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MEntally Disturbed Inmates
Care and Support



MINISTERO DELLA GIUSTIZIA
Dipartimento Amministrazione Penitenziaria
Nucleo Progetti FSE

A common pilot model for countering psychological discomfort in European prisons

Summary

The MEDICS survey, carried out in Italy, Catalonia and Croatia, has confirmed that the psychological discomfort: a) is very much present in the three countries' prisons; b) is linked to high costs of medical care; c) risks to neutralize the rehabilitation attempts of imprisoned individuals; d) is often associated with drug addiction; e) might be the cause – though not the only one – of suicide in prison. From the survey, it has come out that: a) in Catalonia almost 100% of inmates with mental disorders receive effective treatments (psychiatric, psychological, social); b) in Italy, for those cases where the psychiatric disturbances are not related to alcohol or drug addiction, the treatment is essentially psychiatric-pharmacological; c) in Croatia, only 20 out of 100 imprisoned patients with mental disorders are visited by a specialist in mental disease, for lack of resources. The inmates with more serious psychiatric pathologies have more chance to be visited by a specialist, while the majority of inmates suffering from personality disorders receive a much symptom-oriented treatment (anxiety, insomnia). At the beginning, it is necessary to understand that the prison environment cannot and must not be regarded as a place where psychiatric treatments are the daily response to mental disorders and/or where the drug response might become the only solution to the issue. It has to be regarded as a setting in need of a strong integrated action between physical and mental health from the National Health Service and the socio-rehabilitation aspects in charge of the prison service. Similarly, it is well known its importance, the role of community services and the family for the in-taking, accommodation and job placement aspects, which are so fundamental but as much frustrating any attempted model if not implemented.

This short preface is proposing a co-operation model as the only feasible approach to carry out a holistic intervention on the inmate. Its strength, but also its weakness if we are not capable to catch its relevance, is the identification of a steering group which is in charge of coordinating, in a flexible way, all services provided by different public authorities – sometimes not very much at the patient's disposal.

It shall be fundamental, and coherent with the national relationships between prison and healthcare services in each country, to detect a cornerstone in the inter-institutional network that might be working as case manager, and is capable of understanding needs and multiple standpoints of the case patients and to co-ordinate all different interventions and confront the issues of mental discomfort in the prison environment.

It shall be also of much relevance, to start measuring and assessing interventions in terms of efficacy, efficiency and convenience, always taking into account the different set of rules and the variety of approaches in different countries to the issue of mental disorder in prison.

The first-care services model

Behavioural disorders, which are often associated with alcohol and drug abuses, are the most feasible conditions for one's first admission in prison and for relapsing. They are often amplified during detention when anxiety and depression feelings are intensifying. The *2003 Criminal Justice Act*, which has introduced the *Adult Community Sentence*, in England and Wales, provides a set of community orders– especially in case of alcohol and drug addiction or of people with an history of drug abuse or with mental pathologies.

The consensus given by the offender is requested when a community order is sentenced, and if the agreement is not reached the court can decide for custody. If the offender agrees, and later, during the enforcement of the community order, he breaches the community order prescriptions, he can be sent back to court and a decision will be then taken.

In the England and Wales' NHS there is not a possibility to impose a treatment on the offender, as it happens in Croatia instead. In Croatia, together with a sentence to custody, the judge can also decide for additional administrative sanctions, like mandatory and tailored rehabilitation treatments for alcoholic, drug addicts and mental disordered subjects. In case of mental pathologies, if the pathology is recognised as particularly serious, the sentence is enforced in dedicated public health facilities, therefore not within the psychiatric units in prison (in Croatia, it is the Ministry of Justice that is responsible for health care in prison, unlike in England and Wales, in Italy and in Croatia).

In Italy, what we expect as a result from the MEDICS project is to identify, since the admission to prison, the offender with psychiatric pathologies and at risk of suicide, and to immediately start any supporting action. We also expect to agree with the local healthcare service any medical, social, psychological, educational and information action plan, which might be at the inmate's disposal while in custody, and eventually in need of continuing any medical support received before imprisonment from local health services.

The Agreement made between the Italian State and its regions on January 19th, 2012, foresees the realisation of a practical preventing suicide and self-harm plan, taking into account the suggestions given by the WHO¹, and the papers coming from the Italian National Bioethical Committee².

These papers focus on the interaction between the individual and its environment, rather than "... detecting vulnerable subjects..."³. The so called universalistic approach is suggested, which has seen in the empowerment of environmental opportunities the most favourable setting for the promotion of the individuals' skills, starting from the most fragile ones.

Today, the presence of a psychiatric in prison is guaranteed as well as a differently articulated service for mental health, depending on the type of prison and the prisoners' needs.

In Italy, many regions have already their own centres for mental health, called "services for mental health safeguard", working at the care and verification of psychic infirmity on remand prisoners, convicts and internees, and at the Judiciary Authority's disposal if adopting any

¹ World Health Organization – WHO – "Preventing Suicide in Jails and Prisons". 2007.

² Of fundamental relevance the advice paper issued by the National Bioethical Committee, within the Cabinet of Ministers, *Suicide in Prison. Bioethical orientations*", dated June 25th, 2010.

³ *Ibidem*.

eventual decision to assist these patients in dedicated facilities with intense psychiatric care and support, both inside and outside the prison establishments.

