



The challenges of treating the mentally ill in a prison setting: the European perspective

Prisoners show a high prevalence of severe mental disorder all over the world. In many places, suicide is a leading cause of death in prison and suicidal ideation and suicide attempts are major problems for health professionals working behind bars. Most European countries provide access to healthcare for their citizens at a high or at least adequate level of care. For providing mental healthcare in prison in those countries, equivalence of care should be prevailed, which means that treatment standards in prison should be equivalent to treatment standards in public mental healthcare. Mental healthcare in prison should offer outpatient treatment as well as in-patient treatment, the latter ideally with an open-door setting. The principle of confidentiality applies to health professionals working in prison as to all other health professionals. Female prisoners are an even more vulnerable group than male prisoners.

Keywords: compulsory treatment • force feeding • malingering • mental healthcare in prison • principle of confidentiality • principle of equivalence • suicide and suicidal ideation

In comparison to the general population, prisoners all over the world have an increased risk of suffering from mental disorders and in many places suicide is the leading cause of death in prison [1–6]. Therefore, prisoners in general have to be considered as a vulnerable population for severe mental disorder with a high level of individual risk factors and a high risk of poor health outcome and premature death after release [1,7–10]. Mentally ill prisoners are prone to an increased risk of deterioration and victimization during imprisonment as well as to a very high risk of poor reintegration into the community after release [11,12]. This is of particular concern as poor mental healthcare is supposed to increase the risk of re-offending in individuals with mental health disorders [13–16]. The increased consultation of forensic psychiatry experts in this area reflects the interest of the relevant agencies in reducing the risk mentally disordered offenders pose to others as well as in decreasing the high suicide rate in prisons and jails [17].

In Europe, deinstitutionalization, the closure of mental hospital beds and changes to

commitment laws were highly touted initiatives that provided the backbone of mental health reform policies implemented in many countries in the second half of the last century. These initiatives, however, have often given way for increasing demands of forensic psychiatric services and an increase in the number of mental patients in prison [18–21]. In general, in Europe, mentally disturbed offenders who are supposed not to be responsible for reasons of insanity are cared for in special forensic high security hospitals. Nevertheless, there are many individuals who are mentally ill, but sent to prison after committing a crime [43]. That happens for example when mental disorder is not known or when the individual is found to be responsible in spite of being mentally ill. These developments result in the fact that patients who receive a label of ‘forensic’ enter into a mental health ghetto with little connectivity or integration with the general mental health system [22,23]. Therefore, dealing with the challenges of treating mentally ill in prison in Europe has to take in account that mentally ill pris-

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oners often experience double stigmatization inside and outside prison. The authors intend first to prepare the reader for meeting the challenges of working with mentally ill in a prison context. Second, the article aims to establish understanding for the special needs of recently released convicts.

Providing psychiatric care in prison: equivalence of care

Ideally, mental healthcare in prison offers the opportunity of mental healthcare to individuals who may have never seen a psychiatrist before, provides psychiatric care for those who had actually been in mental healthcare and organizes a transfer to general mental health service after release.

Mental healthcare for mentally ill prisoners in general can be provided either inside prison as a part of the general healthcare for prisoners or outside as part of the general mental health service. The question whether mentally ill prisoners should be cared for inside or outside prison is discussed controversially [24–26]. In Europe, in most places, prison care models are preferred especially when caring for mentally ill prisoners considered to be dangerous for the community. Routine application of standardized diagnostic screening instruments should be a component of the admission procedure in correctional facilities supported by the high prevalence of mental disorders [27,28]. In countries that provide free high or adequate community healthcare standards, mental healthcare within prison should not be worse than in a community setting [29]. Regarding countries that lack high or adequate standard healthcare, at least the standards of Council of Europe should be met [30]. If one accepts that mentally disordered prisoners are cared for in penal institutions, possibly in a hospital wing/ward within the prison, then the principle of ‘equivalence’ of care between the community-based mental health service and the mental healthcare offered in prison should be safeguarded [31]. The functional level of the prisoner patient as well as the severity of psychiatric symptoms should guide mental healthcare in prison. Therefore, hospital facilities that keep and care for prisoners suffering from serious mental disorders should be adequately equipped and staffed with appropriately trained personnel. Inpatient psychiatric treatment is more than the distribution of medication to prisoner patients which are otherwise locked up 23 h a day in their cells. The availability of a multidisciplinary team comprising psychiatrists, psychotherapists, psychologists, occupational therapists and counselors is indispensable [32].

