the prison system are formulated in prison legislation, health care legislation and professional codes. The Prison legislation involves the Penitentiaire Beginselenwet (PBW) and the Penitentiaire Maatregel (PM). Relevant health care legislation is the Wet Beroepen In de Gezondheidszorg (Professions in Health Care Act, Wet BIG), Wet op de Geneeskundige Behandeloovereenkomst (Agreement to Medical Treatment Act, WGBO), and the Kwaliteitswet Zorginstellingen (Act on quality of health care institutions). The last report of the Inspection for Health Care about the prison system appeared seven years ago (Zorg achter tralies, 1999).

Rule 92 of the European Prison Rules mentions that prisons should be regularly inspected by a governmental agency. In the Netherlands quality is monitored in several ways (TK, 2005-2006, 30 161, nr. 9). DJI monitors expenditure of public funds by the institutions using planning & control cycles. The audit service of the Ministry of Justice checks whether DJI uses public money effectively.

The quality of the execution of the tasks of the prison system used to be monitored by the Council for the Execution of Penal Law and Protections of Juveniles (Raad voor de Strafrechtstoepassing en Jeugdbescherming, RSJ), and is monitored since January 2005 by the Inspection for the Execution of Sanctions (Inspectie voor de Sanctietoepassing, ISt). They assess the institutions with respect to security, treatment of inmates, and adherence to legislation and regulations. Every institution has a supervisory committee (Commissie van Toezicht) which also hears and assesses complaints of

inmates. The National Health Inspection monitors the quality of medical and mental health care within penitentiaries. Inmates can appeal with the RSJ about medical treatment within the prison system.

A penitentiary medical doctor has a level of education of a general practitioner, with additional training in subjects of psychiatry, infectious diseases and alcohol/drugs abuse. A nurse has to be trained in the same topics. Although psychiatrists will get some forensic psychiatry in their curriculum, forensic psychiatrist is not a specialisation. (Basic) psychiatric care within the prison system has the same objectives as psychiatry outside the prison: stabilisation and treatment of psychopathology. Penitentiary psychologists may have a specialised training as a clinical psychologist or a mental health psychologist.

The (mental) health screening at entry into the prison system is protocollised (DJI, 2003a).

According to Buruma (2001, cited in Bulten, De Jonge and Knol, 2003), in the Netherlands views on penal law have since the beginning of the nineties moved in the direction of more 'uniformity', more 'efficiency', and an increasing 'focus on consequences'. The emphasis on public safety, incidents and rates of criminal recidivism, and doubts about treatment success have promoted efficiency and effectiveness as central goals of penal policies. The consequences of criminality have become more prominent in criminological thinking, with more emphasis on the risk of relapse and on risks for the community. According to Bulten, De Jonge and Knol (2003), views on treatment within the prison system are affected by these tendencies. Another reason to emphasize the need for treatment during detention is that several studies and policy documents have indicated the need for care and treatment of detainees with psychiatric disorder and psychosocial problems, as well as the limited possibilities to meet the needs in this respect (Schoemaker & Van Zessen, 1997; Bulten, 1998; DJI, 2001; DJI, 2003b). Treatment in the prison system is thus viewed from two perspectives: the need for care of psychological and psychiatric problems, and the need to reduce the risk of criminal recidivism.

In the Netherlands a risk assessment instrument for the probation service and a limited set of uniform interventions aimed at reducing risk of criminal relapse are being piloted within the prison system. The operation Terugdringen recidive (TR) thereby follows international examples of risk assessment and treatment within prison systems, such as Canada and the United Kingdom. The implementation of the procedure to use standardised assessment instruments as a guide for their activities, is a major change for the probation service. The prison system, according to Bulten, De Jonge and Knol (2003) will meet a number of bottlenecks. For instance, the prison system focuses on control, rather than care. This means that the psycho-social climate in the units, the staff-detainee ratio and education of the staff, are not yet sufficiently attuned to offering treatment.

Offering effective treatment within detention at a larger and more varied scale, would also require a good connection with chain partners in the judicial process. For instance the imposition of penalties and measures could be directed more than at present, at effective solutions and interventions regarding care and reduction of recidivism (Raad voor Maatschappelijke Ontwikkeling, 2006).

One of the great challenges is the connection between the prison system and the general mental health care system. At present this is problematic. The care and treatment possibilities within general psychiatry do not match with the needs of mentally disordered (former) detainees. Better aftercare in the community is needed with respect to meeting needs of the ex-detainees for care and treatment of disorders, as well as the needs of society to reduce the risk of criminal recidivism. Perhaps new judicial facilities should be created to fill the gap between the prison and mental health systems. Dutch penal law and civil law offer relatively few possibilities for (long-term) supervision and aftercare (De Kogel, Nagtegaal, Neven & Vervaeke, 2006). There are however some developments in this respect, such as (re)introduction of conditional release during the last portion of a prison sentence, and reforming of the civil hospital order that leaves only room for compulsory hospitalisation, to offer more possibilities for compulsory treatment while the person involved remains in the community.

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## Norway

Ellen Kjelsberg & Paal Hartvig

### The Norwegian Correctional System

#### *Organisation*

The Norwegian Correctional Services includes all prison and probation services and is administered by the Correctional Service Department at the Ministry of Justice and Police. The Correctional Services were reorganised in 2001. A new Execution of Sentences Act became operative in 2002. This Act applies to the execution of sentences of imprisonment, special criminal sanctions, community sentences, remand in custody, and other sanctions when specially provided by statute. The Act is intended to reduce the incidence of re-offending, safeguard society, and ensure minimum standards for the treatment of prisoners.

The primary goal of the Norwegian Correctional Services is to enforce reactions set by the prosecution authority and by the courts of law, as soon as they are legally binding, taking into consideration the security of all citizens and attempting to prevent recidivism by enabling the offenders, through their own initiatives, to change their criminal behaviour. Enforcement of sentences should be based on humanity, legal protection and equality before the law. It should also pay due attention to the needs and the total life situation of the prisoner. The prisoner should be supported in his<sup>1</sup> efforts to live a law-abiding life.

The correctional services operate on three levels, which all include different goals and responsibilities:

1. *The central administration*; its main tasks are to manage the correctional services by setting the main goals, allocate budgets to the six regional administrations and evaluate the performance reports that are a condition for their budget allocation.
2. Six semi-autonomous *Correctional Service Regions*; their main tasks are to formulate regional goals and directions in accordance with central guidelines, allocate resources to local units together with clear priorities and result demands, ensure that regional resources are utilized as efficiently as possible, treat complaints concerning decisions made at the local level, and supervise the performance of local units.
3. All *local units*, i.e. prisons and probation offices; their main task is the execution of all court sanctions, including all prison sentences, preventive detention, remands in custody, community services and probation.

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<sup>1</sup> The male pronoun is used throughout for the sake of brevity

### **Execution of sentences**

The Execution of Sentences Act stipulates how sentences should be executed. The Act and its regulations are in agreement with the European Prison Rules, with the exception of one element: Norway has no separate remand prisons.

The Correctional Services aim to execute sentences in such a way that harmful effects of incarceration are reduced so that the individual can start a life free of crime after release. The execution of the sentence is progressive, i.e. the convicted person receives a gradually increasing degree of freedom. In Norway the age of criminal responsibility is 15 years. There used to be special youth prisons but these were closed down a number of years ago. The incarceration of youth under the age of 18 is generally discouraged but is at times unavoidable.

Imprisonment and other penal reactions can be carried out

- in high security prisons (closed prisons), some of which have got extra high security wings
- in low security prisons (open prisons)
- in half-way institutions or pre-release hostels
- as non-custodial sentences and early release under special conditions

A new Penal Code was introduced in Norway in 2002. It stipulates that individuals who are considered psychotic, or unconscious, or severely mentally retarded (IQ<55), can not be punished. The court normally orders a forensic psychiatric examination in cases where suspicion is raised that the defendant at the time of the crime was suffering from psychosis or automatism in such a way that he had reduced capacity to evaluate his actions. If the psychiatric examination concludes that the offender was psychotic, and the court agrees, he cannot be sentenced to prison. He may however, if the act was serious, be transferred to psychiatric care. Similarly, a severely mentally retarded offender may be transferred to compulsory care. If the defendant acted during mental illness and was influenced by this illness in such a way that it is clear that he had reduced capacity to judge his acts, he may be given a reduced sentence. If the offender is found to be accountable for his actions at the time of the crime, he may in certain cases be sentenced to preventive detention. This may happen if the act was especially serious and the court finds that society, due to an estimated high risk of serious re-offending, needs protection beyond that which a sentence of pre-determined length provides.

### **Prisoner categories**

*Arrested persons*, who have not yet had their case heard before a judge, are kept in police custody at the local police station and transferred to prison only after a proper remand sentence is passed by the judge. Nobody should be kept in police custody more than 24 hours before the case is heard by the judge. Individuals in police custody are, as opposed to all other incarcerated individuals, not the responsibility of the Norwegian Correctional Services.

There are 46 ordinary prisons in Norway (2005). There are no jails or other special institutions for remand prisoners; these individuals reside in ordinary prisons but are kept separate from sentenced inmates. Two prisons, one for males and one for females, are servicing the majority of individuals sentenced to *preventive detention*.

Individuals sentenced to *community sentences* live at home but have to report for work at a designated place for a designated period of time. These, and persons *on probation*, are under the supervision of the local probation office and therefore still in the custody of the correctional services.

### ***Prison staff***

All prison officers are educated at the Prison and Probation Staff Education Centre in Oslo. This centre provides education for prison officers and work activities officers, various courses, post-graduate education and training, and research and skills development. The education of prison officers consists of a two-year candidate-training programme, with theoretical and practical studies. Student capacity is approximately 300.

An essential part of the work of a prison officer is to support and motivate prisoners to use their period of incarceration constructively and help them make realistic post-release plans. Every inmate has a designated personal contact officer. This officer's task is to constitute a link between the inmate and the prison system and the inmate and the outside world.

### ***Living conditions and activities within the prison***

The material condition in Norwegian prisons is generally of high standard. Most inmates have single occupancy cells that are often furnished with TV and other amenities. They are served nutritious meals which include a choice of halal food and other dietary specialties, and physical exercise is encouraged, in gymnasiums and outdoors.

Convicts are expected to work on a daily basis, and are rewarded with a regular salary of 50 NOK (approximately 6 €) per day (2005). The correctional services are obliged to provide inmates with meaningful activities, including education and various correctional programs aimed at crime reduction. These entitle the inmate to the same daily allowance as the work assignments. Furthermore, the services are obliged to provide opportunities for participation in leisure activities during leisure hours. These include both physical and cultural activities.

Norway favours the 'import' model for providing services to prisoners, implying that basic services are provided by the municipal authorities. In principle, this means that those serving a sentence have the same right to community services and facilities as other citizens. Hence, primary and secondary education, health services, library services, and employment agency assistance should be provided by the ordinary agencies servicing the society at large. Close cooperation with these public services contributes towards meeting the needs of the prisoner, as well as to facilitate his adjustment to society after release.

Most institutions offer correctional programs to imprisoned persons and persons serving a community sentence. These programs are not therapeutic interventions but structured programs with crime prevention as their primary goal. A wide spectrum of programs based on systematic and well-founded professional standards, including cognitive and social skills programs, substance abuse programs, anger management programs, sexual offender programs, and drunken-driver programs are offered.

A written and agreed plan for the inmate's sojourn in prison and his ultimate release should be developed. It should include strategies for work and education activities, participation in programs, spare-time activities etc. during the incarceration period and be solution oriented. It should also include plans for necessary pre-release meetings with the local social welfare office, the employment agency, the rehabilitation centre, and so on.

### ***The correctional services' activities in 2005: Some key figures***

The 2005 budget for the Correctional Services, including the regional administrations, was approximately 2,000 million NOK. This equals approximately 250 Million €, or 54 € per citizen per year.

Norway had 46 prisons with a total capacity of 3,273 inmates. The largest, Oslo Prison, had a capacity of 354; the smallest, Moss Prison, housed 15 inmates. Two prisons had female inmates

only, while one particular prison housed most inmates on preventive detention. There was no regional variability in the quality between facilities, other than the fact that large prisons tended to be located in more central parts of the country. Small prisons were usually located in the countryside. In addition to the prisons, there were 19 probation offices throughout the country.

A total of 12,002 persons were committed to prison in 2005; 8 % of these were females. 51 prisoners were under 18 years of age; 8 % were from 18 to 20 years of age, and 18 % from 21 to 24 years of age. A total of 3,059 persons, 25 % of all who were committed in 2005, were remanded in custody. The average time spent on remand was 63 days. In 2005, the imprisonment rate in Norway was 68 per 100,000 inhabitants.

At the end of 2005 there were 2,500 persons waiting to commence their sentence. A person that has not commenced serving his sentence within two months after receiving a legally binding sentence is deemed to be placed in a prison queue.

Of all new admissions to prison, 89 % were Norwegian citizens, 5 % were from other European countries, 2 % were from Africa, and 3 % were from Asia. Among the Norwegian citizens, a considerable minority consisted of 1<sup>st</sup> and 2<sup>nd</sup> generation immigrants.

Among inmates, 8 % were remanded or convicted for sex offences, 16 % for violent offences, and 30 % for drug related crimes. The remaining offenders were mainly remanded or convicted for offences against property and traffic offences such as driving while intoxicated.

### ***Future challenges***

Objectively, the greatest challenge for the Correctional Services is the high rate of re-offending after release. Prison employees often experience the repeated return of inmates. Obviously, having been to prison does not always deter a person from re-offending. This fact may lead to disillusionment with the system, but could also constitute a strong incitement towards improving the content and the context of the services rendered.

The Norwegian prison capacity is not satisfactory. The Correctional services are striving to improve the effectiveness of the prisons, in order to reduce prison queues. Prisoners are routinely released after serving two-thirds of their sentence. In addition to this, some prisons accommodate two prisoners per cell. Even so, from time to time remand prisoners have to be released contrary to the courts' advice, due to lack of capacity. This issue is regularly debated in the press.

The Correctional Services aims at improving the services for young offenders and offenders with small children. The Services work to address most inmates' numerous social problems including drug abuse, lack of education, unemployment and homelessness. At the same time, important security issues such as drug peddling and organized crime, have to be addressed.

## **Medical Services and Mental Health Care Provision in Norwegian Prisons**

### ***The goals of the prison health services***

The Norwegian Directorate for Health and Social Services has formulated the goals for the prison health services (Sosial- og helsedirektoratet, 2004). They state that all individuals, including prisoners, should be respected for their uniqueness and their individual needs be met. At the same time they should be given sufficient knowledge about how they themselves may contribute towards improving their own health. In addition, they should obtain sufficient information to form a realistic view of what the health services can contribute with in order to help them reach that goal.

### ***The entitlement to health services***

Access to good health care is one of every Norwegian citizen's rights. This of course pertains to prison inmates as well. Hence, all prisoners are entitled to all necessary medical services and prescription drugs free of charge. The responsibility for securing necessary health services is placed as follows.

An individual apprehended by the police is considered to be in police custody and therefore not the responsibility of the Correctional Services. The person has the right to contact a medical doctor within two hours of being brought to the police station. It is the responsibility of the police to secure adequate medical and/or psychiatric attention from the usual community health services. Individuals in police arrests often represent a difficult challenge: they may be heavily intoxicated or have a(n) (unknown) serious somatic or psychiatric condition requiring immediate attention at the time of arrest. There have been cases where people have died in police arrests due to intoxication or somatic conditions. In addition to this, a few individuals have committed suicide. These types of cases often get a lot of public attention.

Individuals under the supervision of the Probation Services, including those serving community sentences, are serviced by the regular health services in their community of residence.

Only individuals residing in correctional institutions are serviced by the prison health services proper and these individuals will therefore be the main focus of this presentation.

### ***Administration and organisation***

The responsibility for provision of health services to prison inmates was transferred from the Department of Justice to the Department of Health and Social Welfare in 1988. The aim was to fully integrate the responsibility for these health services into the general health services of the country. Hence, all prisoner health services in Norway are funded and run by the health authorities and all health workers are independent of the correctional facilities they service, both on an administrative and on a financial level.

After a structural reorganisation, the country's healthcare has since 2002 been divided into three levels: the central government level; the regional level which consists of five regions with responsibility for hospitals and specialist services, and 432 municipal authorities to whom the responsibility for primary health services have been decentralised. Accordingly, the municipalities that have got prisons in their area are responsible for providing health care to these prisons. Furthermore, each health region is responsible for providing hospital and specialist services to all prisons within its jurisdiction.

There were numerous arguments for carrying out this integration. It was argued that medical staff that are not employed by the prison authorities and thus own their allegiance to the public health service, will find it easier to make independent judgements, and that they will put the needs of the patient before the institutional requirements. In addition to this, independent medical staff will be able to suggest measures to be taken that will improve public health such as harm reduction measures, even if these may cause difficulties within the environment of a prison. Prisoners are more likely to trust medical staff employed by the health authorities than medical staff employed by the prison authorities. Continuity of care is easier to achieve if the same organisation is responsible for the care both inside and outside the prison walls. In addition to this, quality of staff is likely to be better when prison health is a mainstream discipline that provides its staff with wide opportunities for advanced training and research.

The integration has been uniformly positive. A neglected and often secret part of the health provision has been brought out of the shadows and into the mainstream of health policy. It has also made it easier to implement health policies, originally intended for the general population at large, to the prison population.



### **Organisation of services at the local level**

The practical organisation of the primary health services varies with the size of the correctional facility. Larger prisons have particular services established to service that institution while small prisons may use a general practitioner in the vicinity. Typically, each general practitioner in the community must work a certain number of hours a week in a public health setting, such as a nursing home, an emergency unit – or a prison. Health care is not available 24 hours a day even in large prisons. When the medical unit in the prison is closed, treatment must be provided by the local emergency unit.

Similarly, the psychiatric health service in each prison is part of the general psychiatric health services in that particular health region, both organisationally and financially. Larger prisons most often employ specific professionals on a full time basis while smaller prisons typically have professionals engaged part-time.

There are no forensic psychiatric hospitals in Norway. Prisoners in need of psychiatric emergency services are referred to the acute ward at the local general psychiatric hospital. If the prison inmate is considered dangerous, he will be referred to the security psychiatric hospital ward that is servicing that specific municipality (medium security unit) or health region (high security unit).

There is close cooperation between the primary and the psychiatric health services in the prison. The primary health services usually try to establish contact with new inmates as soon as possible, usually within the first week - or sooner, if indicated. Some primary health services do employ a general health questionnaire screening instrument. However, the main source of information comes from personal interviews with the new prisoner. This will usually be carried out by a registered nurse who will then decide upon further actions, if necessary. A number of psychiatric nurses work in the primary health services in Norwegian prisons, and they make a particularly valuable contribution, both towards identifying individuals in need of psychiatric intervention and by providing such services at that level.

Both the primary and the psychiatric health services usually consist of cross-disciplinary teams. Typically, the primary health services consist of registered nurses and general practitioners, while the psychiatric health services employ psychiatric nurses, clinical psychologists, and psychiatrists. While nurses usually are employed in full-time positions, medical doctors, psychologists, and psychiatrists are often engaged on a part-time basis.

Both health care levels work in close co-operation with the prison staff. As already stated, each inmate is assigned one particular prison officer as his or her primary contact officer, equivalent to the primary nurse system in health institutions. If the inmate has got or develops any kind of mental problems, the primary prison officer will arrange for a consultation with the prison's primary health professionals. If the ensuing primary health care intervention does not produce the desired result, or if the problem is of a nature that clearly requires specialist attention, the primary health services will arrange for an appointment with somebody within the psychiatric health team.

### **Areas requiring specific attention**

*Involuntary psychiatric treatment* is heavily regulated in Norway and can only take place within the psychiatric specialist services. Compulsory treatment of mentally disordered prisoners is not permitted in the prison setting. Hence, if an inmate is considered in vital need of psychotropic medication but does not want to comply with the psychiatrist's advice, he has to be transferred to a psychiatric hospital. In order to be admitted to a psychiatric hospital, he has to fulfil the requirements for involuntary admission, as stipulated in the Mental Health Act. Once hospitalised, the psychiatrist in charge will evaluate the patient's situation independently. Only then can involuntary treatment be carried out. Electro-convulsive treatment is under no circumstances carried out on an involuntary basis in Norway.

In Norway any person who is found to be psychotic at the time of committing the crime is usually not sentenced to imprisonment but to compulsory psychiatric treatment. There is broad consensus that *psychotic individuals* should not be incarcerated. Even so, there are individuals with psychotic disorders in prison. These individuals may have developed a psychotic disorder after the trial, for instance during incarceration. He or she should then be transferred to a general psychiatric hospital as soon as possible. If the person in question is considered particularly dangerous he could be transferred to a security psychiatric ward. Sometimes a patient is returned to prison if he has been successfully medicated, voluntarily consents to taking psychotropic drugs and is judged not to be in need of psychiatric hospitalisation any more. And, regrettably, undetected/untreated cases do exist. Hence, there are inmates with psychotic disorders to be found in Norwegian prisons, although most often in remission.

