Generalitat de Catalunya
Departament de Justícia

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ME.D.I.C.S.

MENTALLY DISTURBED INMATES CARE AND SUPPORT

ME.D.I.C.S.
MEntally Disturbed Inmates
Care and Support

PROJECT REPORT:

CATALONIA

General Directorate of Penitentiary Services
(Direcció General de Serveis Penitenciaris-DGSP)

Catalan Health Institute
(Institut Català de la Salut-ICS)

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Barcelona, January 2016

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1. PROJECT PRESENTATION

The origin of the Project ME.D.I.C.S., approved by the European Commission, based on the need raised by its promoter partner, Italy[1], to obtain a framework of clear and detailed information on the situation of prisoners with mental disorders present in the Italian prisons for the following purposes: management of prisoners with mental health problems and drawing up plans to organize an operating model designed to allow the most appropriate actions in the reception, care and treatment of prisoners.

Part of this information and also the improvement proposals were planned to be obtained knowing the practices adopted in different countries around this topic. In Catalonia, there are the Justice Department of the Generalitat of Catalonia and the Catalan Institute of Health the two institutions responsible for managing the implementation of a specific part of the Project, located in Catalonia, and based on a quantitative study being the overall aims and objectives as follows:
Based on the overview of the situation that the workers involved in the ME.D.I.C.S. Project have. Project, the goal is to offer proposals for improvements, changes or new legislative regulations involving a fix, increase or improve the care of inmates with psychopathological problems.

Health of the inmates in Catalan prisons and, in particular, their mental health is an issue always present between the priorities to take into account when designing the most appropriate public policies of intervention. The right to health and to mental health in prison is a basic human right that is essential and inalienable.

[1] Ministero della Giustizia (2015. Scheda sul progetto MEDICS disagio mentale in carcere - Mentally Disturbed Inmates Care and Support - ME.D.I.C.S. - (luglio 2015). Available at: https://www.giustizia.it/giustizia/it/mg_1_12_1.wp;jsessionid=B655CF8FFECF2D9F2A66481484D37D20.ajpAL02?facetNode_1=4_49&facetNode_3=0_0&facetNode_2=1_0(2015)&previsiousPage=mg_1_12&contentId=SPS1165807

1.1. European and Catalan legislative frameworks

Catalonia is the only Spanish home ruled region that has been transferred the responsibility for correctional services and is responsible for the coordination, supervision and implementation of ad hoc policies; legislative regulations are governed by different national and regional authorities but, normatively speaking, they are also linked to several supranational provisions. Indeed, the European Parliament resolution 2011/2897 (RSP)[2] of 7 December 2011 on the conditions of deprivation of freedom in the EU, consider the alarming number of "prisoners with mental and psychological disorders," in his Initiative number 7 asks Member States to "allocate adequate resources for the restructuring and modernization of prisons, to protect the rights of prisoners (...), to provide the police and prison staff training based on current prison management practices and European human rights standards, to monitor prisoners suffering from mental and psychological disorders and to create a specific EU budget heading intended to encourage these projects. "

In the Recommendation R(2006)2 of the Committee of Ministers to member states on the European Prison Rules[3] , two basic principles are fully embedded in the stated objectives of the Project ME.D.I.C.S.: in 40.5, on the right of all prisoners to benefit from the necessary medical, surgical and psychiatric treatment, similar to those available abroad; and in 47.2 .: "Correctional Medical Services should ensure psychiatric treatment to all inmates who require this therapy and pay special attention to the prevention of suicide."

In the same way it is expressed by other European Recommendations as R(2012)12 of the Committee of Ministers to Member States concerning foreign inmates[4] and Recommendation R(2004)10 of the Committee of Ministers to

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[2] Available at: http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+MOTION+B7-2011-0687+0+DOC+XML+V0//ES

[3] Available at: http://www.institucionpenitenciaria.es/web/export/sites/default/datos/descargables/legislacion/REG_PEN_EUR_ES.pdf

[4] Available at: http://www.institucionpenitenciaria.es/web/export/sites/default/datos/descargables/legislacion/RECOMENDACIxN_EXTRANJEROS.pdf

Member States concerning the protection of human rights and dignity of persons suffering from mental disorder[5] .