To achieve the aim of preventing relapse into criminal behavior in individuals with mental disorders who are prone to causing harm to others and to themselves,

mental healthcare professionals working in prison should insist on establishing a good transition management, especially for those who have slipped through the community healthcare system before incarceration. In general, released prisoners face a combination of different problems. Besides the need for housing and money, mentally disturbed ex-convicts need to adhere to medication to remain stable [33,34]. Therefore, cooperation with a local community-based psychiatric hospital would be preferable and reasonable. Ideally, this hospital should be a reliable cooperation partner and offer outpatient as well as in-patient care for released prisoners who are not stable enough for release at home. From this perspective, prison psychiatry is a very important part of community-based mental healthcare and should be an integral part of professional mental healthcare training [35,36].

The dual role conflict & confidentiality

Healthcare providers offering care in the context of criminal punishment encounter apparent conflicts between the treatment interest and the wider interests of the individual, legally protected interests and the public interest [37,38]. Unlike a surgeon or physician working in prison, psychiatrists working in a correctional setting have to deal with large numbers of individuals with ‘prison reactions,’ meaning conditions that are created by the imprisonment itself. To a certain extent, the function of the psychiatric and psychotherapeutic treatment in this situation is keeping the prisoner fit for imprisonment, serving a pacifying and mollifying function. Prison psychiatrists find themselves in this context sometimes in an ethically questionable territory if they carry out psychopharmacological or other medical interventions for which there is no primary medical indication, in order to allow judicial proceedings and the penal system to run smoothly [39]. This leads to an unavoidable tension between conflicting demands. The doctor/therapist following the Hippocratic Oath assigns the highest priority to the restoration and preservation of the imprisoned patient’s health. Therefore, he acts according to the requests and interests of his/her patient. But he/she is at the same time an employee of that authority which carries out the punishment required by the state. The prisoner’s health may well be damaged by the measures implemented in this context.

All doctors, including forensic psychiatrists, are concerned with the basic principle of confidentiality. Most countries govern this complex area by laws and/or professional guidance. To maintain a successful therapeutic relationship physicians working in prison should never disclose information about the patient without consent. There are limited numbers of clearly specified circum-

stances that allow an exception, usually when there is a threat of the patient harming him/her or others. In these cases of unavoidable disclosure, the patient should be informed about the disclosure and the reasons for it. Despite the fact that maintaining confidentiality is of major importance for the therapeutic relationship, there may be limited understanding of correctional staff.

Disciplinary measures

In some cases, mental disorders are not recognized. Deviant behavior of mentally disturbed detainees is misunderstood as a mere disciplinary problem. Therefore, occasionally mentally ill prisoners are placed in disciplinary segregation instead of being transferred to medical treatment. Disciplinary measures are coercive by nature. Due to their misbehavior caused by their symptoms, mentally disordered prisoners are more likely to become the subject of disciplinary measures [40]. Specific coercive measures (e.g., solitary confinement) may aggravate mental disorders. Prior to implementing such a measure, it is therefore crucial to assess the mental state of a prisoner in order to avoid any additional harm. Some European countries (e.g., Germany) provide assessments for their resilience before disciplinary measures are executed of all prisoners for whom punitive or disciplinary measures are intended or of all prisoners known to suffer from a mental disorder. In other European countries, such an assessment is not stipulated [41].

Considerable ethical problems are a result of the participation of medical personnel in the administration of disciplinary measures. The physician working in prison should never be urged to decide if a person is capable to withstand punishment. The role of a physician implies caring for physical and mental health and never means to be involved in punishment, for example, by supporting the prisoner's capacity to sustain such a punishment [42].

Somewhat surprisingly, in Germany like in most European countries disciplinary or coercive measures during imprisonment must be recorded, but are not published, so that scientific analyses are not possible. Such records or files would be an essential tool for investigating the appropriateness of such measures, particularly in the case of mentally disordered prisoners. Because of the negative effects of disciplinary measures on the mental health – especially for mentally disordered patients – close confinement should be reduced to an absolute minimum and be replaced with one-to-one continuous nursing care as soon as possible. Unfortunately, in Germany there is more isolation and observation by video than one-to-one continuous nursing. In such cases the prison psychiatrist is often confronted with ethical conflicts: testifying acute sui-

cidality in a mentally disordered prisoner without the possibility of adequate in-patient treatment means to produce a possibly traumatizing situation, particularly a situation of isolation with the requirement to undress or change clothes and to being exposed to video observation [43].