*Prison suicides* have been closely monitored in Norway over the last 50 years. Cases where the inmate commits the suicidal act in prison but is later transferred for instance to a somatic hospital and dies there are also counted as prison suicides. From about one suicide per year in the 1950s and 1960s the number has increased to two to three per year over the last decades. Those remanded are at higher risk: three out of four suicides are committed by remand prisoners. An increasing number of suicides are committed by non-Norwegians. As could be expected, the vast majority are males. Suicides committed in police custody are not included in the above numbers, neither are drug overdoses, unless these are taken with obvious suicidal intent. The country's Prison and Probation Staff Education Centre emphasises suicide prevention in their curriculum both in basic courses and in post-graduate education and training. Prison officers work in close cooperation with the prison's primary and mental health services in order to minimize the risk of suicide.

Patients with *severe opioid dependence* may in Norway enter a strict rehabilitation scheme consisting of methadone medication and psychosocial rehabilitation. If any such client should be incarcerated, he is entitled to continue his methadone treatment while in custody and during short sentences. If a long sentence is passed the psychiatrist may find indication for discontinuation of methadone treatment during incarceration, even if this is against the prisoner's wish.

Nobody may use any medication while incarcerated unless approved by the medical doctor in charge. Potentially *dependency provoking prescription* drugs should as a rule not be used, unless there is a clear-cut medical condition requiring such medication and that this medication has proven effective for the given condition. General guidelines regarding dependency provoking drugs are issued by the health authorities and should be adhered to.

Health consultations and psychotherapy sessions are in some prisons conducted in the inmate's cell. Sometimes this is necessary due to security measures. However, it is not an ideal therapy setting and should, if possible, be avoided. All prisons should be able to offer enough *suitable office space* for these activities, including areas for group therapy.

Psychotherapies are often unexpectedly *discontinued* due to inmates being transferred between prisons. Whenever a good therapeutic working alliance between patient and therapist is established this should be taken into consideration in the planning of transfers.

As a rule, mental health workers do not participate in the planning and execution of *disciplinary measures* regarding individual prisoners.

## **Epidemiology of mental disorders in Norwegian prisoners**

### ***Psychiatric morbidity***

No large comprehensive epidemiological study on the mental health of Norwegian prisoners has yet been carried out. Even so, a few studies merit attention. All in all, findings from these seem to indicate that the prevalence of mental disorders is similar to that found by Fazel and Danesh in their well-known meta-analysis (2002).

Gamman and Linaker (2000) found mental disorders in 40 (21 %) of 187 newly incarcerated prisoners. Rasmussen et al. (1999) studied 44 prisoners and found that none of these had a current major mental disorder. However, 23 inmates fulfilled the criteria for a lifetime diagnosis of major depression or bipolar disorder, 20 of them had adjustment disorders, and 11 of them anxiety disorders. Axis II disorders were prevalent, as were psychopathy and psychoactive substance use disorders. In another study Rasmussen et al. (2001) found that, among 82 inmates, 30 % had a highly likely adult attention deficit disorder, while an additional 16 % had a probable attention deficit disorder. Personality disorders were prevalent: only 14 % had no personality disorder. Langeveld and Melhus (2004) found that 18 out of 40 assessed inmates had a mental disorder in need of treatment. Thirty had psychoactive substance use disorders and 32 had personality disorders, most often of the antisocial type.

Unfortunately, all of the above studies were carried out in a small scale and most had high attrition rates. Only the following country-wide studies have been conducted.

Hartvig and Østberg (2004) asked the primary health services, who usually are well informed about the health status of the inmates, to count the number of inmates with different mental disorders in their institution. Estimates from health services covering 95 % of the country's total prison population were collected. The estimates indicated a prevalence of 2 % for psychotic conditions and a further 17 % had a markedly deviant conduct. 7 % had anxiety or depressive disorders. All in all the primary health services estimated that 2.7 % of all inmates should not have been in prison but in a psychiatric hospital. When asked the same question, prison officers estimated that 4.6 % of all inmates should have been hospitalised.

Kjelsberg and Hartvig (2005a) conducted a nation-wide epidemiological study of mental disorders in the Norwegian prison population. The method was unconventional, though, as it used medication sheets as its main source of information. Experienced psychiatrists assigned best-estimate psychiatric diagnoses, as inferred from medication sheets, and found that of 2,617 inmates, 919 (35 %) had a psychiatric disorder, as estimated by their prescription drug use. Depressive disorders (11 %) and sleep disorders (11 %) were most prevalent. Four percent of the inmates received medication indicative of a psychotic disorder. The prevalence of substance use disorders and personality disorders could not be estimated by this methodology, as these disorders are not treated with conventional prescription drugs.

We do not have any knowledge about the secular trends in Norwegian prisoners' mental health. Hence, we do not know whether the prevalence of mental disorders is stable, increasing, or decreasing over time. Kjelsberg and Hartvig (2005b) have, however, monitored the use of prescription drugs in Norwegian prisons over the last 26 years. The use of psychotropic drugs increased markedly, from 28.6 DDD per 100 inmates in 1978 to 51.0 DDD per 100 inmates in 2004, with antidepressants increasing most: from 4.3 to 20.6 DDD per 100 inmates over the same period. This does not necessarily indicate increased morbidity, as the increase may also be due to more effective and better tolerated drugs and better health services coverage.

### ***The prisoners' social background***

A large survey was conducted in 2003 by the FAFO Institute for Labour and Social Research in order to explore Norwegian prison inmates' living conditions (Friestad and Hansen, 2004). A representative sample of 260 inmates agreed to participate. The results were compared with those from a general population survey conducted in Norway in 2002.

The main conclusion was that living conditions for inmates were far worse than for the population at large. Two-thirds of the inmates had experienced a traumatic childhood. Three out of ten had been in contact with the child-care authorities before the age of 16 and three out of ten had experienced the incarceration of close family members.

The educational level achieved was low, with marked deviation from the rest of society. Four out of ten had no education beyond lower secondary school; in the adult population at large this is the case

for less than 10 %. Most inmates were poorly integrated into the labour market: only three out of ten were employed at the time of incarceration. One-third of all were homeless. One in four often experienced problems covering current living expenses. Social security allowances and criminality were often cited as a main source of income.

Inmates were asked in detail about symptoms of mental health problems. Three out of ten scored above a clinical cut-off for likely presence of mental health problems in need of treatment. In the general population, one in ten reported similar mental health needs. Six out of ten prisoners abused psychoactive substances; the majority of these had multiple drug and alcohol abuse and dependence. Drug abuse and dependence were more frequent among female than male inmates.

## **Quality standards and ethical aspects**

### ***Quality standards***

The medical services that are offered to the Norwegian population at large are fairly good. A substantial amount of the gross national product is spent on providing health services to the population. Even so, shortages do exist, and among the different medical disciplines, psychiatry has been criticised the most, both concerning treatment capacity and quality of treatment. The prison health services, and particularly the prison mental health services, should be considered against this backdrop.

At times, prisoners have to wait for outpatient and inpatient psychiatric services – as do the rest of the population. The quality of the professionals responsible for the assessment and treatment of mentally disordered prisoners in Norway equals that of those servicing the rest of the population. There is a certain shortage of psychologists and particularly psychiatrists in the country at large, which is consequently reflected in the prisons' mental health services. Psychiatric nurses constitute an important profession within the prison health services, both on the primary and on the specialist level. There is no formal specialist training for employees in the prison primary health service. However, the Directorate of Health and Social Services offers continued educational courses on a biannual basis.

In 2001 the prison primary health services were subjected to a formal inquiry into standard and performance by the government (Statens helsetilsyn, 2002). Thirty-four of the country's 43 prisons, serving about 80 % of the total prison population, were investigated. In this routine check-up a number of shortcomings, such as poorly functioning internal control systems, unclear definition of areas of responsibility, and unsatisfactory handling and storage of medicines, were identified. In addition to this, health workers were not confident as to how medical confidentiality should be handled in the prison setting, and medical records were in some institutions available to non-medical staff.

We have recently completed a descriptive study of all mental health consultations in six large Norwegian prisons, covering about one-third of the total prison population (Kjelsberg, Hartvig et al., 2006). Five out of six participating mental health services reported that the psychiatric therapy needs of the inmates were adequately met. On average, 20 sessions per week per 100 inmates seemed to be required in order to cover the prison population's psychotherapy needs adequately.

Even though some of the above results are encouraging, we have to acknowledge that the prison mental health services are far from perfect. We are presently in the process of conducting a large-scale user satisfaction survey in which prison inmates will be asked to evaluate various aspects of the health services they are offered while incarcerated. The results will, hopefully, enable us to further improve the quality of the prison mental health services.

### ***Ethical aspects***

The principle of medical confidentiality is regulated by Norwegian law and is observed within the prison setting, as in the rest of society. There are strict rules governing the boundaries between any medical professional's different roles – as a therapist, as a civil witness, as a professional witness, or as an expert witness appointed by the court (Sosial- og helsedirektoratet, 2004). Even so, some inmates are distrustful of health workers and are afraid they will “leak” information to the prison staff and/or other authorities. There have been examples of breaches of this confidentiality in the past. Such cases are subjected to reprimands. On the other hand, it is important that medical confidentiality does not hinder necessary communication between medical personnel and prison officers. These cases can usually be solved by asking the prisoner to absolve the health worker from his confidentiality bonds.

A delegation from the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has recently visited a number of Norwegian prisons (2005). They found the material conditions of the prisoners to be generally adequate but they made some critical remarks regarding the rights of people held in police custody. Their main concern was, however, the extensive use of isolation in prison, which is often upheld for extended periods of time. The delegation met some of the prisoners kept under such conditions and found that some of these displayed symptoms – including anxiety, sleeping problems, and depression – which could be attributed to this situation. In addition to this, the delegation expressed misgivings regarding the medical care of prisoners. With the high prevalence of mental disorders in the prison population they found clear indication for the regular presence of a psychiatrist, particularly in situations when restraints by means of seclusion or mechanical means were carried out. They also found it unsatisfactory that no nurses were present on week-ends and at night. They did also draw attention to the difficulties experienced in transferring prisoners in need of psychiatric care to a mental health institution, and, in some cases, their premature discharge from the health institution.

Like all Norwegian citizens, inmates have a right to complain if they feel that they have not received necessary medical attention, that the treatment received has been unsatisfactory, or that the medical confidentiality has been violated. These issues are regulated by the 1982 Municipal Health Services Act and the 1999 Patients' Rights Act. In these Acts the rights of the individual and proper complaints procedures are stipulated.

In this context, the Norwegian Parliamentary Ombudsman constitutes an important institution. It falls within his jurisdiction to protect and promote prisoners' rights. Usually, the ombudsman exercises his supervisory jurisdiction directly by dealing with complaints put forth to him by individual prisoners. But he can also deal with cases on his own initiative, including conducting visits to prisons. Ultimately, some prisoners, having felt that they have not been fairly treated in the Norwegian judicial and correctional system, have succeeded in bringing their case to the European Court of Human Rights in Strasbourg.

### ***Areas in need of improvement***

The fact that convicted offenders have to wait for a long time, sometime even years, to serve their sentence is unsatisfactory, also from a mental health perspective. The offender should be able to serve his time and get on with his life without undue delay. Furthermore, it is hard for the victim or his family to experience that the offender is “still a free man”. The correctional services do, however, try to prioritise the serving of serious sentences so that these are commenced without undue delay.

The use of isolation and other punitive actions with an inherent risk of deterioration on mental health should be minimised. As already stated, Norway has been receiving critical comments from the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. Since, we believe there has been a positive trend towards diminished use of isolation and long remand periods.

Keeping Norwegian prisons free of illegal drugs has proven hard to achieve. This is doubly unfortunate, as a number of prisoners may wish to use the incarceration period to sober up and stop their psychoactive substances abuse. To some, the incarceration period may represent a “golden opportunity” towards achieving this. But illegal substances are available, and sometimes even strongly pushed, within the prison premises. A continued strong effort should be put in force in order to keep our prisons out-of-bounds for illegal drugs. In addition, the current adaptation in Norway of the US Drug Court concept is promising. The goal of these drug courts is to stop the abuse of psychoactive substances and related criminal activity by offenders. The drug courts handle cases involving drug-addicted offenders by offering the person enrolment in an extensively supervised drug treatment program. In exchange for successful completion of the program, the court may dismiss the original charge, reduce a sentence, or offer some lesser penalty.

The importance of vocational and educational training of prison inmates can not be overestimated. Acquiring new skills and mastering of everyday living has a positive effect on the inmate’s mental health through improved self-confidence and self-adequacy and it also improves the likelihood of the inmate’s successful integration into society after release. Hence, these prison activities should be strongly promoted and further developed.

All newly incarcerated individuals are routinely approached by the general health services. Standardised assessment instruments are not in regular use. Nevertheless, a number of primary health services have developed their own checklists to be used as part of the initial evaluation of new inmates; these are most often self-report questionnaires. The quality of the health assessments may possibly be enhanced by more regular use of screening instruments that are aimed at detecting mental disorders.

With an increasing number of immigrants and refugees in the Norwegian society at large, the number of prison inmates with non-Norwegian cultural background has risen sharply. There are strong indications of increased mental health problems among these inmates. Whenever necessary, translation services have to be made available. Some non-Norwegian inmates will be extradited from the country immediately after release from prison. This situation, and various cultural differences, may make it difficult to establish a good and trustful therapeutic relationship.

A proper case referral and close follow-up at the local psychiatric out-patient department after release from prison should be secured whenever appropriate. This is an area with considerable room for improvement.

### ***Currently debated issues***

There is an on-going debate among Norwegian mental health workers about whether psychopathy is amenable to treatment or not. A number of individuals on preventive detention are assumed to be psychopaths. Serious violent and sex offenders are expected to follow correctional programs and group and individual treatment regimes, in order to qualify for release. Indirectly this implies that interventions are effective. Sadly, a number of these individuals are extremely difficult to treat. At the same time, society demands that these individuals enter rehabilitation and treatment programs: “-something has to be done”. Hence, sometimes programs and treatments are offered without proper knowledge about their effectiveness. Current research indicates that differentiation is crucial: any one program does not fit all.

A number of well publicised manslaughter cases have provoked society’s fear of the dangerous psychotic violent offender. This has provoked outcries like: “Lock them up!” Of course, these individuals exist. It is, however, important to put the problem into its proper perspective: most murders are in fact not committed by mentally disordered individuals. Nevertheless, society has a legitimate demand for all possible measures are to be taken in order to prevent these tragic occurrences. Contentions do exist: while society at large insists on long sentences in order to secure society from violent repeat offenders, those responsible for reintegration want the individual gradually re-introduced into the community.

After Rasmussen et al's publication on the prevalence of ADHD in Norwegian prisoners (2001) there has been an increasing demand for diagnostic evaluation and prescription drug treatment for this disorder in the prison setting. Presently, two open drug trials are being conducted, on methylphenidate and atomoxetine, respectively. There is an obvious need for further epidemiological and pharmacological research, in order to settle these issues.

The question about adequate mental health services to our prisoners is not only a question about allocation of financial and human resources. There is an urgent need for research into the effectiveness of the psychiatric interventions offered. Prison inmates are a diverse population with a variety of different needs. So in the end, as in most medical disciplines, the crucial question is: what works for whom? As always, the best and most effective cure is prevention. However, where should we concentrate our preventive efforts and where should we intervene most diligently: against the seasoned repeat offender, the prisoner serving his first sentence, the juvenile delinquent, the conduct disordered school kid or the unruly toddler in kindergarten? Should intervention concentrate on alleviating the imprisoned person's mental suffering or on preventing crime? And who should receive treatment: the rapist or the rape victim? Hopefully, we will have enough resources available to be able to intervene on all adequate levels simultaneously. Even so, these questions have far-reaching economical, legal and ethical implications.

### **Closing remarks**

Norway's official health policy is based on the fact that everybody living in the country is entitled to adequate healthcare. Everyone has this right, regardless of their socio-economic status, beliefs, race, age, gender or being imprisoned. According to this: are our prisoners' mental health needs adequately met? The answer is heavily dependent upon the ideals our society aspires to as well as upon the same society's willingness to allocate the resources necessary to achieve these goals - that is if such goals are indeed attainable. A society is often best judged by its ability to take care of those who fall outside the mainstream. In our opinion the Norwegian mental health care for prisoners is fairly good. Even so, as the above issues have demonstrated, there is definite room for improvement.

### **Acknowledgements**

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## Poland

Andrzej Kiejna, T. Hadrys, M. Ksel & J. Rymaszewska

### Introduction

The Polish Penal Code (1997) conditions the execution of a sentence on the soundness of mind of a perpetrator *tempore criminis* (Art. 31 §1: Anyone who, due to mental illness, mental retardation or other mental disturbance, is unable to control his/her behaviour during a criminal offence or apprehend its meaning, commits no crime). If, during preparatory proceedings or a court trial, appointed experts state that the perpetrator is not of sound mind, he or she shall not be charged, instead preventive measures shall be ordered in the form of psychiatric hospitalization (i.e. placement in a psychiatric hospital and not prison), where the perpetrator will stay as long as symptoms of his/her mental disorder are present (therefore, the length of stay is not defined a priori). Such instances are not within the scope of this text. However, according to the Penal Code, perpetrators with diminished responsibility may still be placed in prison (Art. 31 §2: If, during a criminal offence, the perpetrator's ability to apprehend its meaning or control his/her behaviour was considerably limited, the Court may order commutation of the penalty). Also perpetrators addicted to psychoactive substances are considered guilty and sentenced to imprisonment, unless during an offence they were in psychosis related to an addiction, such as delirium (Art. 31 §3. Provisions §1 and §2 are void if the perpetrator was in a drunken or intoxicated state leading to diminished responsibility, which he or she could have expected or anticipated). If, in fact, the perpetrator was in delirium or any other substance related psychosis, he or she is considered insane and free of all charges. Perpetrators with diminished responsibility due to a mental disorder or addiction face charges and are sentenced and, therefore, the procedures described herein pertain to them.

### Structure of the prison system

#### *Overall structure of the correctional system and its regional diversity*

The Polish prison system is uniform and defined by the regulations of the Penal Executive Code (1997), Prison Services Act (1996) and detailed executive acts resulting from these regulations. Therefore, there is no place for regional variability in the management of the prison system, in the forms of executing sentences, or local systems.

In the Polish correctional system there are two main forms of prison:

- Remand centres (RC)
- Penal Institutions (PI)

Imprisonment is executed in:

- Penal institutions for juvenile delinquents (convicts below 21 years of age),
- Penal institutions for convicts serving their first sentence of imprisonment,

- Penal institutions for penitentiary recidivists (adults sentenced to imprisonment for a deliberate crime or offence, who had previously served such a sentence),
- Penal institutions for convicts serving a military sentence.

A prison of any of these types may be:

- a closed unit,
- a semi-open unit,
- an open unit.

Closed units differ from semi-open and open forms of prisons, especially in the level of security and isolation of convicts and their obligations and rights regarding their mobility inside and outside of the facility resulting from this. There are also maximum security prisons (at present 16 units) for prisoners classified as “requiring placement in a closed institution, RC or PI with conditions guaranteeing the increased protection of society and safety of the remand centre or penal institution”. This especially pertains to “convicts sentenced to imprisonment for membership in an organized group or association aimed at committing crimes and convicts seriously threatening the safety of society or the safety of a penal institution”.

Penitentiaries are under the control of the Attorney General and may constitute independent institutions or be distinct divisions of remand centres or penal institutions (external divisions). One management unit may administer several penitentiaries. Some penitentiaries have special training centres for prison services personnel.

### ***Administration and personnel***

#### Central Executive of the Prison Services

The Central Executive of the Prison Services and all its subordinate units are governed by the General Director of the Prison Services, who is directly responsible to the Attorney General. He is appointed by the Prime Minister on the recommendation of the Attorney General. The General Director defines the role of the penal institutions. (Prison Services Act, 1996)

#### District Inspectorate of the Prison Services

The District Inspectorate of the Prison Services is governed by the District Director of the Prison Services. He is appointed to the post from amongst officers of the Prison Services and released from it by the Attorney General on the recommendation of the General Director of the Prison Services.