This last recommendation carefully stands both, the framework, and the precise strategies to address the issue of mental health in general and when this situation occurs in a prison centre. Thus, Article 7 establishes that Member States are responsible to ensure generating mechanisms to protect vulnerable persons with mental disorders, especially those who do not have the capacity to consent or to object to the violation of rights. Article 33 refers explicitly to prisoners and detainees when provide that if their behaviour suggests that it is suffering from a mental disorder then “should be a proper medical examination as soon as possible and in an appropriate place for to determine whether the person needs medical care, including psychiatric”. Article 35 delves further into this particular aspect when it states that ”persons with mental disorders should not be subject to discrimination in penal institutions”, adding that prisoners: should receive appropriate treatment options; the involuntary treatment for mental disorders should not be in penal institutions except in hospital or medical services adapted to the treatment of mental disorders and, finally, that an independent system should monitor the treatment and care of people with mental illness in prisons.

As for Catalonia, we highlight in this introduction the current Comprehensive Plan of care for people with mental illness and addictions. Priority actions for 2014-2016, Government of Catalonia, 2014). This document contains prioritizing actions to be taken by the Government under the previous plan of November 2010, which determined the Catalan model in the field of mental health and addictions. It was developed through the joint work of the Administration of the Generalitat of Catalonia (the departments involved in public policies of health, education, social services, justice and employment) and social organizations in the mental health sector to determine priority actions which should be promoted in the coming years in the field of mental health.

[5] Available at: https://wcd.coe.int/ViewDoc.jsp?id=775685

Among its strategic lines highlights, following the requirements of the Project ME.D.I.C.S., the Objective 7.1 of the LE 7 ("Improving psychiatric care and mental health in the judicial field, for people in a situation of deprivation of liberty and security measures "):" To qualify the specialized intervention aimed at the attention, in the field of mental health, of the inmates of the Catalonian prisons."(Government of Catalonia, 2014: 20).

1.2. Structure and functions of the prison health services in Catalonia

It must be pointed out that the Catalan prison system has an organizational chart and powers derived from the process of integration of prison health to the Ministry of Health (Decree 399/2006[6]), because this department assigns functions in health of inmates, including children and young adults. That is, the system "is attended by professionals from the public system that supports it. They can attend organic or psychiatric medicine cases of certain entity and, if any, deriving them to public hospitals."[7]

Among the services on prison healthcare of the Justice Department of the Generalitat of Catalonia has a program of mental health care and mental deficiency addressed to prisons with the objectives of:

- Identify, assess and monitor all inmates entering a prison with some kind of disorder, psychiatric disease or mental deficiency.
- Provide continuity for patients admitted with specific treatments.
- Assess the psychopathological status of each inmate in order to assess the activities which he will be allocated in the centre[8].

[6] DECRET 399/2006, October 24th October, which assigned to the Department of Health functions in health and health of persons deprived of liberty and children and young people detained in juvenile justice centers and integrated into the public health system services of correctional health and juvenile justice. Available at: http://www.gencat.es:8000/salut/depsalut/pdf/06296205.pdf

[7] Department of Justice of Catalonia: http://justicia.gencat.cat/ca/ambits/reinsercio_i_serveis_penitenciaris/rehabilitacio_i_insercio_sociolaboral/

[8] Department of Justice of Catalonia: http://justicia.gencat.cat/ca/ambits/reinsercio_i_serveis_penitenciaris/serveis_penitenciaris/assistencia_sanitaria/