Suicide, suicide attempts & self-harming behavior

Self-harming behavior, suicidal ideation, suicide attempts and suicide are major issues for mental health professionals working behind bars. As mentioned above, prisoners are a selection of individuals who are at greater risk for committing suicide than the general population already before imprisonment [10,44,45]. Analysis of prison suicides in different countries indicates that there is no association of suicide rates of prisoners and those of the subjects living in the community [44,46]. The fact that the suicide rates among pretrial detainees are higher than among sentenced prisoners reveal that besides individual factors situational factors have to be taken into account [47–51]. One important factor associated with greater suicide risk is a charge with a serious or violent crime [48,52]. Suicide prevention programs exist, but in many cases mental health professionals face difficulties when trying to revise certain prison practices when trying to implement those programs [53,54].

Although suicide rates in prison are high, suicide in prison is rare in comparison to self-harming behavior and suicidal ideation, which are quite common. In their analysis of 139,195 self-harm incidents in prisons in England and Wales, Hawton *et al.* showed that individuals who do self-harm in prison have a greater risk to die by suicide in this setting [55]. Risk factors among male prisoners were older age and a previous self-harm incident of at least moderate lethality, risk factor in self-harming female prisoners was a history of more than five self-harming incidents per year. Although some cases of self-harming behavior are connected to true suicidal ideation, it has to be mentioned that there are cases in which self-harm is carried out with untold and/or unwanted motives [56]. In most cases, self-harming behavior has been found to decrease and even stop, when the person is transferred to a more 'caring' atmosphere, which also may reduce the tendency to commit suicide [57].

Malingering & exaggeration

Although malingering and exaggeration are considered typical problems of psychiatric work in prison, according to current research only 10–25% of male prisoners show malingering [58]. Because most psychiatric disorders are diagnosed clinically, they may be even more prone to being feigned than somatic disorders. Screen-

ing instruments for mental disorders exist but research conducted no clear categorical distinction between malingers and genuinely disturbed. Malingering a mental disorder may be understood as a personal strategy of coping with imprisonment [59,60]. Good clinical practice to identify malingering of mental disorders is a psychiatric in-patient care with an open door setting, where medical observation can reveal malingering and exaggeration easily in most cases. Caring for prisoners who mangle requires experience, patience and placidity and is often difficult for general mental health staff concerned with daily prison routine [61]. In this context, mental healthcare providers in prison should offer teaching opportunities and psychiatric departments of prison hospitals may function as a place for advanced training. In general, malingering and exaggeration should be understood as a personal strategy of coping with the adverse effect of incarceration and not as an attempt to draw attention.

Female prisoners

All over the world, female prisoners are a minority in prison. In comparison to male prisoners, female prisoners seem to be more vulnerable regarding suicide ideation, self harm and suicide [62]. Severe mental disorder is even more common in female prisoners than in male prisoners [63]. Because gender separation in prisons usually extends to medical practice, in most places the mentally disturbed female prisoners cannot be cared for together with male prisoners. Therefore it seems to be reasonable to establish a ward for intermediate care inside women's prison, where especially trained correction officers together with mental health professionals offer an intensive mental care option. If in-patient treatment for female prisoners is unavoidable, mentally disturbed female prisoners should be transferred to psychiatric hospitals outside prison. In these cases, a close cooperation between the general healthcare in prison, the psychiatric specialist and the prison administration is necessary. Once cooperation with a local psychiatric community hospital is established, contacts to this hospital may provide an additional option for advanced training for mental health workers.

Compulsory treatment & force feeding in prisons

If mentally disordered prisoners are under legal custodianship in Germany, the custodian can request a medically indicated compulsory treatment from the court according to the new civil law. For all other mentally disordered prisoners, compulsory treatment is regulated by the penal law; the pertinent provisions of which correspond to the standards for compulsory treatment within the framework of state commitment laws. Compulsory

treatment occurs within psychiatric facilities of prison hospitals. Unlike Sweden, German rules do not make it necessary to send the prisoners to general psychiatric facilities if compulsory measures become necessary [41].

The prisoner patient's decision to refuse treatment may occasionally result from a conflict relating to non-medical issues, for example, hunger strike as a protest against a judicial or administrative decision. In this case the doctor has to assess the state of health of the person concerned and to document in the patient's file by a detailed note that the individual has the capacity to understand the treatment proposed but has refused treatment on sound intentions after being given detailed information. Psychiatrists are regularly asked to assess the mental state of prisoners, especially to answer the question if the refusal is caused by delusions (e.g., to be poisoned).