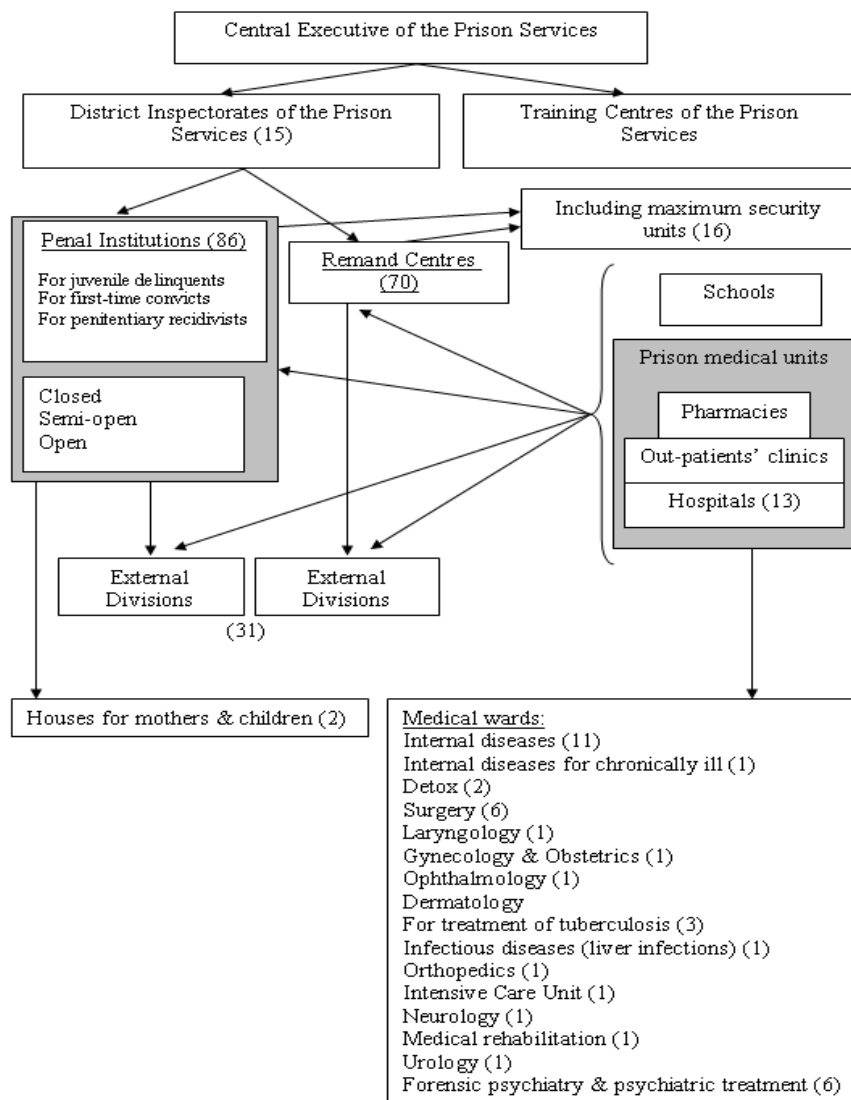
#### Remand Centres and Penal Institutions

The Directors of RC and PI are appointed from amongst officers of the Prison Services by the General Director of the Prison Services on the recommendation of the appropriate District Director of the Prison Services. Officers and employees (the latter not belonging to the uniformed services) are two distinct types of workers employed in the organizational units of the penal system. The scope of a post, the functions carried out and qualifications required are different for each of these categories of workers and are defined by the Cabinet and Attorney General. Officers and employees of the penal institution are superiors of the prisoners.

**Table 1: Officers and employees in prison services and their level of education (Brzostek, Mońska & Przybysz, 2006).**

Prison personnel (as of 31.12.2005)			Incl. ♀	Level of education				
				Higher Msc MA	Higher professional	Bachelor's	Secondary	Primary vocational
Officers & Employees		<b>24,980</b>	<b>4,194</b>					
Officers only	Officer	6,097	1,667	5,518	350	34	195	0
	Warrant officer	2,379	591	263	406	128	1,580	2
	Non-commissioned officer	15,212	1,268	348	562	606	13,548	148
Employees only		1,292	668					

**Figure 1: Structure of the penal system (number of units in parentheses, as for year 2005)**



### ***The capacity of the Prison System and the number of prisoners***

Mean number of places in all penitentiaries (as for year 2005; Brzostek, Mońka & Przybysz, 2006):

- In standard cells – 68,729 including
  - Remand Centres – 22,032,
  - Penal Institutions – 42,585,
  - External Divisions – 4,112
- In houses for mothers & children – 50
- In prison hospitals – 1,201
- In temporary accommodation units for convicts – 207

Mean number of temporally arrested, convicted and penalized (2005):

- Total – 82,761 (incl. ♀: 2,348)

The present number of inmates exceeds capacity by about 20 %.

### ***Quality control and protecting prisoners' rights***

All penal units are under the supervision of the Penal Commissions which operate inside these units. They are responsible to the penitentiary court.

#### Penitentiary judge

A penitentiary judge chairs the penitentiary court. He controls the lawfulness and correctness of the execution of sentences such as imprisonment, arrest, temporary arrest, custody and safeguard measures based on placement in a closed unit, safety measures taken during the execution of sentences, as well as coercive measures related to the deprivation of liberty. He may also order a psychiatric examination without the convict's consent. The penitentiary court may overrule decisions taken by penal commissions.

#### Penal Commissions

The director of a penitentiary appoints officers and employees of that institution to the penal commission. Other trustworthy persons may also be invited by the director to join the commission, but these persons only play an advisory role. This especially pertains to representatives of foundations, associations, organizations and institutions, churches and other religious assemblies.

The following lie within the duties of a commission:

- Referring convicts to an appropriate penitentiary and specifying the manner in which a sentence should be served unless the court has specified these,
- Defining individual correctional programs for convicts and evaluating their realization and the progress of social rehabilitation,
- Assigning prisoners to training courses and schools,
- Classifying convicts to maximum security units and reviewing these decisions at least once every three months,
- Reviewing individual correctional programs and individual therapeutic programs for convicts, as well as assigning them to and removing them from therapeutic divisions,
- Giving opinions on granting a convict leave or a reward.

Apart from the national control system described here, Polish prisons are also regularly controlled by international bodies such as the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). For more details see section "European prison rules and human rights in Polish prisons" below.

**Prison budget**

The following tables present different aspects of the prison budget. Mean exchange rate in each table as of 30.05.2006. 1€ = 3,94 PLN.

**Table 2: Prison budget – expenditure in 2005**

Budget		PLN	Euro
Total expenditure		2,318,694,000	588,994,335
Including	Prison system	1,682,534,000	427,397,058
	Monetary benefits	622,430,000	158,109,584
	Other activities	13,730,000	3,487,693

**Table 3: Costs of the functioning of the prison system in 2005**

Costs of functioning		PLN	Euro
Total expenditure		1,682,534,000	427,397,058
Including	Payments to private persons	74,079,000	18,817,538
	Wages	968,636,000	246,052,785
	Purchase of commodities and services	436,842,000	110,966,546
	Other running expenses	67,977,000	17,267,508
	Expenditure on property	135,000,000	34,292,682

**Table 4: Maintenance expenses per prisoner (in 2004)**

	Currency	Total	Daily	Monthly	Yearly
Maintenance expenses and functioning costs of penitentiaries	PLN	1,692,309,000	56	1,704	20,448
	Euro	429,880,103	14	433	5,194
Including running expenses (except wages)	PLN	448,012,000	15	451	5,413
	Euro	113,803,947	4	115	1,375

### ***Systems of executing sentences of imprisonment***

A sentence of imprisonment may be executed according to one of three different systems:

- programmed intervention – intended for juvenile, as well as adult offenders, who after having learned the sentence program consent to cooperate in its further development and execution; all interventions are intended to benefit the social rehabilitation of convicts.
- therapeutic intervention – intended for convicts requiring specialized psychological, medical or rehabilitation care, especially those suffering from non-psychotic mental disorders, mentally retarded, addicted to alcohol or other psychoactive substances, physically impaired. The sentence is mainly executed in therapeutic wards of the relevant specialty. The approach to a convict may be characterized by „prevention of deterioration of their psychopathological personality traits, restoring their mental stability and shaping their ability to live in society”. The execution of the sentence is fine-tuned to the needs of the convicts in terms of treatment, employment, teaching and hygiene.
- regular intervention – intended for the remainder of convicts, also for those who do not need to stay in the therapeutic division any longer. Convicts are free to participate in employment, learning, sport and cultural activities and opportunities available in penitentiaries.

Women serve their sentence in women's prisons, normally in semi-open units, unless their level of demoralization or safety reasons requires them to be placed in another type of unit. Pregnant or breast-feeding women have medical care ensured. In order to enable a mother deprived of her liberty to care for her child, there are two houses for mothers & children in two penal institutions. A child may stay there until it reaches 3 years of age.

#### Dealing with sexual offenders

According to new regulations of the Penal Executive Code (1997), the prison system is obliged to introduce a special therapeutic system for this group of convicts and such a system is available to them. It is strange that no corresponding therapy is available in public healthcare institutions, which could prevent the committing of sexual crimes and after liberation would be an extension or continuation of therapeutic programs initiated during imprisonment.

**Table 5: Convicted and punished according to different systems of executing sentences in different types of penitentiaries (as of 31.12.2005)**

Type of unit	System of intervention		
	Regular	Programmed	Therapeutic
Closed	17,059	16,281	3,119
Semi-open	14,577	15,214	510
Open	363	2,408	1
Total	31,999	33,903	3,630

**Table 6: Convicts qualified to therapeutic divisions (as of 31.12.2005)**

Category of disorder	Placed in the division	Qualified for the division, but temporarily placed outside
Non-psychotic mental disorders, mental retardation	1,709	222
Addiction to psychoactive substances	435	184
Addiction to alcohol	635	444
<b>Total</b>	<b>2,779 (♀ 156)</b>	<b>850 (♀ 43)</b>

## Medical services and mental health care in prisons

### General information

Medical services are fully available to prisoners in “medical units for persons deprived of their freedom”, which are all within the organizational structure of the penal system and individual penitentiaries. These units encompass out-patients’ clinics with sick rooms, prison hospitals, diagnostic laboratories, dentist’s rooms, prosthetics workshops, rehabilitation and physiotherapy wards. Medical units for persons deprived of their freedom are supervised by the Attorney General. Formally they are public institutions, but unlike civil institutions they do not have any autonomy, their own administration or accounting and are completely subject to the penitentiaries in which they are placed. Prison medical services are supervised by the Prison Physician-in-chief, together with a team of experts from the Central Executive of the Prison Services. In each of the 15 District Inspectorates of the Prison Service there is one Chief Physician of the District Inspectorate, whose duty is to supervise and coordinate the functioning of prison health care in that district.

Medical units for persons deprived of their freedom provide the following services:

- physical examination, laboratory diagnostics, counselling and treatment of disorders,
- psychological examination and psychotherapy,
- medical rehabilitation and nursing,
- care for women in pregnancy, labour, puerperium and care for newborn babies,
- inoculation and prevention of disorders,
- examination and dental treatment, prosthetics,
- certification of state of health

In justified cases medical services may be provided to prisoners by public medical institutions outside the penal system. The obligation of cooperation between prison and civil medical institutions is imposed by Article 115 of the Penal Executive Code (1997): „medical services, medicines and sanitary items are available to convicts free of charge; medical services are primarily provided to convicts by medical units for persons deprived of their freedom and civil medical institutions outside the penal system cooperate with them in providing necessary services, especially when:

- immediate provision of medical services is required, due to imminent danger to a prisoner’s life or health,
- specialist check-ups, special forms of treatment or rehabilitation are required,
- a prisoner is on leave or temporarily released from the penitentiary and requires medical attention.”

Detailed regulations, the extent and form of cooperation between prison medical services and civil medical institutions are defined by the Ordinance of the Minister of Justice and Minister of Health of September 10<sup>th</sup> 2003.

**Table 7: Number of medical consultations for prisoners in year 2005**

Medical consultations		Prison out-patients' clinics	Civil medical institutions (outside prisons)
General Practitioner (GP)		1,330,787	453
Dentist		266,097	646
Specialist	Surgeon	22,242	1,949
	of infectious diseases	1,341	433
	Internist	23,831	406
	Dermatologist	36,017	740
	of tuberculosis	5,040	524
	Gynaecologist	6,595	220
	Cardiologist	1,964	306
	Laryngologist	21,208	1,068
	Ophthalmologist	22,481	2,294
	Orthopaedist	9,430	866
	Neurologist	19,924	619
	<b>Psychiatrist</b>	62,476	615
	Urologist	2,437	505
	Other	8,188	3,347
<b>Total</b>		1,840,058	14,991

According to the table 7, general consultations for prisoners provided by civil medical institutions are rather rare (0.8 % of all general consultations for prisoners). In 2005 the largest number of consultations in civil medical institutions was provided by surgeons, laryngologists and ophthalmologists. Psychiatric counselling is primarily done within prison medical units (only 1 % of all psychiatric consultations were done in civil institutions). It also appears that psychiatric counselling is the most common specialist care provided to prisoners (62,476 consultations in 2005), almost twice as many as laryngological or ophthalmologic consultations (the second and third most common).

The main problem in cooperation between prison mental healthcare units and corresponding civil psychiatric institutions are the protracted procedures of transferring prisoners from penitentiaries and placing them in civil mental hospitals for psychiatric treatment. Such a procedure is used whenever a perpetrator is diagnosed by a psychiatrist as being insane tempore criminis and, as such, all charges against that person must be dropped. The court then orders a preventive measure in the form of placement in a civil mental hospital instead of penalty (see Introduction). The time that passes before an appropriate institution is assigned often exceeds several months and sometimes even more than a year, especially when the perpetrator is finally assigned to a standard civil mental hospital and not a top secured hospital under the jurisdiction of and financed by the Ministry of Justice. In such a case, a perpetrator who is not of sound mind according to law (and not guilty according to law) stays in prison in a psychiatric ward until he is assigned to a civil mental hospital.



***The availability, size and capacity of prison medical wards***

The penal system has at its disposal six psychiatric wards with a total capacity of 222 beds. The largest ward has 51 beds (RC Warsaw) and the smallest one 26 (RC Poznan). In total there are 26 full-time posts for psychiatrists. However, the actual number of psychiatrists employed is higher because of the fact that many are part-timers (see next section). Of the total number of psychiatric beds 47 are assigned to the treatment of mentally disordered prisoners (22 beds in RC Wroclaw and 5 beds in each of the other 5 penitentiaries). This means that approximately 21 % of the psychiatric beds available in prisons are used for treatment; the remainder are used purely for observational purposes. Tables 8 and 9 show that the need for treatment beds is greater than the number of beds supplied and that the beds used for observation are not being utilized at 100 %. The turnover of patients in treatment beds is very close to that of those in observational beds, yet there are almost 4 times as many observation beds.

**Table 8: Capacity and utilization of psychiatric wards in prisons (2003, according to data from the Healthcare Bureau of the Central Executive of the Prison Services).**

RC or PI	No. of beds	Full-time posts	Average No. of patients per psychiatrist	No. of patients according to % of bed utilization	
				Observation	Treatment
RC Cracow	35	3.5	10	82.00	222.74
PI Lodz	40	4	10	56.00	276.0
RC Poznan	26	3	8.7	58.00	169.00
RC Szczecin	28	3.15	8.8	83.00	80.00
RC Warsaw	51	7.5	6.8	86.07	134.41
RC Wroclaw	42	5	8.4	76.00	83.00
<b>Total</b>	222	26.15	8.8		

**Table 9: Patients in medical wards and sick rooms (outside medical wards) in 2005 (yearly report of the Healthcare Bureau of the Central Executive of the Prison Services).**

Medical wards / sick rooms		No. of beds (fixed capacity)	Patient turnover in 2005		No. of ill on the day of the report
			Admitted	Discharged or died	
Internal diseases		332	3022	2986	255
Detox		35	842	843	30
Treatment of tuberculosis		292	439	522	108
Surgery		179	1606	1610	111
Psychiatry	Observation	175	692	693	111
	Treatment	47	525	522	83
Orthopaedics		30	211	208	25
ICU		4	318	319	0
Laryngology		21	267	261	20
Obstetrics & gynaecology	Gynaecology	6	55	55	1
	Obstetrics	7	51	54	1
Neurology		40	113	123	19
Urology		18	162	171	6
Hepatology		19	110	113	11
Dermatology		30	131	131	14
Ophthalmology		18	84	84	12
Chronically ill		25	475	467	51
Medical rehabilitation		9	50	41	9
Total		1287	9153	9203	867
Sick rooms (outside medical wards)		863	2766	2732	209

**Medical and psychiatric personnel within the penal system****Table 10: Medical personnel in the prison healthcare system (as of 31.12.2005, based on data from the Personnel Department of the Central Executive of the Prison Services)**

<b>Prison healthcare staff</b>	<b>Full-time posts (no. employed in parentheses)</b>	<b>Incl. ♀</b>	<b>Incl. officers</b>
Physician	646* (1 203)	502	226
Including psychiatrist	59* (116)	51	13
Other higher staff	69* (90)	66	41
Nurse	827	745	785
Other secondary staff	102	83	70
Other	67	61	43
<b>Total</b>	<b>1,711</b>	<b>1,457</b>	<b>1,165</b>
For comparison: full-time posts in public civil mental healthcare institutions – hospitals and out-patients' clinics (2004)			
Psychiatrists and psychiatry specialists	2 649		
Nurses	8 150		

\* Many doctors (those who are not officers of the prison services) are part-time employees and are available for only a few hours a day or every other day. The most common place of primary employment of these doctors is a civil mental healthcare institution. Therefore, the actual number of psychiatrists working in prison mental healthcare is higher than the number of full-time posts and is hard to estimate. Probably, it is approximately 116 psychiatrists (there are about 1 203 doctors in total and about 90 other personnel with medical higher education qualifications).

The prison healthcare staffs have either higher education (doctors, psychologists, matrons) or secondary education medical qualifications (nurses). Candidates are carefully selected according to professional qualifications, personality traits (the following are desirable: resistance to stress, ability to adapt, control over emotions, good interpersonal skills and the ability to react appropriately to difficult situations). Staff cannot have been convicted. Medical staff (doctors, psychologists, nurses) occupying higher and middle posts in the prison healthcare system must have the professional qualifications for being an officer, warrant officer or non-commissioned officer. Such qualifications can be gained in the special training centres of the prison services and are confirmed by a certificate received after passing the relevant examinations. Also, a specified duration of employment in the prison services is required – the higher the post to be held, the longer the service required. For instance, the head of a medical ward has to have at least 8 years of work experience in the prison services, a senior assistant – 6 years. Psychologists must have additional professional training. Junior assistants (physicians and psychologists) and nurses, i.e. the lowest in the hierarchy of medical employees do not need to fulfil any special requirements (they are not required to have officer rank, any work experience in the prison services or any special training courses).

**The budget and financing of prison healthcare**

The reform of the Polish public healthcare system introduced in 1999 changed the model of financing the medical services under the jurisdiction of the Ministry of Health (financed from the National Health Foundation (NFZ) and not the state budget), but it did not affect the medical services provided within the penal system. Prison healthcare is still financed from the state budget and its financial needs are governed by the director of a given penitentiary, not from the NFZ. A similar situation exists in the case where medical services are provided to prisoners by civil public medical

institutions. Such services are also financed from the state budget, in particular from the Ministry of Justice budget. Detailed regulations pertaining to financing medical services for prisoners are presented in the Ordinance of the Cabinet of December 20<sup>th</sup>, 2004. When a prisoner is referred to a civil medical institution for consultation or treatment, all the amounts due are paid by the penitentiary unit where the prisoner is held.

The Prison Services budget has the following positions:

- purchase of medicines, dressings and other medical articles (15,271,366 PLN = 3,879,230 € in 2005),
- purchase of medical services from civil public medical institutions for prisoners not covered by national health insurance (6,648,013 PLN = 1,688,727 € in 2005).

Purchase of anti-retroviral agents (approximately 5,000,000 PLN = 1,270,099 €), which HIV-positive prisoners receive within the prevention program for patients with HIV launched by the Ministry of Health, is not financed from the prison services budget.

### ***Legal procedures of admission to a penitentiary (initial medical check-up)***

Each person admitted to a penitentiary is placed for a maximum of 14 days in a transitional cell for preliminary medical examination, sanitary procedures, preliminary personality assessment and to acquaint himself/herself with the fundamental legal acts on sentence execution and internal code of practice in the given unit. The preliminary medical check-up is a kind of screening performed by a physician (general practitioner) no later than three days after admission. It includes an interview with the prisoner and physical examination. This procedure is obligatory according to the Penal Executive Code (Art. 116; 1997). Additionally, within 14 days of admission prisoners have a dental check-up and chest X-ray carried out. If a prisoner's medical condition justifies it, a prison doctor may order secondary tests. There may also be a psychiatric consultation. However, there are problems in arranging such consultations in some penitentiaries, especially those located outside large cities where there is a lack of trained psychiatrists. During their stay in a penitentiary, prisoners periodically have medical examinations (for example, a chest X-ray is carried out at least every two years). Specialist consultations are provided to prisoners based on a written referral from a prison doctor, as well as from a civil general practitioner.

In order to individualise the approach to each prisoner, prisoners are classified according to information acquired during this preliminary screening. The following factors are taken into consideration: sex, age, previous sentences of imprisonment, intentionality of the offence, medical condition (physical and mental, addiction to alcohol or psychoactive substances), level of depravity and threat to the public, type of crime committed.