As for specialized care in mental health resources and services available in the prison environment are organized into three levels: the first focuses on primary health team centre and psychiatric care patient support; the second focuses on prison centres that have psychiatric nursing unit or versatile unit in charge of specialized hospital care of the mental health and addictions team (psychiatric emergency, intensive care, hospitalization on medium, long, or partial term); and, the third level, focuses on hospital care of more complex cases offering psychiatric rehabilitation services, day hospital, psychosocial rehabilitation services, residential unit and special unit for driving transition to ordinary life. (Office of Rehabilitation and Health Programs, 2011: 124-125)

1.3. Features and paragraphs of the Project

So far we have raised the overall framework which will develop this report, both as regards to the overall objective of the Project ME.D.I.C.S. as to this work itself, as well as to the global regulatory Catalan environment.

It is a study that reflects the views of the professionals who work in the subject exposed. The methodology is quantitative and focused on one technique for exploiting data, the questionnaires designed by Italian promoters of the Project, according to the professional group to which it was addressed. The Catalan team did not change, although in Catalonia the questionnaires directed to prison educators were aimed at the treatment area teams, since they share a comprehensive project altogether (the treatment teams in Catalan prisons is composed by : educators, psychologists, social workers and pedagogues). So, they were sent to seven groups: prison Directors, treatment staff, surveillance officers, teachers, doctors, nurses and volunteers.

Should be kept in mind that prisons tend to receive many requests for information related to the penitentiary and criminological research (interviews, surveys, focus groups ...) with the resulting fatigue to interference that can lead to the development of normal daily activity of the staff... That is why, initially, the reception of these questionnaires by the professionals was not quite

enthusiastic: they find them too large, amalgamated concepts and difficult to understand and respond swiftly. However, if we do not count the volunteers, who had a very small participation (4%), the other professionals who responded represent a 23% of these groups of personnel.

The report contains the following chapters:

Chapter 1, Project presentation, with comments on international standards and also includes a section with general information about Catalonia in order to facilitate the comparison with other partner countries in the study (with socio-economic and demographic data).

Chapter 2 deals with concepts of mental disorder and mental disorder at the Catalan prison environment in a brief manner.

Chapter 3 explains the methodology of the research, its purpose and objectives

Chapter 4 address the results and analysis derived from them.

Chapter 5 includes the main conclusions, proposals and some general reflections on the fruits of research.

1.4. Catalonia and the Catalan Correctional Services

1.4.1. Catalonia[9]

Catalonia is one of the 17 home ruled regions that make up the Kingdom of Spain and is located geographically in the north east of the Iberian Peninsula. Its official languages are Catalan, Spanish and Occitan, and its capital Barcelona.

[9] The data present in this section have been taken from: Government of Catalonia. Statistical Institute of Catalonia (http://www.idescat.cat) Expansion. Macro Data (http://www.datosmacro.com) and the Justice Department of the Generalitat of Catalonia (http://justicia.gencat.cat).

With an area of 32.106 km2, its population is 7,518,903 inhabitants (2014). It has a Gross Domestic Product (GDP) of 199.786 million € (2014); its GDP per capita is 26.9 thousand € (2014).

The age distribution of the population in the following percentages (2012): 0 to 14 years 15.9%; 15 to 19 years ,4.5%; 20 to 34 years, 18.9%; 35 to 64 years, 43.2 and 65 years and over, 17.5%. Regarding gender, 50.1% of the population is women.

It is divided into four provinces, divided into regions, and the highest governing body is the political and administrative own government, Generalitat de Catalunya, which exercises executive functions and regulatory power.

The Generalitat of Catalonia has broad powers and manages various fields and facilities (education, health, social affairs, traffic, determination of economic, trade, etc.).

Catalonia has several responsibilities transferred by the State (culture, tourism, housing, credit planning, banking and insurance, prisons, police, etc.). It has its own regional police (*Mossos d'Esquadra*) with full responsibilities in security matters, except those functions attributed exclusively to the General Administration of the State, for example, monitoring of ports, airports, coasts and borders.