Prisoners persistently refusing food in order to make a protest are rare, but cause a big challenge because knowledge about the hunger strike quickly spreads and gets into the political arena, especially when the demands have political implications. On the one hand governments want to resist these demands, on the other hand they do not want prisoners to die. They impose pressure on the prison healthcare staff, including prison psychiatrists, to keep the prisoners alive, if necessary, by force feeding. Nevertheless, treatment requires (informed) consent from the prisoner patient, except for an emergency when the patient is incapable of giving consent. The end stage of food refusal is coma, and it is foreseeable that the prisoner patient will become incapable of giving consent at that stage. Doctors are then allowed for intervening by artificial feeding to save the patient's life. However, this is not allowed if the patient has made it clear beforehand that he refuses interventions to prevent death (e.g., by an advance directive).

Conclusion & practical implications

Mental healthcare in prison should be accepted as an integral part of general mental healthcare. Cooperation with community mental healthcare providers should empathically be fostered as part of an advanced strategy against recidivism. Mental healthcare in prison should offer outpatient service as well as the opportunity of in-patient care in a psychiatric department of a prison hospital. In general, prisoners with acute psychotic disorders or acute suicidal ideation should be transferred directly to psychiatric in-patient care, because prisoners bear a high risk to die from suicide. In European countries, that offer mental healthcare on a high or adequate level, in-patient mental healthcare in prison should provide a treatment setting that is as similar to a community-based mental hospital as possible. Ideally during the stay on a psychiatric ward of

a prison hospital, there should be no lock up, neither at day nor at night, so that inmates have the opportunity to communicate and move freely inside the ward. There should be the offer of occupational therapy as well as opportunity for work for those who have to stay for a long time. For individuals who are for reasons of the severity of their mental disorder have difficulties to adapt to prison environment after finishing the in-patient treatment in a psychiatric ward of a prison hospital, a ward for intermediate care is an optimal option. This ward should be run by especially trained correction officers under supervision and counsel of mental health professional. Regarding the fact that poor release management of mentally disturbed prisoners is known to be connected with a higher risk of re-offending mental healthcare in prison should provide the option for intensive pre-release care.

Future perspective

Regarding psychiatric work in prison there is a strong need for further research. Up to now, it is not known

whether special prison conditions (i.e., solitary confinement) are causing continuing mental problems in detainees and should therefore be avoided as part of a prevention strategy. To reduce deaths from suicide inside correctional institutions, suicide prevention programs should be established. Standardized screening for risk factors for suicide is an essential component of such a prevention program. Psychiatric care inside correctional institutions should be seen as a part of general mental healthcare. Therefore, transition management should generally be established.

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Practice points

Epidemiology

- All over the world, prisoners bear an increased risk of suffering from mental disorders and of committing suicide.
- In Europe, mentally disturbed prisoners are mostly cared for inside correctional institutions.

Providing psychiatric care in prison

- Because of the high prevalence of mental disorders inside prison, routine application of standardized diagnostic screening instruments should be part of the admission routine in correctional institutions.
- Although prisoners persistently refuse food in order to make a protest, prison psychiatrists are regularly asked to assess the mental status of starving prisoners in order to answer the question if the refusal is caused by delusions (e.g., to be poisoned).
- Successful transition management after release from prison helps to prevent relapse in criminal behavior in individuals with mental disorders.

Confidentiality

- When working as a psychiatrist inside prison, confidentiality has to be maintained, otherwise there is no chance of establishing a successful therapeutic relationship with the detainee.
- When disclosure of information is unavoidable, for example, in case of threatening self-harm, the patient has to be informed about disclosure and its reasons.

Disciplinary measures

- Solitary confinement is known to aggravate mental disorders and should therefore be avoided for mentally disturbed prisoners and replaced by one-to-one continuous nursing care.

Suicide, suicide attempts & self-harming behavior

- Regarding risk factors for suicide, prisoners are a selection of individuals who show a high burden of specific risk factors even before imprisonment.
- Suicidal ideation and self-harm are quite common in correctional institutions. Although self-harming behavior could be an indicator of true suicidal ideation, there are cases in which self-harm is carried out for other reasons.

Malingering & exaggeration

- Quite frequently mental disorders are malingered.
- Malingering a mental disorder should be understood as a personal strategy of coping with imprisonment.

Female prisoners

- All over the world, female prisoners are a minority in prison.
- Female prisoners seem to be an even more vulnerable population regarding mental disorders, suicide ideation, self-harming behavior and suicide.

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