Therefore, it has been decided that each region and autonomous province, through the Mental Health Departments, shall implement, together with the prison service, in at least one prison facility, a specialised unit for mental disorders in charge of the health service, which shall guarantee:

- The reception and in-taking of inmates with mental disorders already in custody;
- The admission and care of individuals with psychic infirmity occurred during detention (ex art. 148 of the Criminal Code) or receiving a sentence mitigated by reason of mental defect (ex art. 111, paragraph 5 and 7, Presidential decree 230/2000);
- The assessment of the psychic infirmity as per art. 112, Presidential decree 230/2000;

Thus doing, it is possible to provide a wider psychiatric care, which shall support the inmate, while **implementing** a psychiatric prevention and care scheme that can impede the **psychic** discomfort or at least mitigate it and enforce the medical and specialist centres needed. Together with the enforcement of targeted legislations, in each prison it is necessary to foresee a qualified and specialised care and support.

In Italy, a scheme for overcoming the Judiciary Psychiatric Hospitals (where security and custody were prominent) has been carried out: it consists of the opening of facilities – REMS – where the rehabilitation and treatment aspects are major with respect to custodial needs. At the moment, many REMS have been opened – there is one REM in almost each Italian region. And the closing of the past Judiciary Psychiatric Hospitals is almost due, even if some critical situations are still ongoing.

It has been commonly observed that just a limited number of prisoners is affected by serious mental illness (like schizophrenia, paranoid syndrome, deep depression and so on). Nevertheless, a wide range of disturbances, that require particular attention, is still existing. They may turn into more serious psychopathological conditions that need to be taken in charge by the mental health services.

During daily activities, an approach which involves prison and health care services should be guaranteed: it shall implement a proactive model, which is not based on emergency and improvisation, but on early detections of any psychic discomfort. All this shall be therefore translated in better medical cares to the prison population, in the attenuation of tensions and the amelioration of prison staff wellbeing at work – notwithstanding the lessening of costs.

The quality of the pharmacological treatment of psychic disorders

There are some very effective drug treatments for different psychopathological disorders, but many inmates are still misusing psychiatric drugs, sometimes even continuously. Moreover, specialists encounter many difficulties in having advanced pharmacological tools available and carrying out qualified interventions: this can explain why a relevant number of treated inmates continue to have the same problems. One has also to take into account the influence of the environment on mental disorders, which cannot be countered on its own, not even by implementing an appropriate pharmacological treatment, while in some cases it results in more critical conditions. Furthermore, any pharmacological treatment has limited and not adequately efficient results, if it is not an outcome of an integrated and multidisciplinary approach.

The nodal points of the common model

Starting by saying that some modifications to national legislations are unavoidable – in particular the suspension of the sentence and some forms of probation orders for those inmates who are affected by psychiatric pathologies – the effort made to ameliorate the approach the psychic discomfort in prison shall focus on:

- 1) Screening at induction and also in custody (periodical), to catch eventual psychopathological disturbances from the scratch or non visible disorders which have not been sufficiently examined, especially if covered by adjustment disturbances. The screening is to be considered for special patients who have already been in charge of the local mental health departments for problems associated with psychiatric disorders, drug and alcohol addictions. The experience of a screening test (cornerstone for preventing organic pathologies such as diabetes, hypercholesterolemia, hypertension, breast cancer and so on) should become practice also to prevent the consequences of psychic discomfort;
- 2) Implementing motivational interviews and behavioural approaches to react to and solve imminent problems or at least considered as such by the patient;
- 3) Involving the inmate in awareness raising and conscious processes about the objective of the intervention to foster consistency of treatment and its efficacy;
- 4) Realising rehabilitation schemes based on life in prison spent within the inmate community. They shall therefore privilege interrelationships and time spent in common spaces;
- 5) In-taking by the Department of Mental Health and the Addiction Service for special cases;
- 6) Teleconsultive support between prisons and the Department of Mental Health;
- 7) Involving the inmate's external contacts (family, friends, volunteers);
- 8) Elaboration of procedures and protocols that involve prison services, public bodies and health care services. To built up a task force in each prison establishment made of a psychiatrist, a psychologist, a nurse, a probation officer, a rehabilitation officer, a security officer and coordinated by the psychiatrist; each inmate shall be taken in charge by the team and shall be monitored and assessed through social adjustment and clinical scales so to vary the necessary interventions and proceed by steps;
- 9) Arranging tools that guarantee the circulation of information among the medical staff in prison, the health care local service (or eventually the hospital), the specialist and the prison service (this last only for the information requested and needed);
- 10) Developing national/regional rehabilitation guidelines for the prison population and constant assessment of their application;
- 11) Continuous refresher training for prison front liners (medical staff, nurses, security staff, rehabilitation and probation officers).

Pilot combinations of these interventions are suggested in prison establishments.

Some critical aspects and the need for joined training courses

The implementation of efficient models is demanding a substantial change in practices carried out in the prison establishments. Those efforts can encounter some obstacles, such as the lack of qualified staff. This critical aspect came suddenly to light in Italy, with some different

nuances in Croatia and in Catatonia. All professionals from diverse public services shall therefore be trained at a Specialisation Centre where groups of national experts (from all bodies) shall provide staff with all basic elements. Staff will therefore be capable to carry out the needed specific functions and will implement the proposed model at induction in prison until release and reinsertion in the community and social life.