### ***Psychiatric and psychological examination, involuntary treatment***

When a prison physician, after having done a preliminary screening of a prisoner, suspects he or she might be mentally disordered, mentally retarded, addicted to alcohol or other psychoactive substances, then this doctor indicates the section or division within a penitentiary where this prisoner should be placed, defines further actions such as observation of behaviour and methods of dealing with the prisoner and refers the prisoner to a psychiatrist. Psychiatric consultations may also be provided on the written and justified request of the psychologist employed in a given penitentiary. Finally, the prisoner also has the right to seek a psychiatrist's or psychologist's attention at will. The prisoner is then subject to voluntary psychiatric or psychological examination. Should a prisoner refuse to be subjected to psychiatric examination, the penitentiary judge has the force to order such an examination. Psychiatric examinations are conducted in appointed diagnostic wards in remand centres or penal institutions (see above section "The availability, size and capacity of prison medical wards"). The goals of examination are:

- to understand the psychological and sociological grounds of pathological behaviour,
- to diagnose potential mental disorders,
- to decide on further treatment and rehabilitation.

Prisoners who have been diagnosed with addiction to alcohol or other psychoactive substances undergo voluntary treatment and rehabilitation. If such a prisoner refuses to be treated, the penitentiary court decides whether treatment should be carried out on an involuntary basis.

To summarise – prisoners are placed in psychiatric wards in prison hospitals in two main instances:

- if the court ordered psychiatric examination and observation (for example during legal proceedings when the offender’s mental condition needed assessment as to whether he or she was of sound mind tempore criminis),
- if an offender was convicted and sentenced to imprisonment and then diagnosed with a mental disorder requiring further examination or hospitalisation and treatment. In such a case admission to the psychiatric ward in the prison is based on referral from a psychiatrist and according to the provisions of the Polish Mental Health Act. For instance Art. 21 §1 states that „a person, whose behaviour suggests that due to a mental disorder he/she may either impose a direct threat to his/her own life or the life or health of other persons, or is not capable of securing his/her own basic needs, may be subjected to psychiatric examination, also on involuntary basis.” Similarly, Art. 23 §1 states that „a mentally disordered person may be admitted to mental hospital against his/her own will, only when his or her present behaviour suggests that due to a mental disorder he or she imposes a direct threat to his/her own life or the life or health of other persons. If this person refuses admission to mental hospital, direct compulsory measures are allowed.” (Mental Health Care Act, 1994)

If psychiatric observation and examination lead to the diagnosis of a mental disorder, mental retardation or other mental disturbances mentioned in Art. 31 §1 of the Penal Code (1997), in justified cases and based on the decision of the head of the psychiatric ward, a mentally disordered prisoner stays there until the court makes appropriate judgment. If the convict is considered legally insane tempore criminis and, therefore, not guilty according to law, the court should order transfer to a mental hospital outside the penal system (a preventive measure), where he or she shall be treated for his/her mental disorder until recovery and then released after a court order.

**Table 11: Number of medical opinions issued in 2005**

Psychiatric and forensic opinions	Leading to psychiatric detention	61
	Not leading to psychiatric detention	602
Medical certificates		10 753

***Procedures in emergency cases***

Autoaggression and rejection of food

Prisoners with self-inflicted wounds receive medical assistance appropriate to their medical condition. Prisoners who refuse treatment are placed, according to their medical condition, either in prison cells or sick rooms and stay under close medical supervision.

Prisoners who reject food have their blood pressure and heart rate measured and are weighed. A prison doctor decides on the frequency and extent of any medical intervention, necessary specialised laboratory tests and on the place of further stay of such prisoners.

Reasons for autoaggression and suicide are various. Some violent acts directed against oneself are induced by the prison administration (217 incidents in 2005), court or public prosecutor's office (81), pressure from the prison subculture (4) or being a member of this subculture (22). Other acts have a different background (449), some of which may be of a morbid nature. However, no detailed data are available.

**Table 12: Incidents of autoaggression (year 2005)**

Total	Food rejection	Autoaggression	Attempted suicide	Committed suicide
773	16	570	187	32

#### Suicidal tendencies

There are no special procedures or questionnaires for screening for suicidal thoughts or tendencies of prisoners. However, each newly admitted convict has a preliminary examination carried out by a doctor and is talked to by a counsellor or, should this be necessary, by a psychologist. It is obligatory for these professionals to enquire about suicidal tendencies.

#### Withdrawal syndromes

If a withdrawal syndrome requiring hospitalization develops, a prisoner is referred to the prison hospital ward (either detox or internal medicine). Should specialised medical intervention unavailable in the prison hospital be required, a prisoner is escorted by wardens to a civil medical institution outside the prison. Usually, withdrawal syndromes develop in prisoners addicted to alcohol.

#### Life threatening medical conditions

If a given penitentiary has no round-the-clock medical care or its own hospital wards, any acute states threatening a prisoner's life are then handled by a civil emergency unit. In all other cases medical assistance is provided by in a prison medical unit.

### ***Collaboration of medical and judicial institutions***

The previously described problem of protracted procedures of transferring legally insane offenders from prisons to civil mental hospitals illustrates the difficulties in cooperation between these two important public services. The fact that prison medical units are not financed and governed by the Ministry of Health constitutes another important problem in that public healthcare and penal healthcare are two incompatible systems. Therefore, cooperation at the ministerial level needs significant improvements.

## **EPIDEMIOLOGY OF MENTAL DISORDERS IN PRISONS**

### ***Availability and quality of epidemiological data on mental disorders in prisons***

Poland lacks appropriate and detailed epidemiological information on mental disorders in prisons. The main reason for this is the manual collection of all statistical data, because the long-awaited computer system has still not been introduced into the penal system. Moreover, due to numerous transfers of prisoners between penal units, reliable statistics are hard to collect. In 2003 the Healthcare Bureau of the Central Executive of Prison Services attempted to evaluate the mental condition of sentenced and temporarily held prisoners (Ksel, 2003)

A survey was conducted in eight penitentiaries. Interviews were performed by prison physicians during the routine preliminary examinations of newly admitted prisoners. In total 1,305 subjects were interviewed. The results give an impression of the epidemiological situation in prisons (see table 13).

**Table 13: Percent of prisoners with psychiatric diagnosis according to main ICD-10 categories before imprisonment and afterwards.**

Psychiatric diagnosis (ICD-10)	% of all prisoners	
	Before imprisonment*	After imprisonment**
F00-F09 Organic, incl. symptomatic, mental disorders	0.2	0.5
F10 Mental & behavioural disorders due to alcohol	3.2	5.3
F11-F19 Mental & behavioural disorders due to psychoactive substance	1.5	2.4
F20-29 Schizophrenia, schizotypal and delusional disorders	0.8	0.4
F30–F39 Mood (affective) disorders	1.5	0.7
F40-F48 Neurotic, stress-related and somatoform disorders	1.9	0.9
F60-F62 Disorders of personality and behaviour	1.8	3.7
F70-F79 Mental retardation	0.1	0.3
Other	0.4	0.2
No mental disorders	88.7	85.6

\* Data from medical records and interview with prisoners.

\*\* Diagnosis reached after the obligatory examination on admission to the penitentiary.

Analysis of the diagnoses extracted from medical records of newly admitted prisoners shows that mental and behavioural disorders due to alcohol use are most frequent. Second and third place are occupied by anxiety disorders and personality disorders. Mental and behavioural disorders due to psychoactive substance use and mood disorders (depression) are in fourth place. Schizophrenia, schizotypal and delusional disorders are relatively rare.

Analysis of the diagnoses made from preliminary examinations on admission to penitentiary gives similar information. The main difference is the underestimation of the number of prisoners with mood disorders, anxiety and schizophrenia, caused by not recognizing such disorders, despite them being diagnosed before imprisonment.

Prisoners who were diagnosed with a mental disorder during their preliminary examination were in most cases referred to a psychologist and/or psychiatrist. Only 1.8 % of them were not referred anywhere.

This survey unmasked the weaknesses of the diagnostic processes routinely used in penitentiaries. The percentages of prisoners diagnosed with a mental disorder on admission to penal units are significantly lower than the corresponding percentages in other countries. It is unlikely that the prevalence of mental disorders in Polish prisons is different from the prevalence in other countries. Therefore, it is possible that a significant proportion of mental disorders are not recognized. A relatively large percentage of prisoners admit to previously having problems with the heavy use of drugs and alcohol or having been treated psychiatrically in the past, yet are not diagnosed with any mental disorder or even addiction.

**Present epidemiological trends**

The Healthcare Bureau of the Central Executive of the Prison Services only monitors the prevalence and incidence of infectious diseases such as tuberculosis, AIDS and hepatitis. The incidence of tuberculosis has fallen in the recent past, while the incidence of HIV and AIDS is constant and stable. Annually there are 1,000 HIV infected prisoners within penitentiaries (taking into account the large

turnover of prisoners), the number of prisoners requiring anti-retroviral treatment is rising though. Over recent years there has been a constant increase of the number of inmates infected by hepatitis C.

**Table 14: Number of deaths in prisons over the last 16 years (actual numbers)**

Cause of death	Years 1989 - 2004															
	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04
Disease	79	59	67	85	65	56	36	59	44	68	65	57	88	54	86	69
Autoaggression															37	30
Suicide	21	27	29	25	17	22	18	17	39	38	32	46	47	37		
Self-harm	8	25	14	19	12	8	9	4	6	4	4	3	7	4		
Other	7	16	5	8	5	2	27	4	0	0	1	0	0	1	4	10
Total	115	127	115	137	99	88	90	84	79	110	102	106	142	96	127	109

Suicide rates are not routinely calculated, because there is still controversy regarding whether this rate should be calculated according to the static population of prisons or the dynamic one? For instance, in 2004 the static population was 80 thousand and the dynamic population 168 thousand (number of prisoners held for at least some time that year).

***Priorities in and the extent of epidemiological studies in Polish prisons; the main publications in this field***

There are very few epidemiological studies of the Polish prison population. Apart from the initiative of the Healthcare Bureau of the Central Executive of the Prison Services mentioned above, there is also a study by Sieroslowski et al. (2001). Due to the constant increase in the number of prisoners addicted to psychoactive substances between 2000 and 2003, the Institute of Psychiatry and Neurology in Warsaw coordinated a study by the Polish Committee for Scientific Research on drug addiction in prisons. The study by Sieroslowski (2000-2001) was aimed at describing this problem and investigated two populations: prisoners in therapeutic divisions and general prisoners. A representative, random sample of 1 186 men was examined. The results indicated that in Polish prisons, as in all other prisons in the world, there are drugs:

- 19.5 % of all those imprisoned occasionally used drugs before arrest (in the group of 17-24 year-olds, 30 %),
- the most popular drugs taken before arrest were: cannabis, amphetamine, ecstasy, and cocaine,
- 22.5 % of prisoners disclosed having had contact with drugs inside prison walls (in the group of 20-24 year-olds, 33 %),
- the most popular drugs inside prison walls are: sedatives and hypnotics used without doctor's prescription, cannabis and amphetamine,
- 3.3 % of prisoners admitted to having used intravenous drugs within prisons, of which 1 % used shared syringes and needles,
- drugs are more easily available in prisons than alcoholic beverages.



## QUALITY STANDARDS AND ETHICS

### *Education of personnel*

Medical staff working with mentally disordered prisoners, as well as all other medical personnel, regardless of their primary place of employment, are obliged to participate in CME (Continuous Medical Education). This obligation was placed on all doctors by general laws, mainly by the Physician's Profession Act (1996). Moreover, professional training courses organised by the Healthcare Bureau of the Central Executive of the Prison Services and the Forensic Psychiatry Section of the Polish Psychiatric Association are available.

### *Use of standardised questionnaires*

The psychiatric examination of a prisoner is usually based on a non-structured interview and a clinical evaluation of mental condition. This procedure is quite similar to the one employed in other mental health institutions. A doctor may choose to use a specific questionnaire or a structured clinical interview. However, there are no specific procedures or regulations in this respect. Moreover, there are no psychiatric questionnaires specifically for prisoners.

### *Medical data secrecy and confidentiality*

The medical confidentiality of the results of examinations and treatment of mentally disordered prisoners is not separately regulated and is subject to generally applicable laws. The official body in which a prisoner is serving his/her sentence has the right to peruse his/her medical documentation.

Article 40 of the Physician's Profession Act (1996) states that all information on patients gathered during a professional doctor's activities must be kept secret. Medical confidentiality may be restricted only when patient him-/herself or his/her legal representative approves, or when it is necessary to inform other medical personnel about a patient in order to provide the appropriate healthcare services. Medical confidentiality may also be overruled by a court or prosecutor (Art. 180 §1 of the Code of Penal Proceedings, 1997) However, there is a discrepancy in the laws regarding when a doctor may be interrogated as a witness in a court case. Article 180 of the Code of Penal Proceedings allows such a possibility, yet Article 52 of the Mental Healthcare Act (1994) does not permit the interrogation as a witness of any person obliged to keep medical confidentiality as to whether, during medical interventions allowed by the act, a mentally disordered person confessed to a crime. The same also pertains in the situation where a doctor acts as an expert appointed by an authorized body to issue a psychiatric opinion in court.

The report of the CPT (2004) states: "the confidentiality of medical information is generally respected. Only health-care staff have access to prisoners' medical files. Furthermore, prisoners' medical examinations in general take place without the presence of non-medical prison staff (except for N-status prisoners i.e. dangerous ones)".

### *European prison rules and human rights in Polish prisons*

The European Minimum Rules are in general observed. The major problem regards minimum space per prisoner. European norms in this respect (3m<sup>2</sup>), as well as norms set forth in the Polish Penal Executive Code are not kept because of the overcrowding of penitentiaries (the prison population is 120 % of the norm). This problem was mentioned in the last two reports of the CPT.

The functioning of the penal system and healthcare for prisoners is constantly monitored by many independent institutions. Prisons are regularly visited by penitentiary judges and representatives of the Commissioner for Civil Rights Protection, who observe whether human rights are respected. Moreover, international bodies, such as the CPT mentioned above, also observe Polish prisons. There have been three visits of the CPT over the last 12 years. After each visit a detailed report on the observance of human rights and rights of mentally ill prisoners was issued. The most recent

report of the CPT on Polish prisons was generally positive. However, there were minor reservations and suggestions, namely:

- The health-care team should be reinforced and, in particular, the nursing staff resources should be substantially increased in some prisons.
- It should be ensured that someone qualified to provide first aid, preferably with a recognized nursing qualification, is always present on the prison premises, including nights and weekends.
- Measures should be taken to ensure that all newly arrived prisoners are seen by a health-care staff member within 24 hours of their arrival, because there were instances when this obligation was not fulfilled.
- Steps need to be taken to ensure the respect of the principle of medical confidentiality during the medical examination of “N” status prisoners (dangerous ones), who have been medically examined in the presence of prison guards. Special security measures may be required during medical examinations when a security threat is perceived by the medical staff but there can be no justification for prison guards being systematically present during such examinations.
- A comprehensive policy for the provision of care to prisoners with drug-related problems should be developed and implemented. The CPT considers that such services should be varied, combining medical detoxification, psychological support, life skills, together with rehabilitation and substitution programmes for opiate-dependent patients. Furthermore, they should be associated with a policy of prevention.
- Steps need to be taken to ensure that an individual approach is followed as regards patients’ clothing in forensic psychiatry wards (patients in a forensic psychiatry ward were dressed in pyjamas around the clock, even when taking exercise outdoors). Individualisation of clothing should form part of the therapeutic process.
- CPT invites the Polish authorities to further develop psycho-social therapeutic activities for patients in forensic psychiatric wards, in particular for those who remain there for extended periods and to introduce a more therapeutic material environment.
- Improve the state of patients’ rooms in psychiatric wards: the living space in patients’ rooms is unsatisfactory (e.g. nine prisoners in a room measuring 33 m<sup>2</sup>), the rooms are in a rather poor state of repair and cleanliness, as well as furnished in an austere manner.
- The Polish authorities are invited to review the practice observed in some prisons of prison doctors treating both prisoners and prison staff. The resources allocated to the medical care of prisoners are often limited and the sharing of doctors’ working time could be to the detriment of the quality of the care provided.
- During the 2004 visit, the delegation heard a number of complaints from prisoners concerning the possibilities of transfer to hospital facilities outside the prison system for treatment. It appeared that in practice such transfers were rarely authorised and only for persons at an advanced stage of a terminal disease.
- Comments from the Polish authorities on the delays in transferring patients from forensic psychiatric wards at remand prisons to maximum security civil hospitals are required.

### **Problems of the penal system – resume**

- Overcrowding (population increase of about 50 % between 1999 and 2004),
- Increase in the number of offenders committing serious crimes and members of organised criminal groups,
- Shortage of personnel, including medical staff (the number of officers in the last 5 years has only increased by 2.6 %),
- Lack of financing and indebtedness of the system,
- Obsolete prison buildings (only 23 % of all prison buildings were built after the Second World War),
- Living space per prisoner is too low (<3m<sup>2</sup>),
- Difficulties in achieving adequate standards for the isolation of prisoners,

- The budget for prisoners' healthcare does not enable the modernisation of medical equipment,
- Increase in epidemiological threats such as infection with HIV, HCV, HBV in prisoners taking drugs intravenously,
- Overcrowding leads to the decreased availability of medical services and to work overload for medical staff,
- Lack of adequate cooperation between the judicial system and civil healthcare, especially when it comes to transferring mentally disturbed, in the eyes of the law, offenders from prison medical wards to civil mental health hospitals.

Prison healthcare needs to be reformed. The wages of prison officers are no longer competitive compared to wages in civil institutions and that is why medical personnel have been constantly drained from the system for several years. Moreover, leaving the prison health service as a tiny unit in the budget sector, when the health service is funded by a completely different system leads to the problem of the incompatibility of the two services.

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## Portugal

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### Structure of Prison System

#### *General organization*

Portugal's prison services are administered by the Directorate-General of Prison Services (DGSP), which answers directly to the Ministry of Justice. The DGSP's mission is to: i) direct the services that are involved in detaining prisoners and executing sentences and security measures; ii) superintend their organisation and operation; iii) conduct studies, propose measures and define working rules and techniques concerning the treatment of inmates; and iv) foster the vocational education and training of, and the acquisition of working habits by, inmates.

The prison services are publicly funded, although the DGSP possesses the autonomy to generate income from its own sources, which must then obligatorily be used in certain areas laid down by law, such as investments in improving the quality of the prison services themselves.

The latter's organisational structure was defined at the beginning of the 1980's by Executive Law no. 268/81, dated 16 September 1981. The Law says that the DGSP shall be composed of **management bodies** and **services**. The management bodies, which possess specific competencies and functions, include the Director-General (who is assisted by four Deputy Directors-General), a Technical Board, an Administrative Board and a Consultative Board. The DGSP's services (or departments) contain a variety of organisational structures, which are known as support services and operational services, including the Directorate of Health Services (DSS).

#### *Prison facilities*

Prison Facilities (EPs) fall under the direct authority of the Director-General and are divided into three categories: i) **central**; ii) **special**; and iii) **regional**. The central EPs are responsible for inmates who are sentenced to prison terms, while the special EPs are intended for the populations of women and young people. The regional EPs hold the inmates who are on remand, although the lack of prison places means that many inmates who have already been sentenced remain there too. Central and special facilities are managed by a Director, a Technical Board and an Administrative Board, and have access to a medical assistance service. Regional prison facilities are managed by a Director and a Technical Board, and are supposed to possess the staff needed to provide medical assistance.

According to the data that was published in the recent report on the work of the DGSP (2006), the Portuguese prison system includes 56 Prison Facilities (EPs), of which 17 are central, 34 are regional, 4 are special (for women, and young men) and one is a Support Prison. We are currently awaiting the operational start-up of a high security prison facility that is entirely reserved for inmates with special security needs (Monsanto Special Prison Facility – EPEM), which is expected to hold 142 people.

The annual data since 2000 shows an average prison population of 13,288, with a peak occupancy rate of 120.1 % in 2002 (table 1). In 2004 the EPs possessed 12,435 homologated places and the occupancy rate was 105.8 %. However, the closure of certain units due to poor housing conditions meant that the actual capacity was only 11,413 places and the real occupancy rate was 115.2 % – about nine percentage points above the European Union average (106 %). Despite the improving trend, this is undeniably one of the most significant problems facing the Portuguese prison system.

**Table 1: Occupancy rate of the Portuguese EP's**

Year	Prison population	Homologated places	Occupancy rate (%)
2000	12,771	11,221	113.8
2001	13,112	11,372	115.3
2002	13,772	11,465	120.1
2003	13,635	12,109	112.6
2004	13,152	12,435	105.8

Source: DGSP, 2006

The occupancy rates for the various types of EP differ: for the central EPs it was 109.2 %, for the special EPs 96.7 %, and for the regional EPs 136.2 %. Only 15 EPs were not overcrowded. We should note that the most notorious overcrowding occurs in the regional EPs, in some of which the occupancy rate exceeds 200 %. This overcrowding is due to the lack of places for sentenced prisoners, who therefore have to stay longer in regional facilities.

### **Characterization of the Portugal's prison population**

On 31 December 2004 Portugal's prisons held a total of 13,152 inmates (table 2) – a slightly lower figure than those for the preceding years (a variation of -3.5 % in relation to 2003). The number of inmates on remand has been falling, which has meant more places for sentenced prisoners.

**Table 2: Prison population**

Year	On remand		Convicted		Total	% annual change
	n	%	n	%		
2000	3,854	30.2	8,917	69.8	12,771	-0.3
2001	3,690	28.1	9,422	71.9	13,112	2.7
2002	4,219	30.6	9,553	69.4	13,772	5
2003	3,492	25.6	10,143	74.4	13,635	-1
2004	3,000	22.8	10,152	77.2	13,152	-3.5

Source: DGSP, 2006

In gender terms 92.9 % of the prison population was male and 7.1 % female. The 25-to-39 year-old band contained the largest number of inmates of both sexes. The average age of the population was 35.4 years, although the age structure does display a relative predominance of males above the age of 50 (10 %), compared to young inmates aged below 21 (4 %).

Foreign citizens made up 17.3 % of the total. Of these, the majority were of African nationalities (54.4 %), followed by Europeans (26.7 %) and persons from other continents (18.9 %). In terms of schooling, nearly half (48.9 %) the inmates had not completed compulsory education (9<sup>th</sup> grade) – a situation that is even more serious among female inmates, of whom 35.9 % had completed no more than the first basic education cycle (4<sup>th</sup> grade).

Where the type of crime is concerned, we find that crimes against property were the most frequent (32.5 %), followed by crimes involving narcotics (28.8 %) and crimes against people (24.2 %). It is

worth noting that in the last five years the proportion of crimes involving narcotics has been falling, while that of crimes entailing violence towards people has been on the rise.

As regards the length of sentences, more than half (57.6 %) the prison population is serving terms of between 3 and 9 years, with a substantial proportion (34.9 % of the total) serving between 3 and 6 years. Having said this, the relative weight of the inmates who are sentenced to more than 9 years imprisonment (21 %) is greater than that of those sentenced to less than 3 years (19 %).

### **Quality assurance**

Internally, the Audit and Inspection Service (SAI), which reports directly to the Director-General, is responsible for guaranteeing inmates' fundamental rights and the quality of their treatment in prison. As part of its mission the SAI brings disciplinary and assessment proceedings, draws up formal reports when asked to do so by the EPs, carry out audits, and monitors prison occupancy. A substantial part of the SAI's work involves the inspection of prison facilities from both a general and a sectoral point of view.

Over and above the internal control conducted by both the Audit and Inspection Service and the Ministry of Justice (Inspectorate-General of Justice Services – IGSJ) itself, the various different areas of the DGSP's activities are monitored by external control bodies: the Sentence Execution Court (TEP), which evaluates both appeals against disciplinary decisions concerning inmates and the latter's complaints; the Ombudsman; and the Assembly of the Republic (Parliament), acting either via Parliamentary Committees or on the initiative of individual Members of the Assembly.

If there is to be a continuous improvement in quality, it is essential to know the perspectives of both prison inmates and prison directors (Torres, 2001).

The inmates say that the most negative aspects of living conditions are: 1) the food (46.2 % say that it is bad); 2) the health services (32 % consider that they are bad and 19.2 % that they are insufficient); and 3) the accommodation (30.4 % consider that it is bad and 14.4 % that it is insufficient).

Their greatest concerns include communicable diseases (64.8 % are very concerned), overcrowding (59.4 % are very concerned), and drugs (39.7 % are very concerned, albeit 32.1 % say that they are not concerned at all). Drug users are much more sceptical as to the efficacy of greater control and surveillance as a way of stopping drugs from getting into prison. The majority of inmates consider that the following are the most important measures where drug addiction is concerned: easier access to therapeutic programmes (81.3 %); the creation of more drug-free wings/units (66.9 %); easier access to substitution programmes (65.4 %); increased surveillance (63.6 %); needle exchange programmes (51.0 %); and assisted injection rooms (40.4 %).

The opinion of prison facility directors differs significantly from that of inmates in a variety of areas. When it comes to living conditions in prisons, they mainly highlight positive aspects as regards both food (55 % consider that the food is good and 45 % that it is reasonable) and quality of accommodation (22.5 % consider that the accommodation is good and 40% that it is reasonable). The directors are mainly concerned with the lack of funds (77 % are very concerned), drugs (48.8 % are very concerned), communicable diseases (48.7 % are very concerned), and overcrowding (39.5 % are very concerned).

As regards the relationship between drugs and prison, the directors corroborate the opinions expressed by the drug users: 92.5 % of directors consider that it is very difficult to control the entry of drugs into prisons. However, they do think that it is important to implement the following measures: holding training actions on the issue of drugs for both prison staff and inmates (90.2 %); easier access to therapeutic programmes (92.5 %); increased surveillance (67.5 %); and easier access to substitution programmes (66.7 %).

## **Budget**

The executed budget for 2003 involved total expenditure of 219,049,828 Euros, of which staff costs made up 136.1 million Euros, operating expenses 62.9 million Euros, and capital expenditure 8.1 million Euros (80 % of staff costs were funded by the State Budget and 20 % by the Institute for the Financial and Asset Management of the Justice Ministry – IGFPJ). If we combine these figures and the average prison population, the resulting daily cost per inmate was 41.30 Euros.

## **Medical Services and Mental Health Care Provision in Prison**

### ***Service facilities and staff***

The Directorate-General of Prison Services has its own Health Directorate, which organises the provision of healthcare in prisons. We are currently awaiting new legislation that will incorporate prison healthcare into the general National Health Service (SNS). Once it is in place this new law will standardise healthcare for every citizen, be he/she a prison inmate or anybody else.

The Health Directorate's main objectives are to ensure that every inmate is adequately provided with healthcare, to promote the acquisition of healthy lifestyles, and to implement measures designed to detect and prevent communicable diseases and drug addiction. Its function is to establish rules, while supporting and supervising (where necessary) the work of the health services in prison facilities.

An existing analysis of various surveys shows that when they enter the prison service, inmates display high levels of morbidity that are reflected in the existence of a large number of communicable diseases (AIDS, hepatitis, tuberculosis) and addictions to drugs. The realisation that this is the situation led to a proposal for a new model for the organisation and operation of the provision of healthcare in a prison environment, which was made in the wake of the issue of Joint Ministerial Order no. 33/03, dated 10-12-2002. The essence of the latter is based on technical oversight by the Ministry of Health on the one hand, and the responsibility of the Ministry of Justice for providing the necessary logistical resources and for ensuring the functionality and articulation of the various sectors involved on the other.

The technical committee that was appointed to study and propose the measures needed to implement the new organisational healthcare model selected the following ten areas of intervention in which to cover the health needs of the inmate population: public health; health promotion; general care (general clinical care, specialist areas, hospital inpatient care, and emergency treatment); tuberculosis; communicable viral diseases; drug addictions; mental health; oral health; auxiliary means of diagnosis; and medication.

Within these areas it was established that the first priority should be the prevention and treatment of drug addictions and communicable diseases. This has led to various interventions, the most significant of which are: AIDS research/action projects in a prison environment; programmes that target abstinence and the pharmacological substitution of drug consumption; and participation in the Substitution Treatment in European Prisons (STEP) programme, which is backed by the European Commission.

Healthcare is directly provided by the health units in the various prison facilities, some of which have infirmaries that cover various prisons in their geographic area. When the needs exceed the response capacity of the prison health services, inmates are sent to National Health Service institutions. This is equally true of medical/surgical emergency situations and cases that require technically complex therapeutic treatment which is not available in prison.

The overall prison healthcare staffs is composed of 42 hospital doctors (7 of whom are psychiatrists), 29 psychologists, 97 nurses, and 38 diagnostic technicians and medical auxiliaries. In addition to the health units in each prison facility, the size of which is proportional to the number of places in each institution, the Health Directorate also has some larger units that take inmates from prison facilities

within a given geographic area that possess fewer health resources of their own: a) São João de Deus Prison Hospital (in the Lisbon area), which has inpatient (surgery, clinical medicine, infectiology, psychiatry) and outpatient departments; b) the psychiatric and mental health department at Santa Cruz do Bispo Prison (in the Oporto area); c) infirmaries at Alcoentre, Funchal, Leiria, Linhó, Lisbon, Paços de Ferreira and Oporto Prisons.

The universe of health units possesses 196 beds, 27 of which are in psychiatric infirmaries. Specifically in the mental health area, the format under which care is provided is the same as that in other health areas in Portugal – i.e. a mixed model.

Prisoners may receive mental healthcare from one of the country's two special prison service mental health inpatient units (São João de Deus, Santa Cruz do Bispo), from external general NHS mental healthcare services, or even from private psychiatrists who are recruited to work on a part-time basis (only available in some prisons).

In the event that the existence of a mental disturbance is suspected, either the prison doctor or a psychiatrist conducts an initial assessment. If such a situation is confirmed and inpatient care is required, the inmate patient can be sent to one of the two psychiatric inpatient units that exist in the country.

The major reason for referrals of mentally ill prison inmates to civil mental health care services is the request for hospitalisation when psychiatric prison wards have their capacity exceeded or psychiatric emergencies arise (suicide attempts, agitation, etc).

Another area of large cooperation between civil mental health and prison services is drug addiction: there are one protocol between the Drug Addiction Institute (IDT) and the General Directorate of Prison Services to cooperate in the delivery of care for addicts inmates. Within this field a variety of resources and interventions are available, including: Drug-Free Units (ULDs); Treatment motivation programmes; Methadone substitution programmes; Antagonist programmes; Facilitated access for prison inmates to treatment programmes promoted by the Drug Addict Reception Centres (CATs) and/or NGOs (which must have a formal protocol with the NHS).

There are currently seven Drug-Free Units (Leiria, Lisbon (2 units), Oporto, Santa Cruz do Bispo, and Tires). These are spaces which are physically differentiated from and independent of the normal prison areas and receive inmate addicts with the motivation to abstain from drugs. In these residential units the treatment programme lasts for an average of 18 months and incorporates educational, occupational and therapeutic activities. It is conducted in a group context, thus offering a background against which to learn and try out personal and social skills that facilitate and promote the organisation of a drug-free lifestyle.

The treatment motivation programme seeks to structure and consolidate the addict's adherence to a future treatment that is designed to achieve both a general change in lifestyle and abstinence.

The methadone substitution programme seeks to put a brake on the deterioration that is caused either by drug use when the addict proves incapable of changing his/her behaviour, or by the existence of serious illnesses that make such a change difficult. Except for the Lisbon, Oporto and Tires EPs, which possess their own capability, the pharmacological drug substitution programmes in the various prisons are articulated with the (NHS) Drug Addict Reception Centres, which provide technical guidance.

The antagonist programme uses a medicine that blocks the opiate receptors in the organism, thereby preventing heroin and/or other opiates from taking effect. In various prison facilities the pharmacological approach is complemented with support of a psychological/psychotherapeutic nature.



### ***Pathways and delivery of care***

Beyond the health care prison services, only the public health services, belonging to the National Health Service (NHS), are eligible to treat prisoners: i. the emergency room may assess referred prisoners anytime due to emergent episodes (self-harm, suicidal behaviour), ii. when psychiatric prison wards have their capacity exceeded, hospitalization may occur in a psychiatric ward from the NHS and iii. drug addicted inmates under treatment may be referred to facilities belonging to the Drug Addiction Institute (IDT), such as therapeutic communities or out-patient clinics.

Concerning the process of evaluation and delivery of care, mental health assessment and screening at prison admission is not mandatory. However, where this is given (always by a psychiatrist or psychologist), it always employs the same format as that used in the assessment of any NHS patient, including the exploration of events such as previous psychiatric inpatient treatment, suicidal behaviour, alcohol and/or drug abuse and so on.

In a similar way, regular reassessments/screenings are not mandatory, unless there is a recognized need to do that (previous psychiatric history, court order, etc). In these situations, the prisoners' mental status assessment is conducted when requested by the prison general physician. The regularity of re-assessments depends on clinical grounds, and all the information has to be recorded in the patient file.

The rules of confidentiality are the same as for any other patient (all citizens have the right to confidentiality regarding clinical status, diagnosis, etc. – this is an obligation to all the staff/people involved in care delivery).

Regarding the pathways to psychiatric treatment, the approach may be different according to the clinical condition. In the event of an acute psychotic episode or a suicide attempt, after an initial assessment conducted by the prison general physician or nurse, the inmate is referred to the prison psychiatrist (if one is available, which depends on the size of the prison). If the prison has no psychiatrist (not even a part-time one), the inmate may be referred to a prison psychiatric service (in Lisbon or in Oporto).

If the situation is urgent (i.e., agitation, suicidal risk etc), the inmate may be immediately referred to a NHS emergency room (the assessment there is conducted by a psychiatrist belonging to the NHS). In the event of alcohol or drug addiction with acute withdrawal symptoms, if the prison physician is not able to deal with the situation (i.e., cardiovascular problems /complications), the inmate is referred to an NHS emergency room. While staying at a NHS facility, the inmate is permanently surveilled by prison guards.

The pathways to care are similar whether the acute episode occurs at the moment the inmate is admitted to prison, or later on during the course of his/her imprisonment.

There are no specific procedures stipulated for persons with specific behaviour other than the above-mentioned disorders (e.g. personality disorder, violent behaviour), no matter the disorder or behaviour is diagnosed during an initial assessment at entry into prison or later on, during imprisonment.

Concerning access to care, while there are no waiting lists, sometimes there are delays for referrals of mentally disordered prison inmates to medical/psychiatric prison wards. The major reason for delays in access to prison wards (medical/psychiatric) is the shortage of beds, although in this case the hospitalization may be done at civil inpatient units. Other reasons for delays include obstacles caused by bureaucratic procedures like hierarchical authorizations, transportation difficulties, etc. Usually these delays last just a few days.

In summary, if there is a confirmed need for inpatient treatment, it takes place in a psychiatric infirmary which in principle will belong to the prison system. Treatment can be administered voluntarily or involuntarily: the legal framework governing compulsory inpatient care (Law 36/98,

dated 24 July 1998) can be applied to EP inmates whenever the preconditions laid down by the mental health law are met (Xavier, 2002; Talina, 2004).

At the moment there are no specific programmes for sex offenders. However, the DGSP has taken part in the Project on Sex Offenders, which was created in 2002 by the Council of Europe's European Committee on Crime Problems and which is expected to present guidelines for good practices in the field of the therapeutic approach to convicted sex offenders. In Portugal, offenders suffering from borderline personality disorder or dissocial personality disorder are usually placed in prison.

Despite the attempts that have been made to improve the situation in recent years, the mental healthcare that is available in our prisons suffers from some very significant limitations, particularly in the psychosocial, psychotherapeutic and specific programme (e.g. sex offenders, eating behaviour disorders, personality disorders etc.) areas.

### **Epidemiology of mental disorders**

In the mental health field no standardised system for recording cases is currently operating in the Portuguese prison system. There is therefore a huge shortage of epidemiological data, both at the level of the pattern of use of the relevant services, and in terms of the occurrence of warning events and the typology of diagnoses.

As regards the use of services, the available data concern the Prison Hospital S. João de Deus, which receives psychiatric cases for assessment/treatment from all of the country's prisons. In 2005 the psychiatric service had 114 inpatients with a mean length of stay of 61 days.

If we look at warning events, the most relevant available data refer to the number of suicides that occur in Portuguese prisons. Suicide is the second most frequent cause of death, the first being that which is generically classified as "illness" and encompasses all the other causes of an organic nature (in 65 % of cases, these are problems related to HIV infection).

According to the available reports the number of deaths by suicide has been rising in the last few years (2002–12, 2003–15, 2004–21), in opposition to the tendency towards a decrease in the overall number of deaths in a prison environment (2001–106, 2002–97, 2003–100, 2004–84) – a fact that is a source of concern for the prison authorities.

When it comes to the prevalence of psychological symptomatology (general morbidity), a study of 116 female inmates in a prison in the north of the country using the Brief Symptom Inventory revealed that 60.3 % of cases possessed a significant symptomatology (Marins, 2005). The predominant aspects present in the sample group were obsessive-compulsive, psychotic, depressive, anxiety-related, and somatic symptoms.

In the nosological field the area that has been most widely studied in a prison environment is drug addiction. One of the largest studies with a national scope that have been conducted in this area (2,601 people in 47 prison facilities) permitted an assessment of: i) the relationship between the reason for the imprisonment and drugs; ii) the profile of the drug users; and iii) their consumption practices (Torres, 2001). In relation to i) it was found that 72.9 % of all the subjects were imprisoned for drug-related crimes – a percentage that rose to 80.3 % among re-offenders. 65.4 % of all inmates said that they had taken drugs at some point in their lives, with an average age of 18 the first time (an average of 21 in the injectable sub-group). The most widely used substances in this group were cannabis (96.4 %), heroin (84.1 %), and cocaine (84.4 %).

Where consumption in a prison environment was concerned, 39 % of inmates said that they had used cannabis, 27 % heroin, and 20 % cocaine. Only a small number of respondents said that they had started taking drugs in prison (4.4 % for cannabis, 4.9 % for heroin, and 3.1 % for cocaine) – the only significant figure in this respect involved the consumption of commonly used psychopharmacological drugs (17.9 %). As regards the forms of consumption, 11 % of all the

inmates who responded to the survey said that they had already injected themselves in prison, despite a tendency to move from injectable use to inhalation, particularly in the case of cocaine and heroin. If we compare these data to previous studies (Rodrigues, 1989), they seem to reflect a trend towards a worsening of drug use in prison.

A more recent study (Justice/Health Working Group (GTJ/S), 2006), which was carried out as part of the 'National Action Plan to Combat the Propagation of Infectious Diseases in a Prison Environment', assessed the types of consumption in ten central EPs, two special EPs and eight regional EPs (total population – 10,182 inmates). It was found that: i) 40 % of inmates took drugs; ii) cannabis was the most widely consumed drug (52.5 %); iii) half the consumers used various drugs; iv) 31.8 % of users took cocaine; and v) 30.5 % of users took heroin.

### **Quality standards and ethical aspects**

The academic differences between the various mental health professionals who perform functions in the prison environment are the same as those in the community. The minimum academic requirement for psychiatrists and psychologists is a "licenciatura" (an extended initial university degree) and for nurses a "bacharelato" (a short initial university degree). Medical auxiliaries must have completed at least the 9<sup>th</sup> grade.

Health professionals do not have to undergo specific training for a prison environment, and the shortage of staff willing to work in this context means that virtually none of them have done so when they begin working in prisons. The Directors of the EPs and the Directorate of Health Services (DSS) are jointly responsible for selecting these professionals and motivating them to undergo such training.

Where the procedures for assessing patients' mental states is concerned, there is no mandatory requirement to employ specific assessment instruments and each individual service is free to choose the ones they feel most appropriate.

The confidentiality of inmates' clinical files is protected by the same legal principles as those that apply to ordinary citizens, which restrict access to the health professionals who are involved in caring for the person in question. However, there are two exemptions from this duty of medical confidentiality – threatening harm to others, and suicidal behaviour – when a court can release a doctor from this duty.

The European Prison Rules, which the European Union countries adopted in 1987, are followed in their entirety in Portugal and any deviation from them automatically entails attention from both internal and external supervisory bodies.

In addition to the public bodies we have already mentioned in item 1.3, various private organisations are also involved in evaluating the conditions under which inmates are held and in defending their rights. At the international level we should particularly point to the European Observatory on Penal Execution and the Criminal Justice System, and Amnesty International. Domestically we should note the Lawyers' Guild's (OA) Human Rights Committee (CDH), Forum Justice and Liberty (FJL), and the Prisons Observatory (OP). These bodies, which tend to have a major impact on public opinion, frequently receive complaints from inmates and promote the defence of their legal rights.

### **Professional training and research**

Mental health care provision in prison is not usually covered during the regular psychiatric training in medical schools or universities in Portugal. Despite this, research is increasing during the last years, even if too focused on drug abuse.

Clinical, biological and pharmacological research on prison inmates are allowed by the general law, but the informed consent of the person concerned is always mandatory.

## Conclusions

The provision of mental healthcare in Portuguese prisons, for which the DGSP has thus far been directly responsible, suffers from the same problems as other areas of clinical practice in a prison context: inadequate facilities, human resources that are both few and far between and often changing, and insufficient links to the National Health Service.

The 2003 Ombudsman's Report says the following about the health field and the provision of care in a prison environment:

"Taken as a whole, the issues involving the recruitment of medical and paramedical staff for the prison system are probably the most delicate problem that the prison system is facing in the area of the provision of health assistance to inmates.

Quite apart from anything else, we should emphasise that in this particular respect the DGSP's current staff roster is practically identical to that mandated by 1987 Ministerial Order no. 316, whereas at present there are 6,000 more inmates than there were at that time.

What is more, with the phenomena of drug addiction and the proliferation of the so-called communicable diseases, protecting inmates' health now entails some things that differ greatly from the same concept fifteen years ago.

We can sum this up in a conclusion which no one disputes: that today's quantitative and qualitative needs are not the same as those set out in the (still) applicable – but not very up-to-date or implemented in practice – DGSP staff roster. This situation means that it is necessary to use other formats to engage staff (ranging from retainer agreements to service contracts), which necessarily involve a certain instability of tenure. At the time of the visits to which this Report refers, around 60 % of the medical and paramedical staff working in the country's prisons were not actually employed by the DGSP".

As we can deduce from all this, the problem of specialised human resources is of key importance to the organisation of healthcare in a prison environment. The precarious nature of contracts, the specific difficulties inherent in working in a prison context, and the difficulties involved in securing career advancement are sometimes insurmountable obstacles that end up leading to a very high (and very undesirable) turnover among doctors and nurses.

The Ombudsman has made some suggestions for solutions, but they have not yet had any palpable results: "Probably the best way will imply a conjugated solution, which will entail expanding and adapting the DGSP's staff roster, revising the career structure of the medical and paramedical staff who belong to it, negotiating with the Ministry of Health in order to make it easier for NHS doctors to come to prisons, and debureaucratising the processes involved, without forgetting the virtues of an appealing remuneratory system."

In the specific case of the mental health area, the shortage of psychiatrists leads not only to difficulties for inmates to gain access to one in the regional prison facilities, but also to a very severe overload on the staff in both of the country's prison psychiatric clinics (São Cruz do Bispo, and São João de Deus), which has led those in charge to propose placing psychiatrists in the larger EPs and, in a second phase, in the regional EPs as well. To date this proposal has not been met with a positive response, so the limitations in the human resource field are still a pressing reality.

However, the shortage of specialised resources is not the only problem at the moment. The fact is that be it in a prison context or otherwise, the provision of mental healthcare is first of all related to the way in which the mental health services are themselves organised. It is not possible to properly organise services for a given population without first having a more or less clear picture of both the magnitude and impact of the mental health problems in that population, and the latter's most significant needs.

The enormous lack of reliable epidemiological data (quite apart from data on the frameworks in which substance abuse/dependence occurs) is thus one of the greatest obstacles to organising these services correctly, and may compromise both access to them and their quality in various fields of the provision of care.

It is thus urgently necessary to characterise the prevalence and incidence of psychiatric disturbances in the Portuguese prison population, and to assess that population's needs for care, both at the level of the problems/dysfunctions that exist, and in terms of the type of responses which the services with responsibility for these issues are providing (or failing to provide).

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## Slovenia

**Olga Perhac, Vita Poštuvan, Jerneja Svetičič, Barbara Bernik Župančič & Andrej Marušič**

### Structure of Slovene Prison System

In 1995 the National Prison Administration was established as a body within the Ministry of Justice. The prisons and the juvenile correctional home became internal organisational units of the Administration.

The National Prison Administration carries out administrative and expert tasks pertinent to serving of sentences, organisation and management of prisons and the correctional home, ensuring of financial, material, staff, technical and other conditions for the operation of prisons, staff training and exercise rights and obligations of persons deprived of liberty. The headquarters is in Ljubljana.

In Slovenia, prison sentences are served in six prisons with facilities at 13 different locations. The largest is central Dob Prison, where male prisoners serve prison sentences of over 18 months. The other central prisons are Ig Prison (female) and Celje Prison (juveniles). Regional prisons are in Koper, Maribor and Ljubljana. Every prison facility has an open section, a semi-open section and closed section. The Juvenile Correctional Home Radeče also operates within the Administration.

Based on international recommendations and the findings of Slovene experts, the National Prison Administration adopted common principles for the determination of prison capacities in 1997, with the size of single cells being 9 m<sup>2</sup> and the size of group cells being 7 m<sup>2</sup> per inmate. Taking into consideration the aforementioned standards, the Slovenian penal institutions had a total capacity of 1,103 persons in the year 2005. The average number of inmates was 1,137, total occupancy was therefore 103.10 %.

After 1984 the number of prisoners dropped steadily until 1996, when the number reached 25.6 prisoners per 100,000 inhabitants (the lowest rate since the Second World War), and started increasing after that. In 2001 the number of inmates had nearly doubled by the end of this period. During recent years, the number has settled down and is comparable to the years prior to Slovenia's attainment of independence. The Slovene prison population rate now is 56 inmates per 100,000 of the national population.

**Table 1: Capacity and average number of inmates in 2005**

<b>Prisons</b>	<b>Capacity</b>	<b>Average no. of inmates</b>	<b>Occupancy (%)</b>
Dob Prison	233	294.81	126.5
Slovenska vas Semi-open and Open Department	63	53.22	84.5
Ig Prison	79	40.74	51.6
Celje Prison	96	88.27	92
Koper Prison	110	97.36	89
Nova Gorica Department	32	20.63	64.5
Ljubljana Prison	128	226.68	177
Novo mesto Department	35	35.33	101
Radovljica Department	22	27.33	124.3
Ig Open Department	27	17.26	64
Maribor Prison	133	142.38	107
Murska Sobota Department	41	30.4	74.1
Rogoza Open Department	36	35.56	98.8
Radeče Correctional Home	68	27.32	40.2
<b>Total</b>	<b>1,103</b>	<b>1137.29</b>	<b>103.1</b>

The most populated prisons were Dob, Ljubljana and Radovljica detention centre, followed by the detention centres in Novo mesto and Maribor whereas the least overcrowded are the women's prison at Ig and the juvenile correctional institution at Radeče. Since the year 2000, the problem of overcrowding in prison institutions has become problematic. This means that, on average, more persons are being imprisoned daily than is the total capacity of all prison institutions. The problem is being solved by redistributing inmates from more crowded to less crowded rooms, departments and institutions. The prison system also tries to alleviate the negative consequences of overcrowding (prevention of conflicts, emphasized concern for hygiene, medical care, etc.) by applying different measures. The best comprehensive solutions of this problem are promotion of alternative forms of prison and detention and increasing and improving accommodation capacities of the existing institutions.

**Table 2: Average structure (categories) of inmates in 2005**

<b>Inmates</b>	<b>Average number</b>
Convicted prisoners	772.95
Misdemeanours	5.44
Remand prisoners	323.68
Juveniles	7.89
Juveniles in Correctional Home	27.32
<b>Total</b>	<b>1,137.29</b>

There have been no rebellions or other riots of major dimensions in prisons and the correctional institutions in Slovenia in the last 10 years. The number of escapes and other emergency situations is not increasing – these incidents have even been fewer during recent years than in the first half of the nineties, despite the larger number of prisoners.

The whole prison budget in 2005 was 26,707,194 Euros and most of it was spent on salaries.

### **Medical Services and Mental Health Care Provision in Prison**

Health care in the Slovene prison system is conducted in conjunction with public health, meaning there is not one single central prison hospital. The medical doctors who work in the prison system are guaranteed complete professional independence. The health care of prisoners is carried out and based on the Enforcement of Penal Sanctions Act, of the Republic of Slovenia, Health Insurance and Health Care Acts of the Republic of Slovenia in conjunction with the European prison system laws.

The prison healthcare network constitutes twelve prison's outpatients' clinics, which employ medical personnel (nurses) who work within the system, and medical doctors who work outside of the system (and are from regional health centres, hospitals or private practices).

The following health care services are carried out in the aforementioned health care clinics:

- primary health care
- dentistry
- gynaecology
- psychiatry

Institutional health care staff is available to prisoners eight to twelve hours daily. General practitioners work from one to three times per week (depending on prison size), while specialists work from once weekly to once per month. In the event that medical personnel are not available and there is an emergency, emergency services are called. An exception is the outpatients' clinic in the largest Slovene prison in Dob, where there is a doctor on staff and available daily. All specialist appointments and hospitalizations are conducted out of the prison system, in outpatient health clinics and hospitals.

All psychiatric care in prisons is carried out with contracted psychiatrists (none of them is employed within the prison system). Psychiatric patients are hospitalized in the public psychiatric hospitals. There is no forensic department or hospital in Slovenia.

A challenge is posed by prisoners with diagnoses related to being in a locked facility such as reaction to being in prison, antisocial personality disorder, etc.... Despite the fact that the number of hospitalization days with these patients is minimal and the number of patients does not exceed five patients daily in all the psychiatric clinics in Slovenia, they represent a substantial encumbrance for the correctional and psychiatric systems. Among other things, it burdens the security personnel, which must be on constant watch of the prisoners during their hospital stays. This also brings unpleasantness and concerns to other patients and psychiatric hospital staff.

The public network principal is present even in the hospitalization of prisoners – psychiatric patients who are obliged to take part in psychiatric treatment and living in a clinical mental health care institution. Mandatory psychiatric care is determined by the court, which also decides to which hospital the particular patient will be sent (after the consensus of a consulting committee). The committee is formed by the justice minister in conjunction with the health minister.

Every prison's psychiatrist works closely with a prison's general practitioner, medical nurse and psychiatrist – specialist in addiction treatment. This collaborative practice by the medical personnel of each prison diminishes prisoner's manipulation of obtaining proper corresponding medications.



There are currently 36 medical doctors in the prison system, out of which eleven are psychiatrists. There are thirteen nurses employed on a full time basis. Prisoners are also helped by institutional psychologists, of which there are eleven.

The Penal Sanctions Act pays for the entire health care of prisoners including underage individuals. The health care debts for prisoners are paid as part of the criminal charge incurred and remunerated by the justice system. In 2005 1,064,070 Euros (3.98 % of the prison budget) was allocated for prisoners. This amount includes money intended for health of prisoners (the amount spent on mental health care is not available). The above referenced guarantees the same quality of health care for prisoners as for the general public.

The mental health care of prisoners is measured using standardized instruments by physicians and psychiatrists from public mental health institutes, and when necessary collaborating with institutional psychologists. Psychiatrists chose treatment methods for patients independently. All prisoners are screened for suicidal thoughts, alcohol and substance dependency and sexual abuse.

### **Epidemiology of Mental Disorders**

The diagnosis of a prisoner's mental disorder is written in his/her medical chart. Access to this data is possible only thru doctors or psychiatrists, while guards and other members of prison's staff do not have access to it.

The government monitors the state of mental health of imprisoned persons on the basis of daily reports of extraordinary events in prisons. Additional information on the subject is published annually as a report of the Prison Administration, which monitors the following indicators:

- the number of psychiatric evaluations in prisons
- the number of psychiatric evaluations in outside psychiatric wards
- the number of hospitalizations in psychiatric hospitals
- the number of self-inflicted injuries, attempted and committed suicides

Prison psychologists have carried out 4,373 conversations, a third of them being counselling, or debriefing, 18 % of conversations were of informative nature and in 3 % they were crisis interventions (in suicidal cases, self-injuries, depressions or acute states of emotional distress). In comparison to the year 2004, the number of prisoners having different kinds of conversations with the prison psychologist, decreased by almost 13 %, particularly the number of debriefing conversations with juveniles. On the other hand the number of introductory meetings with psychologists increased for 18.7 %. Based on psychologist's and psychiatrist's evaluation three inmates were sent to psychiatric treatment, 13 to treatment of alcoholism and 23 prisoners to treatment of substance dependency.

In 2005 the number of prisoners with self-inflicted injuries (mostly by cutting, hanging, self-poisoning or swallowing objects) increased for 15 %, compared to the previous year. Among them were 21 serious suicide attempts and two completed suicides by hanging. Since 2003 psychologists in all prisons in Slovenia have been assessing suicidal risk for every newly accepted prisoner, following the accepted strategy for preventing suicides. Furthermore, medical staff, psychologists and social workers (in co-operation with psychiatrists and clinical psychologists) are being systematically trained for better recognition and treatment of suicidal behaviour in inmates.

Because of great independence of the psychiatric staff and confidentiality of assessments and treatment of patients in prison system, there is no available clear epidemiological data for specific disorders.

## Quality Standards and Ethical Aspects

Legislation frameworks for health care in Slovene prisons are the Penal Sanctions Enforcement Act, adopted by the National Assembly in 2000, and the Rules on Prison Sentence Enforcement.

Professional work with prisoners has its basis in the following principles:

- the principle of humane treatment,
- the principle of active participation of prisoners in the treatment programme,
- the principle of individualisation demands,
- the principle of social rehabilitation demands.

Inside penal institutions, prisoners must be separated from those imprisoned for a misdemeanour, juveniles from adults and men from women.

Mental disorder assessment of prisoners is made by a medical doctor – psychiatrist. When there is a need for additional assessment by a clinical psychologist, this is made in a psychiatric hospital. Psychologists in prisons do not have a specialisation from clinical psychology (the system provides work places for BA in psychology). There are no data available about specific standardized assessment instruments for mental health problems in prisons. The assessment and treatment conclusions are available only to medical staff.

On the basis of diagnoses, a psychiatrist decides on medication therapy and gives advice on how to treat a prisoner with a mental disorder. Usually the prisoner with a mental disorder gets involved in individual treatment with the prison psychologist. Other professionals get involved in additional treatment when necessary – pedagogues, social workers, occupational therapist....

The Slovene prison system does not provide any organised systematic (obligatory or optional) professional education on the field of mental health of prisoners. Employees get their knowledge in regular education programs (as a medical doctor, psychiatrist, psychologist...), and they are broadening their knowledge with participation in seminars, conferences and with their self-education. The only obligatory professional exam for personnel employed inside the prison system does not include any knowledge testing about mental health in prisons.

Quality standard of treatment of mental health prisoners is under CPT (European Committee for the Prevention of Torture) control. It stresses out the control on implementation of European prison rules (last visit was carried out in February 2006). The National Prison Administration tries to eliminate some deviations from European rules, most of all:

- to assure a higher daily presence of prison's medical staff in outpatients' clinics
- to enable education of medical nurses on mental health
- to make an association between non-governmental organisations, which are active in this field

The data about mental health of prisoners is being forwarded only to WHO for its analysis needs.

There are no significant prison mental health research activities going on. There are also no lobby groups or influential NGOs that would be addressing the needs of mentally disordered prisoners in Slovenia. Public awareness arises only with media attractive events (like suicide of a well known prisoner).

In summary, we can say that some changes will need to be done in the Slovene prison mental health system. First of all, prison psychiatry should be included in the public health system. The other thing is the construction of a forensic hospital or forensic department, which might fulfil the needs of Health and Justice Ministry of the Republic of Slovenia.

**Spain**

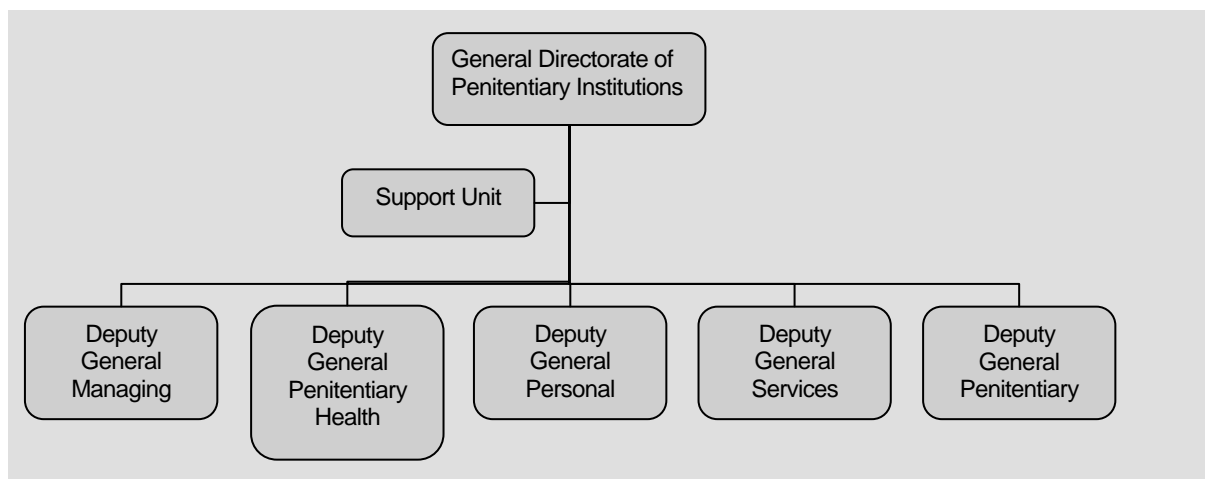
**Francisco Torres-González & Luis F. Barrios-Flores**

**Structure of the Penitentiary System**

The Spanish prison system is a national system that included 77 penitentiaries (75 prison services and two psychiatric penitentiary facilities; open centres for execution of punishment in the final phase of the judgment (Centres for Social Insertion) are not included). The services are distributed throughout all Spanish autonomous provinces and communities and are managed by the central Spanish Government. Only Catalonia has independent control of the currently eleven penitentiaries currently located within the Autonomous Community of Catalonia.

For the Spanish Government the penitentiaries are administrated and managed by the General Directorate of Penitentiary Institutions, that is attached to the Ministry of Interior (see structure shown in figure 1), whereas in Catalonia, the penitentiary net is managed by the Secretary of Penitentiary Services, Rehabilitation and Juvenile Justice, which is headed by the Department of Justice of the Generalitat of Catalonia (autonomous government). Coordination between the two administrations is regulated by the Royal Decree 1436/ 1984, of 20 of June, on provisional norms of coordination of the penitentiary administrations.

**Figure 1: Structure of the Spanish Penitentiary Administration**



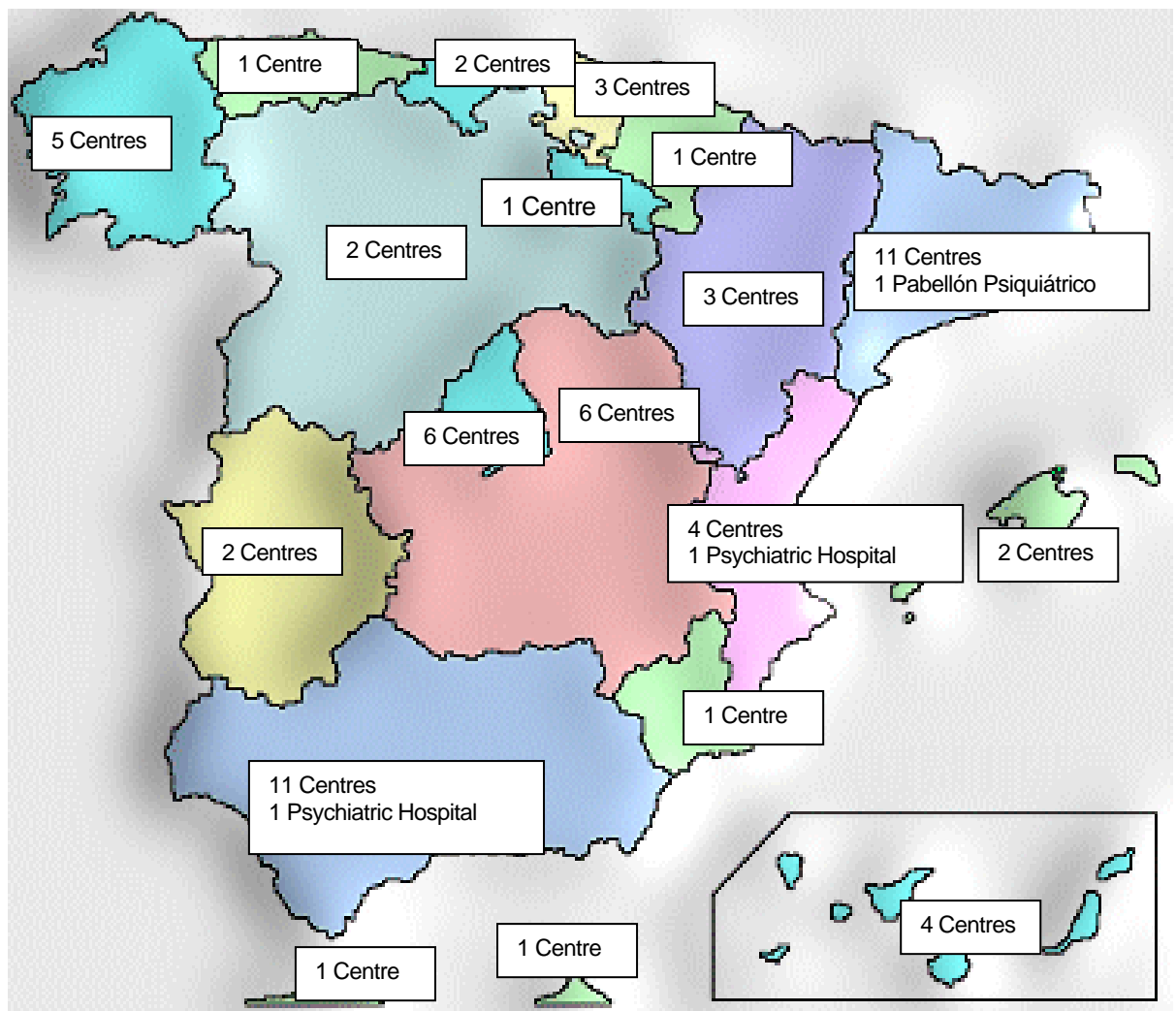
The whole Spanish penitentiary system is regulated by the same legal norms and frameworks, which include the following laws and codes:

- the Organic Law 1/ 1979, of 26 of September, General Penitentiary (LOGP) (basic norms of the penitentiary system),

- the Royal Decree 190/ 1996, of 9 of February, Penitentiary Regulation (RP 1996) (detailed regulation for regime and operation of penitentiaries),
- the Royal Decree 1201/ 1981, of 8 of May, Penitentiary Regulation (RP 1981) (regulation of functions and duties of psychologists and health care staff of penitentiaries),
- the Organic Law 10/ 1995, of 23 of November, Penal Code (regulating security aspects for mentally ill offenders, e.g. conditional release),
- the Law of Criminal Prosecution of 14 of September of 1882 (regulation of procedures for inmates that are diagnosed and declared mentally ill after the sentence).

Both, the General Penitentiary Administration and the Catalan authority operate on two different levels: a central level and a peripheral level. The central level includes the various services and administrative units for direction, inspection and coordination. The penitentiary centres as such (see distribution in figure 2) constitute the peripheral level.

**Figure 2: Distribution of Spanish penitentiary centres**



Quality assurance and controlling of the penitentiaries is also implemented on two levels. These include

- external control applied by the “Tribunals of Penitentiary Surveillance”, specific judicial organs (each consisting of one person) specialized in penitentiary matters, prosecutors attached to each Tribunal of Penitentiary Surveillance, ombudsmen who might receive complaints or reclamations of inmates,
- internal control mechanisms by penitentiary administrations, that may investigate complaints, aggressive acts, suicidal behaviour etc.

The Spanish penitentiary system is not very specialized. There are no especial high security centres, although security wards or pavilions do exist in numerous centres for aggressive or violent inmates. There are no specialized divisions or departments related to the typology of crimes or for recidivists.

The only specialized penitentiary centres in Spain are the psychiatric penitentiary hospitals of Alicante (with a capacity of 380 beds) and Seville (170 beds) and the psychiatric pavilion in Barcelona (70 beds).

All in all, Spanish prisons have a total capacity of approx. 44,000 places (although in the last years official data of capacity are not published). The development of the prison population between 1990 and 2006 is shown in table 1.

**Table 1: Prison Population in Spain 1990-2006**

<b>year</b>	<b>Total</b>
1990	33,035
1991	36,512
1992	40,950
1993	45,341
1994	48,201
1995	45,198
1996	44,312
1997	43,453
1998	44,747
1999	45,384
2000	45,309
2001	46,594
2002	50,537
2003	54,497
2004	58,655
2005	60,707
2006*	62,023

\* 2006 has been estimated using data published to date

The total budget of the General Directorate of Penitentiary Institutions - excluding Catalonia - for the year 2007 is 955,078,000 €. For Catalonia for the year 2007 is 260,235,000 €. The total of the penitentiary budget for Spain is for 2007: 1,215,313,000 €. The prison mental health care budget is not separately declared.

### **Medical services in prison**

Each penitentiary administration provides an organism responsible for prison health. On the national level, it is the General Sub-Directorate of Health Penitentiary that is responsible for health care provision. A similar organism manages prison health care in Catalonia.

This means, that at the present time, any health staff in prison is under the authority of the General Directorate of Penitentiary Institutions, either from Catalonia or from the State. In future it is foreseen that the prison health subsystem will be transferred on the level of the Autonomous Communities, which already are responsible for the health services of the general population.

According to [art]. 213.1 RP 1996, each prison centre should have a medical ward with a capacity that is proportional to the actual number of inmates. All in all medical prison wards in the regular penitentiaries provide approx. 2,000 beds. Medical wards will run by approval of the Direction Committee (as a maximum administrative organ) of each prison after being proposed by the sanitary services of each penitentiary establishment (art. 213.2 RP 1996). Usually, primary care is provided by own resources of the penitentiaries. For specialized care, however, services of the public National Health System are preferably used ([art]. 209.1 2 RP 1996). Inpatient care for prisoners is offered by specific hospitals in each county designated by the health authority. These hospitals provide specific wards for prisoners, called Units of Restricted Access (UAR) ([art]. 209.2.2 RP 1996). There is at least one UAR in each province. In 2004, 292 UAR-beds were available.

### Mental Health Care in prison

Prisoners suffering from a mental disorder are detained in regular penitentiaries, when they are sentenced or under remand measures (pre-trial custody, preventive detention).

Mentally disordered offenders, who were declared criminally not responsible and subjected to a measure of security are referred to one of the two psychiatric penitentiary hospitals. At times, remand prisoners who are mentally disturbed are also referred a psychiatric penitentiary hospital, but only for observation or assessment purposes. After the assessment they return to their origin prisons.

Regular specialized psychiatric care provided at the State Penitentiary System usually relies on external psychiatrists acting as consultants. The majority of prison centres do not employ psychiatrists on a full-time basis, neither do they provide specialized psychiatric nurses. However, in Catalonia, the Psychiatric Penitentiary centre is run by a non-governmental religious body, the Brothers of San Juan de Dios, who provide fully specialised health care staff.

**Table 2: Consultations of specialized care (2003)**

	In prison centres*	Outside prison centres**	total
<b>Mental Health Care Consultations</b>	<b>21,675</b>	<b>1,148</b>	<b>22,823</b>
<b>Total Health Care Consultations</b>	<b>75,652</b>	<b>42,965</b>	<b>118,617</b>

\* Specialist doctors that are not integrated in the penitentiary staff (dentists and psychiatrists, especially) pay visit to inmates in prison.

\*\* At times, the inmates are taken to outside centres the public health system for assessment or treatment

In prison centres that do not employ psychiatrists, the general physician of the respective penitentiary is responsible for the mental health care of inmates. Usually he collaborates with an external liaison psychiatrist, to whom the inmates in need are referred to. It is also possible for inmates to receive specialized care being paid by themselves (36.3 LOGP). For this purpose, the penitentiary centres should have a cooperating psychiatrist periodically available ([art]. 209.1.1 RP 1996). Table 2 shows the frequency of specialized medical contacts of prisoners inside and outside of the penitentiary centres due to mental problems and general health care problems in 2003.

Psychiatric inpatient treatment is provided in general hospitals, although it is also prescribed by specialist doctors that visit the patients in the centres.

**Table 3: Number of Discharges of Prisoners from Non-Penitentiary or General Hospitals and Median length of stay (2003)**

disorder	discharges	length of stay (median)
mental disorders	204	12.8 days
all disorders	3,989	8.4 days

### Mental Health assessment

The following staff is eligible for assessing the mental state of prison inmates:

- *General physicians* screen or assess each prisoner at prison entry to identify possible physical or mental disorders ([art]. 288.1<sup>a</sup> RP 1981). Furthermore, general physicians will look after physical or mental health problems during imprisonment ([art]. 288.2<sup>a</sup> RP 1981).
- *Psychologists*, who usually are not part of the regular health team. They are enrolled within the so-called "Team of Observation" (for remand prisoners) or within the "Team of Treatment" (for regular inmates). Psychologists assess the personality of each inmate and apply psychological treatment when needed ([art]. 282.1<sup>a</sup> 7<sup>a</sup> RP 1981).
- *Psychiatrists*: In the few prison centres having employed a psychiatrist as a penitentiary officer on a full time basis (which is the case in the two psychiatric penitentiary hospitals and in a very few regular penitentiary centres), psychiatrists are responsible for psychiatric assessment, medical-psychiatric treatment and the regular supervision of the inmates' mental health ([art]. 284.1<sup>a</sup>. 2<sup>a</sup> 5<sup>a</sup> RP 1981). In the remaining centres these tasks are taken over by external consultant psychiatrists visiting regularly the prison centre or patients are referred to a general hospital.

In most cases, mental state assessments or screenings in prison initially are done by general physicians. Only in case of signs or symptoms for a mental disorder the person concerned will be referred to a psychiatrist (usually to a consultant psychiatrist, since the majority of the prison centres do not have full time psychiatrists available).

### Access to health service

After the initial mandatory physical and mental state screening or assessment by the general physician at prison entry (288.1<sup>a</sup> RP 1981), further contacts due to mental health problems will take place either by demand of the inmate, or by means of a programmed consultation of the medical services. In case of provisional isolation, it is stipulated that the isolated inmate has to be visited daily by a physician ([art]. 72.2 RP 1996). Even prisoners who are restrained due to disciplinary causes before any assessment or report by a physician must be visited daily, too ([art]. 254.1 RP 1996). Inmates also have the right to request an interview with a prison-psychologist, who is obliged to inform the "Teams of Observation" or the "Teams of Treatment" about the psychological state of the respective inmate.

### Detection / prevention of the suicidal behaviour

The detection and prevention of the suicidal behaviour is carried out following the "Frame Program of Prevention of Suicides (PPS)", where the whole staff in contact with inmates should participate actively. The acting program was approved by the General Directorate of Penitentiary Institutions,

though the Instruction 14/ 2005, of 10 of August. Recently, a “Program of Integral Attention to the Mentally Ill Person in Prison” is being started.

The prison services should be informed by the so-called Office of Regime (archives of penitentiary dossiers and files) about every new prisoner at entry about the criminal record, previous suicidal attempts or any previous stay at the psychiatric penitentiary facilities or any other penitentiary centre. Staff members who are supposed to see and interview the new prisoner (general physician, educator or social worker in case of preventive prisoners or general physician, educator, social worker, jurist and psychologist for regularly sentenced prisoners) will assess any risk factors, and eventually inform the Deputy Director for Treatment.

During the prison stay, any staff member or prison guard who will detect signs of suicidal behaviour is supposed to communicate this and call for assessment by a physician or a psychologist. Together with the Deputy Director of Treatment these professionals might propose the inclusion of the respective prisoner into the PPS suicide prevention programme. As specifically of risk situations are considered: a) weekends or periods of absence of health care staff, b) restrictions or limitations requested by inmates itself for safeguarding their life or physical integrity, c) seriously affective or family conflicts, d) modifications of criminal case or penitentiary procedures of inmates, e) the proximity of the release, f) the isolation of inmates, g) negative administrative or juridical decisions.

PPS measures are weekly reviewed by the Treatment Council, whether they should be continued or modified. PPS measures may include

- preventive measures: placement in shared cells and avoiding periods of time in situation of isolation; facilitating calls to relatives,
- provisional urgent measures: urgent referral to a hospital, medical treatment under close supervision, mechanical restraint for therapeutic reasons with close observation, urgent assignment of a supporting inmate, a withdrawal of all sort of material of risk, special supervision by surveillance officers,
- programmed measures: a) by medical services (medical programmed consultation, referral for assessment by a psychiatrist, placement in the medical ward for observation and medical treatment); b) by treatment services (programmed psychological consultation, direct pursuit by educator, assessment by social worker); c) regime of life (continuous internal support, also during office closing hours and in times without scheduled activity programs, stimulated communication with families and social networks, stimulated attendance in occupational activities, sport and social activities etc.),
- specific measures: surveillance by prison guards, withdrawal of objects that may be of risk for suicidal behaviour, placement in a special observation cell etc.

One of the basic instruments in following the patient and provide adequate support and care is the inclusion of other inmates into these tasks (so-called “supporting inmates”). Adequate persons would be proposed by the department or the educator and will be entrusted by the Treatment Council. Supporting inmates will receive training for this task.

### **Specific programs for drug-addicts**

Penitentiary centres have implemented various intervention programs for illicit drug-addicts, which are promoted and supported by the "National Plan on Drugs." In 2004, 34 NGOs or other organisations participated in these programs. Additionally, there are treatment programmes for drug-addicts outside the prison premises. Table 4 shows the number of inmates participating in these programs from 1988 to 2003.



**Table 4: Number of Prisoners participating in external Drug Addict Programs**

year	1988	1989	1990	1991	1992	1993	1994	1995
number	12	35	113	220	374	384	630	757
year	1996	1997	1998	1999	2000	2001	2002	2003
number	729	707	765	872	938	977	956	821

Additionally, prisoners in the final stages of their prison term (the so-called “third degree” stage), there are "External to prison Units" which are aiming at the detoxification of drug-addicted inmates ([art]. 182 RP 1996). In 2003, 145 inmates were attending the 12 authorized "External to prison Units". These units are administrated by NGOs and foundations, with a few exceptions.

### Specific Programs for Sex Offenders

Only a few penitentiaries offer specific programs for sex offenders. Unfortunately, the authors have not available further information about these programs.

### Compulsory treatment for mentally ill inmates

Compulsory treatment of mentally ill inmates is not regulated separately. Laws for civil detention are applicable, fundamentally [art]. 9.2.b of the Law 41/ 2002, of 14 of November. This is a basic law regulating the autonomy of patients and the rights and obligations related to information and clinical documentation. It defines that physicians are eligible to conduct indispensable interventions for the benefit of the patient’s health without consent in case of immediate serious risks for the physical or psychic integrity of the person concerned.

That means that in routine practice, a representative of the inmate (legal representative or family members) will not asked for consent, which in a non- penitentiary environment would be required when patients are not able to take decisions ([art]. 9.3. of the Law 41/ 2002).

### Epidemiology of mental disorders

There is a serious lack of epidemiological data on the topic of prison mental health in Spain. Prevalence data for mental disorders in prisoners are not available. Currently an initial epidemiological study on mental illness is conducted in four penitentiary centres. The only information available refers to suicide rates in Spanish prisons, which are shown in table 5.

**Table 5: Annual Suicide Rates in Spanish Prisons**

year	total number of prison suicides	rate (per 1,000 prisoners)
1999	29	0.74
2000	21	0.54
2001	21	0.52
2002	25	0.57
2003	28	0.60
2004	40	0,68

## Quality Standards

The educational standards and requirements for medical prison staff are shown in table 6. So far there is not been an organized system of training, neither obligatory nor optional, for the personnel responsible for the assessment and treatments of the mentally ill interns.

**Table 6: Educational Requirements for Medical Staff working in Spanish Penitentiaries**

Staff	Education/training
Psychiatrist	Specialized university study (specialist in psychiatry)
Psychologist	Specialized university study (different to working in the National Health System, a specialized training in clinical psychology is not required in prison health care)
General Practitioner	Specialized university study (specialist in family and community medicine)

Regarding standardized assessment and treatment procedures, there is a "Program of care in mental health and psychological deficiency" provided in the Autonomous Community of Catalonia aiming at identifying, assessing and managing mental disorders, psychiatric pathologies or psychological deficiencies in any prison inmate at the start of their prison term.

Medical confidentiality is regulated by law. Particularly [art]. 215 RP 1996 guarantees the confidentiality of data integrated in clinical or medical files. Additionally, all general laws regulating medical confidentiality are applicable to prison inmates as well.

The already mentioned Law 41/ 2002, of 14 of November, is applicable to all public or private health centres. In [art]. 7 14-19 it regulates the right of privacy of a patient and the confidentiality of clinical files or medical data. The Organic Law 15/ 1999, of 13 of December, regarding the protection of personal data covers also prison inmates.

Comparing the presumable prevalence of mental illness in Spanish prisons (there are not reliable data on this) with current amount of specialized staff available for prison mental health care suggest some care deficits. Collaboration between the penitentiary health care network and the National Health System is reasonably well established and supervised by juridical authorities, e.g. judges.

## Ethical aspects

European Laws or Norms for Prisons are not of direct application in Spain since they have not been integrated in the national juridical body. However, they constitute standards that are not to be avoided or omitted in the routine practice. The approval of the Penitentiary Rules in January 11 of 2006 (RPE) implement a wide range of European standards into Spanish prison health care. The rules refer to the

- Duty of the penitentiary Administration of protecting the health of the inmates (39 RPE and 3.4° LOGP).
- Coordination between the medical penitentiary and general services (40.1 2 RPE and 207.2 RP 1996).
- Guarantee of the access to the health benefits in regime of equality (40.3 5 RPE and 208.1 RP 1996).
- Identification and assessment of the physical and mental illnesses of the inmates (40.4, 42.3 b and h and 43.1 RPE and 282. 284 288 RP 1981).
- Endowment of at least one general medical service in each penitentiary centre (41.1 RPE and 209.1.1 RP 1996).

- Initial assessment by a physician at prison entry (42.1 RPE and 288.1<sup>a</sup> RP 1981).
- Guarantee of medical confidentiality (42.3.to RPE and 215 RP 1996).
- Guarantee of medical attendance in case of isolation (43.2 RPE and 72.2 254.1 RP 1996).
- Referral of patients who need specialized attendance (46.1 RPE and 209.2 RP 1996).
- Need of informed consent in case of medical research (48.1 RPE and 211 RP 1996).

The approval of LOGP set into effect the minimum rules for treatment of prison inmates as stated by the UN (1955) and by the Council of Europe (1973). However, not all details stipulated by the RPE are implemented in the penitentiaries to date. This refers particularly to rule 12.1 establishing that people suffering from mental disorders should be placed at services able to provide adequate care (it is also said at 47.1 RPE). In routine care admission to a psychiatric penitentiary facility will only happen in case of a) detainees and prisoners for observation and assessment, b) prison inmates under a measure of security ("mentally ill offenders") and c) sentenced prisoners developing a serious mental disorder that requires a measure of security at a psychiatric penitentiary facility (184 RP 1996).

So there is no general regulation that may stipulate that mentally ill detainees or prisoners must be treated at a specific or specialized service. Additionally, continuous training programs for the prison health care staff are also not available (41.4 RPE). The wide varieties of NGOs are basically involved in the treatment of drug-addiction cases.

The most exhaustive report on this issue in Spain to date is "The mental health care of the prisoner population," published by the Spanish Association of Neuropsychiatry. This book presents a number of reports from the National Congress of the Association held in June 2003 in Oviedo.

### **Recommended reforms**

An improvement of the situation of the mentally ill inmates in Spain would require:

- to know the real prevalence of mentally ill people within the Spanish penitentiaries, in order to organize care, provide the needed staff and infrastructure and adapt the legal measures that might be required,
- to organize a currently non-existing continuous specific training for prison staff responsible for assessing and treating mentally disordered inmates,
- to provide the majority of penitentiaries with specialists in psychiatry (a proposal was discussed when the LOGP was debated in 1979),
- to design an system of alternative placement and treatment options for mentally ill persons in prison. A legal option is included at the [art]. 60 CP: when after the firm sentence a durable situation of mental serious disorder is appreciated in a condemned, the execution of the pain of privation of freedom will be suspended, guaranteeing that the person receives the needed medical care; medical care that usually supposes the entrance of the inmate in a psychiatric penitentiary hospital (184.C RP 1996). This option is in contrast to similar cases of somatic illnesses. In these cases, courts are eligible to grant the suspension of any imposed pain, without subjection to requirement, whenever the person concerned is suffering from a very serious or incurable illness ([art]. 80.4 CP);. Moreover, it would be possible to conditionally releasing the person concerned for similar reasons ([art]. 92.1 CP); however, these advantages are only applied to physically ill persons.
- to regulate the application of coercive measures for therapeutic reasons in all penitentiary centres. So far this is regulated only at psychiatric penitentiary facilities, while at regular prisons only coercive measures for disciplinary reasons are regulated, causing considerable juridical uncertainty, since in prison the only allowed measures are those specified in the [art]. 72.1 RP 1996: provisional isolation, physical restraint, rubber defences, aerosols and shackles.
- to implement specific services for the treatment of detainees, prisoners and sentenced mentally ill persons.

## Sweden

Orsolya Hoffmann

### Structure of the prison system

#### *General information*

The Swedish Prison and Probation Service is a part of the judicial system. The aims of Sweden's criminal policy are to reduce criminality and increase security in society. The Prison and Probation Service's main duties are to implement prison sentences and probation services, to be responsible for the supervision of conditionally released persons, to implement community service sentences and to prepare pre-sentence reports in criminal cases.

The Swedish Parliament abolished capital punishment in peace in 1921 and in war in 1972. However, no executions were carried out after 1910.

The Prison and Probation Service is also responsible for remand prisons. In addition, it operates its own transport services and also transports detained persons who are, for example, to be deported from Sweden.

To achieve its goals and carry out its duties the Prison and Probation Service has a Head Office, six regional offices and a Transport Service. Each region has remand prisons, prisons and probation units which co-operate to help its clients adjust in the best possible way to a life without crime.

In terms of administration, the Prison and Probation Service is also the senior authority for the National Parole Board and the 30 probation committees.

The head of the Prison and Probation Service is the Director General. The six regions are led by the Regional Directors and all the prisons and remand prisons have a Governor. The Regional Director is also the head of the medical services. From this year these Regional Directors also have a coordinator (mostly a nurse) for the medical services.

The Prison and Probation Service has an annual budget of 5,688 MSEK for 2006. [1, 2, 3]

#### *Prisons*

There are 57 prisons in Sweden. These prisons do not differ from region to region, with the exception of the maximum security facilities. The aim is to place all inmates depending their needs. They are accommodated in rooms 7-9 m<sup>2</sup> in size, furnished with a bed, a fixed table and a chair, a wash-basin with running water and a television set. In some prisons and remand prisons there are small units for inmates with psychiatric or somatic needs, and those rooms are also furnished with a toilet. The prisons are divided into six security levels, where A is the highest level and F the lowest. Some prison can have two units with different security level (table 1).

**Table 1: Security level of prisons**

	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>
<b>Number of prisons</b>	2	2	4	7	29	15

There are 4,895 prison places available, (96 %, occupied 2005). The maximum number of inmates per prison is 245. In 2005 the number of persons sentenced to prison was 13,800. 2,700 persons served their prison sentence in freedom under close supervision with electronic monitoring. Number of clients under probation was 18,300. The basic approach of Swedish criminal policy is that the sanctions involving deprivation of liberty should be avoided wherever possible, since such sanctions do not as a rule improve the individual's chances to re-adapting to a life in freedom. In Sweden there are 76 persons in prison per 100,000 inhabitants compared with over 700 per 100,000 inhabitants in USA and Russia.

There are special ward units for the motivation and treatment of drug addicts. These are divided (2005) into:

- 765 places for motivation
- 525 places for treatment
- 96 places for advanced motivation [1, 3, 4]

### ***Remand prisons***

In Sweden there are 30 remand prisons with a total number of 1,865 places (2006 January 1<sup>st</sup>). The largest remand prison has places for 291 inmates, but these prisons have been overcrowded during the past few years; for example in December 2005 the places were 107 per cent occupied.

Some inmates can have restrictions imposed for a long time while being detained in a remand prison. This means they are not allowed to meet other inmates, make phone calls or have visitors. In some case, even access to television and newspapers is denied.

In addition to housing inmates who are awaiting investigation by the police, trial or transport to prison, remand prisons are also used to detain individuals who are in custody in accordance with various laws:

- LVU (The Care of Young Persons Act)
- LVM (The Care of Alcohol and Drug Abusers Act)
- LOB (The Care of Persons under the Influence of Drugs Act)
- UTL (The Aliens Act)

Detainees in accordance with LVU, LVM and LOB are few in number and are held on remand for only a short time (from a matter of hours to 1-2 days). There are more UTL detainees and they may be held for several months. [1]

### **Medical services and mental health care in prison**

#### ***General information***

The medical services provided for inmates are regulated by law. There are medical care service units in all prisons and remand prisons in Sweden. This means that there is a nurse on duty during normal working hours and in some remand prisons there is a nurse on duty even at weekends and on public holidays. Some of the nurses have psychiatric training, but this is not a job requirement. Doctors visit

the prisons mostly on a weekly basis and the larger prisons and remand prisons also have psychiatrists who visit the prisons regularly. The nurses are employed by the prisons while the doctors are contracted as consultants and are paid by the prisons. The doctors are mostly remunerated at the same rates as private doctors in the community, which is higher than the salaries in the County Council Hospitals. All health care is at the level of an outpatient unit. If an inmate needs medical care as an inpatient, he or she will be transported to the local County Council Hospital. There are no prison hospitals in Sweden. [5]

### ***Committee for Prison Medicine***

The Swedish Prison and Probation Service has had a Committee for Prison Medicine since 1981. The reason for the establishment of this committee was the unexplainable differences in the prescription of the medications used as drugs among the various prisons (benzodiazepines, opiates). Since the committee was very active in following up the prescription of these medications, we have a unique material concerning the prescriptions in different prisons and remand prisons and of the different groups of medicines, classified according to the ATC system (Anatomical Therapeutic Chemical classification system). The Committee publishes the statistics every year and these provide a very good feedback for every doctor. Since 1983 the Committee has published *Basläkemedel inom kriminalvården* (Basic Pharmacotherapy in the Prison and Probation Service); this is a booklet with recommendations for medication for the most common symptoms and diseases in the prison population. There is a new edition every second or third year. [6]

### ***Health screening***

There is a health screening program for inmates in remand prisons. This is mostly carried out by nurses, but in some remand prisons all the inmates meet a doctor within a week after arrival. This screening program is for both mental and somatic problems. The security staff in Swedish remand prisons are trained to recognize deviant behavior and contact the health services. Many of them are specially trained to recognize suicidal behavior. The risk of parasuicide or suicide is highest in the remand prisons. Screening for suicidal behavior is carried out at the beginning of the detention by the medical staff and afterwards by the medical staff, if the inmate has contact with them on a regular basis, or by the security staff.

All inmates with substance abuse are offered screening for HIV and hepatitis A and B and C, and those who have not had hepatitis B are vaccinated.

Inmates may be isolated from other prisoners, either at their own request or on a compulsory basis if necessary. A doctor must examine a prisoner if he or she has been continuously isolated for a period of one month.

Any prisoners who are kept isolated from other prisoners because they present a danger to their own life or health, or who are kept bound by belt must be examined by a doctor as soon as possible.

There are round-the-clock routines for handling emergency health cases at every prison. If there are medical staff at the prison, they make the first assessment, otherwise the inmate will be taken to the nearest hospital.

According to the Official Secrets Act there is restricted access to information about patients within the health care services. The medical staff do not share information with the security staff and the patients' medical files are kept separate, accessible only to the medical staff. Sometimes, mostly in case of suicidal or self-destructive behavior the security staff form part of the treatment group; in this case they get the information about the patient they need. [5, 7]

### ***Psychiatric care***

The quality of psychiatric care in a prison is likely to meet the general mental health standards. The waiting list for evaluation by a psychiatrist is shorter inside prisons than outside. Most of the psychiatrists have been working for a long time with inmates and can handle their problems well. However, the most of the psychiatrists are not trained in addiction medicine and there is a need for it. Almost all the medication is administered under supervision; the treatment in prisons is followed much more closely than outside. All inmates who want to meet a psychiatrist are allowed to do so. In Sweden there is a shortage of psychiatrists in the general health care services.

Collaboration with the general mental health care services varies from region to region. If there is a need for psychiatric hospital care, mostly as compulsory treatment inmates have to be referred to a General Psychiatric Hospital. The staff on those ward units are usually not trained to handle the special problems of inmates (substance abuse and aggressiveness) and this mostly results in an early return to the prison. In some towns there are special wards which treat patients mostly from prisons (for example in Stockholm) and there the cooperation between the general mental health care services and the prisons is excellent.

The compulsory psychiatric care of inmates in Sweden is regulated by law: the Forensic Psychiatric Care Act, which is different from the Compulsory Psychiatric Care Act. Compulsory psychiatric care is only allowed at a psychiatric clinic and never in prison. For security reasons, the wards that can accept inmates for compulsory treatment must be approved by the government.

There are psychologists employed in every region, but the number varies from region to region. These psychologists are involved in both psychotherapy and treatment programs. Some prisons have consulting psychologists as well. Most of the psychologists have had psychodynamic training, but some of them work with cognitive methods and there are a few cognitive-trained psychologists. Accessibility to a psychologist varies from prison to prison; in some places the psychiatrist assesses the need for psychological treatment, in other places the selection of clients to meet the psychologist is not made on the basis of evidence.

There are three diagnosis groups that are clearly overrepresented in the prison population: substance abuse, personality disorders (including psychopathy) and ADHD. The treatment of withdrawal symptoms is very common in remand prisons and is similar to the treatment used in Addiction Clinics. There are special treatment programs for preventing relapses into substance abuse and for sex offenders. Both drug addicts and sex offenders are placed in special ward units with treatment programs. These inmates are generally not allowed to meet other prisoners. The drug addicts are saved from contact with drugs and the sex offenders from harassment by the other prisoners.

Concerning personality disorders, there are cognitive training programs to reduce criminality and aggression. For the diagnosis and treatment of ADHD there are projects that are starting this year.

In Sweden there has been a media discussion about the treatment of criminals suffering from substance abuse and mental disorders. This debate has not been about the treatment of inmates in prisons but about their treatment they did not get before they committed the crime.

### ***Substance abuse***

Since 1987 (with an interruption from June 1999 to February 2002) an HIV epidemiological study has been carried out at the main remand prison in Stockholm. All persons arrested or detained who were identified by injection marks or otherwise as illicit drug users were invited to participate in a voluntary study consisting of an HIV and hepatitis test and an interview on risk behaviour. This study helped to spread information about HIV and about possibilities for testing and improved the early identification of new cases. The number of HIV-tested drug addicts in Sweden is high and seroprevalence is low. This study developed into a program for screening inmates with substance abuse for HIV and hepatitis in all remand prisons in Sweden.

To improve the treatment of substance abusers in prisons, CDG (Central Drug Group) was started up in 2001. CDG is a specialist group connected to the Head Office, which prepares action plans, provides support and ensures quality. As a result of their work there are outreach teams in remand prisons, special units for motivation and treatment and therapeutic communities with evidence-based treatment programs. For the assessment of substance abuse the ASI (Addiction Severity Index) and MAPS are used generally. Treatment of heroin addicts with buprenorphine or methadone starts before their release from prison if it is necessary.

The aim of the Swedish Prison and Probation Service is to offer a drug-free environment to all inmates. In the battle for this goal there are some improved security arrangements; for example, sniffer dogs are now used.

There are no needle-exchange programs in the prisons in Sweden. [4, 8]

### ***Economy***

The budget for mental health care is a part of the overall prison budget. The nurses' salaries are negotiated by their Trade Union, which is generally and traditionally very strong in Sweden. Up to now the doctors have negotiated their appointment every second or third year with the Governor of the prison. These Governors are not medically trained, so they have a limited capacity to judge the doctors' ability to cope with the inmates. This has resulted in big differences in the doctors' competence in prison medicine and addiction medicine. From 2006 negotiations concerning the doctors' appointments are the responsibility of the Regional Director. Also from 2006 there is a centrally-placed coordinator for the medical services in every region to assist the Regional Director.

At present there is an ongoing efficiency program for prison health care. This means that the number of nurses will be decreased and their tasks will be more strictly by medical purpose. The goal is that one nurse will be responsible for 100 inmates in the prisons.

There is no limit to the cost of medicine and every inmate is offered all necessary medication, but there is a central discussion about costs and the medical units try to use the cheaper generic medicines. For the general public the pharmacists are supposed to provide patients with the cheapest generics.

## **Epidemiology of mental disorders**

### ***General information***

The Forensic Psychiatric Act was passed in 1992. The purpose of this new act was to reduce the number of offenders sentenced to forensic psychiatric care and the number of forensic psychiatric assessments and to limit the extension of forensic psychiatric assessments. This has also resulted in an increased number of prison inmates with psychiatric problems. There are no central statistics in Sweden about the number of inmates treated for mental disorders apart from suicide rates and substance abuse. However, the epidemiology of mental disorders has been investigated several times during the last 15 years.

### ***Research***

To assess the need for psychiatric care in the prison system, Westin carried out an investigation in all the prisons in Sweden. A questionnaire was sent to the various prisons to find out how many inmates they had with a psychiatric disease (psychosis) and with psychiatric disturbances (all those with a need of psychiatric care but without a psychosis) and how many of them had substance abuse.

This questionnaire was completed mostly by the nurse, sometimes by the psychiatrist and sometimes by one of the security staff. The highest number of inmates with a psychiatric disease and



disturbance was reported by the psychiatrist. This means that the results of the investigation underestimate the problem. The last column shows the number of inmates with substance abuse among the inmates with psychiatric disease or disturbance (table 2). [9]

**Table 2: Psychiatric morbidity in prisons by Westin (1992)**

	Number of inmates	Psychiatric disease	Psychiatric disturbance	Substance abuse
<b>Prisons</b>	3,538	74 (2.1 %)	588 (16.6 %)	460 (13 %)
<b>Remand prisons</b>	1,163	31 (2.7 %)	105 (9 %)	96 (8.3 %)

A study carried out by Levander et al. (1997) assessed a prison population in south Sweden. The dropout rate was more than 50 %, due to difficulties in speaking Swedish or English or in getting transport to other prisons. An Axell I diagnosis showed that 30 % of the inmates had had a psychiatric disease in their lifetime and 28 % at the time of the assessment; 75 % had a personality disorder and 23 % had a PCL-R score >26; 41 % suffered from dyslexia. [10]

**Table 3: Substance abuse in prisons by Levander et al. (1997)**

substance	percentage
Alcohol + sedatives	17 %
Narcotics	24 %
Alcohol + narcotics	19 %

In another study, 50 inmates on Gotland (an island south-east of the mainland) were assessed. Personality disorders and substance abuse were diagnosed for 75 %, psychopathy for 25 %, dyslexia for ca. 50 %, and Axell I diagnosis for 33 %. Ca 25 % had symptoms of ADHD. [11]

During one year (September 1996 – September 1997) Holmberg et al. investigated a total of 12,687 individuals who were detained at some time during the observation period. Of these, 294 inmates (2.3 %) received psychiatric treatment in hospital or in a psychiatric unit at least once. Inmates convicted of murder/manslaughter, arson, rape or unlawful threat, were two to five times more likely to require psychiatric treatment than the general prison population as a whole. Furthermore, their average individual number of psychiatric inpatient days was approximately twice that of inpatients convicted of other types of crime.

While 10 % of the total study population underwent a pre-trial forensic psychiatric examination, 45 % of those who ended up receiving psychiatric treatment during their prison term had been investigated by a forensic psychiatric specialist before being tried in court. [12]

**Statistics**

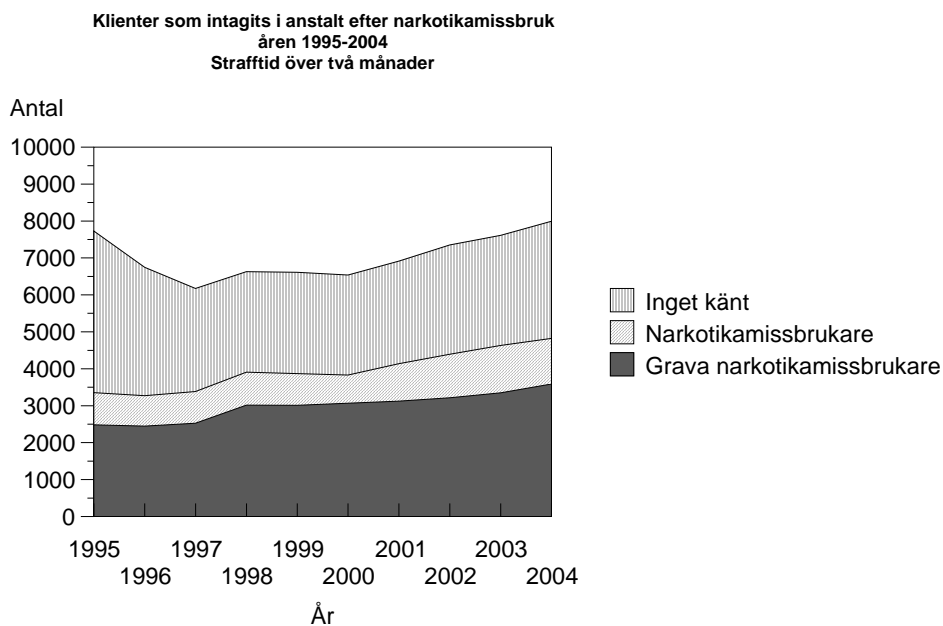
There are central statistics of suicide rates within the prison system. The number of suicides has been stable at a low level throughout (table 4).

**Table 4: Suicide rates in prisons and remand prisons in Sweden [13]**

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
<b>Prison</b>	2	3	1	3	1	1	2	3	1	2	3
<b>Remand prison</b>	2	3	4	7	1	4	2	5	7	5	4

CDG reports that the percentage of inmates with substance abuse has been increasing over the past 15 years (figure 1).

**Figure 1: Inmates with and without substance abuse**



**Table 5: Substance abuse in the Stockholm Remand Prison, 2005**

	Invited to participate	Accepted	Women	IDU	IDU women	IDU amphetamine	IDU opiates
<b>Stockholm</b>	718	612 (85 %)	11 %	403 (66 %)	14 %	64 %	36 %
<b>Gothenburg</b>	371	329 (89 %)	10 %	182 (55 %)	14 %	76 %	24 %

**Table 6: The average age, HIV test rate and new HIV cases from the Remand Prison Study [8]**

	Average age, amphetamine	Average age, opiates	IDU, HIV tested before	New cases of HIV
<b>Stockholm</b>	38.3	33.0	90.5 %	5 (3 A, 2 OP)
<b>Gothenburg</b>	35.0	30.3	91.8 %	0

## Quality standards and ethical aspects

### *Quality system*

The National Board of Health and Welfare, which is the ministry responsible for health care in Sweden, was made responsible for supervising health care within the Swedish Prison and Probation Service from 1 January 1997. The Director General has set up a quality system for health care in prisons which is developed and described in a manual. This manual presents the principles of a quality system and the general performance of health care, including the special demands of the prison system and the laws concerning health care in prison. Following the directives in this manual, all the health care units have prepared local routines for ensuring quality. This quality system is a dynamic and flexible system that is updated regularly. It includes an incident reporting system, which means that all events that might involve a risk for the patient must be reported (the most common problem concerns the distribution of medicaments). These reports are sent to the Head of health care, who is also the Regional Director. There are meetings held in every region, called quality meetings, at which the health care representatives (doctors and nurses), the governors of the prisons and remand prisons and the Regional Director participate. The frequency of these meetings varies from region to region, but the required frequency is at least twice a year.

Apoteksbolaget (the national pharmaceuticals retailing monopoly in Sweden) has the responsibility for the quality control of the storage and the administration of the medications.

Lex Maria is a law in Sweden which states that all health care units are bound by law to report all incidents in which a patient, in connection with treatment or examination, suffers a serious injury or illness or runs the risk of a serious injury or illness.

This report must be sent to the National Board of Health and Welfare, which does not otherwise actively participate in the quality control of health care in prisons.

Those inmates who are dissatisfied with the health care in prison have the same possibility to complain as patients in general in Sweden. During the last few years, the Board responsible for dealing with health care complaints, HSAN (Hälsa- och Sjukvårdens Ansvarsnämnd), received about 35 complaints yearly from prisons, but did not find any lack of treatment or maltreatment.

The assessment of mentally-disordered inmates in prison is the responsibility of a psychiatrist. All the consulting psychiatrists are specialists, some of them with many years of experience dealing with patients with personality disorders and substance abuse. Every year about 350 people undergo forensic psychiatric examinations before going to prison. Evaluation of mental health with the same depth is not possible in the prisons. There are no standardized instruments for screening or investigating mental disorders.

The staff dealing with the treatment of mentally-ill inmates (nurses, security staff) have no psychiatric training. There are a few psychiatric units in some prisons, but neither the level of training of the staff nor the accessibility to mental-health professionals really differs from the other units.

The further training of mental-health staff (psychiatrists, nurses) is not centrally organized. The training of the nurses is dependent on the prison budget, which is very limited; the training of the psychiatrists is their own, private business. The Swedish Prison and Probation Service has organized two two-days conferences for the doctors during the last 10 years. [7, 14]

### *Medical confidentiality*

Medical confidentiality is regulated by law and is taken seriously. The medical file of an inmate is never accessible to others than those who are involved in the health care of the inmate. To avoid problems, like knowledge of current abuse which cannot be shared with the security staff, the medical staff never check the urine samples for drug-screening, but they have access to the results from the security staff. Sometimes there is a need to share information with the security staff in the

inmate's own interest (for example, risk of suicide attempts, self-harm, out-acting behavior, etc.). In such cases, the information is limited to the emergency needs.

### **Ethics**

Sweden conforms to The Ethical and Organisational Aspects of Health Care in Prison with one exception: remand prisoners are not entitled to ask for consultation with their own doctor. In view of the high number of inmates in remand prisons with substance abuse, to follow this recommendation could end up in current drug abuse. However, the prison doctor contacts the inmate's own doctor, if the inmate allows it, in both remand prisons and prisons.

The Declaration of Malta (WMA Declaration of Hunger Strikers) and the Declaration of Tokyo (WMA Guidelines for Physicians Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment) are followed without restrictions in Sweden.

The Swedish prison doctors organized a society 1994 called SKLF (Sveriges Kriminalvårdsläkarens Förening, the Swedish Society for Prison Medicine).

This society deals, among other things, with ethical questions. The discussions during the last few years included the following topics: whether it is ethical that prison nurses should take specimens by order of the prosecutor; how to handle the fact that doctors could be forced by law to perform a body search of inmates by order of an authority and the fact that all doctors, including prison doctors, are forced by law to report to the police mentally-ill patients who are not able to handle a licensed weapon.

Tobacco smoking is another issue that has been discussed. Tobacco smoking is not permitted in the common areas in the prisons, but the staff are not able to enforce this ban. The result is that inmates, both smokers and nonsmokers, as well as the staff, inhale smoke all day long. In some prisons, young inmates under the age of 18 are allowed to buy tobacco, which is forbidden by law. [15, 16]

### **Current projects**

Treatment with buprenorphine and methadone during the last period of the sentence along with treatment with slow release methylphenidate has been introduced into Swedish prisons. Guidelines for this treatment exist, as a part of the "Basic Pharmacotherapy" ("Basläkemedel"), to ensure high-quality treatment, and an evaluation is planned.

CDG is working on stepping up the battle against drugs and the treatment of addicts.

The Remand Prison Study will continue to investigate the occurrence of substance abuse and blood-carried virus infections in the remand prison population.

The Remand Prison study is continuing the work about the epidemiology of the blood burn viruses.

Smoking cessation campaign by the suggestion of the Director General is going on. The goal is no smoking prisons at least 2008 January 1<sup>st</sup>.

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## Appendix 2 - List of Experts and Collaborators

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