Legislative power is exercised by the Parliament of Catalonia, with legislative powers, the responsibility for approving budgets and controlling government action and government policy.

1.4.2. The Correctional Services

Concerning basic penitentiary general data, excluding the data of juvenile offenders, 31 December 2015 there were 9294 inmates incarcerated in the Catalan prisons.
Currently, Catalonia has 15 Prison facilities:

Closed centres:

Barcelona Men's Prison
Barcelona Women's Prison
Juvenile Detention Facility in La Roca del Vallés, Barcelona
Quatre Camins Prison in La Roca del Vallés, Barcelona
Brians 1 Prison in Sant Esteve Sesrovires, Barcelona
Brians 2 Prison in Sant Esteve Sesrovires, Barcelona
Lledoners Prison in Sant Joan de Vilatorrada, Barcelona
Puig de les Basses Prison, in Girona
Ponent Prison, in Lleida
Mas d'Enric Prison, in Tarragona

Open centres:

Barcelona Open Prison 1
Barcelona Open Prison 2
Girona Open Prison
Lleida Open Prison
Tarragona Open Prison

It also has **two hospitals**:

Penitentiary Prison Pavilion at the Tarrasa Hospital for organic disease.
Psychiatric Hospital Prison Unit, integrated into the large complex of Brians 1.

2. THEORETICAL FRAMEWORK

2.1. The concept of mental disorder

Physical and mental health are essential for the successful development of the individual such as such as individual life in society. As for the mental disorder that is defined by the WHO[10] as a syndrome characterized by a clinically significant alteration of the state cognitive, emotional regulation or individual behaviour, which reflects a dysfunction of psychological processes, biological or developmental.

Mental disorders, usually associated with stress or significant disability, such as social and work problems, can be given in all its crudity in the prison environment due to the particular idiosyncrasies of life in prison.

The diagnosis of a mental disorder should be a priority in order for the doctor to determine the prognosis, treatments and possible outcomes on their patients. However, the diagnosis of a mental disorder does not entail the need for treatment: a complex clinical decision that should consider the severity of the symptom, not always equivalent to the need for treatment and its meaning (for example, presence of suicidal ideation), the suffering of the subject, including disability associated with these disorders that involve the risks and benefits of available treatments, and other factors such as psychiatric symptoms that complicate other diseases and vice versa (e.g.: drug for psychiatric effects).

Mental disorders are diverse and each is accompanied by different symptoms. However, often characterized by a mixture of thoughts, emotions, behaviour and abnormal social relationships. The WHO (2013: 42) divides in the International Statistical Classification of Diseases and Health Related Problems, 10th revision (IDC-10), as follows: F00 to F09, organic mental disorder, including symptomatic disorders; F10 to F19, mental and behavioural disorders

[10] World Health Organization (2015). Mental disorders. Fact sheet N° 396. Available at (Spanish version): http://www.who.int/mediacentre/factsheets/fs396/es/

caused by psychoactive substance use; F20 to F29, schizophrenia, delusional disorders and disorders schizotypic; F30 to F39, mood disorders (affective); F40 to F48, neurotic disorders, stress-related disorders, and somatoform disorders; F50 to F59, behavioural syndromes associated with physiological disturbances and physical factors; F60 to F69, personality disorders and behaviour in adults; F70 to F79, mental retardation; F80 to F89, disorders of psychological development; F90 to F98, emotional and behavioural disorders usually appear in childhood and adolescence; and F99, unspecified mental disorder.

2.2. The mental disorder in the prison environment

As pointed out by the Criminal Code, is exempt from criminal liability and, therefore, is in imputable, who at the time of committing the offense cannot, due to any anomaly or psychic alteration, understand the illegality of the fact or act according this understanding. Also who, because of suffer from disturbances in perception from birth or from childhood, has severely altered consciousness of reality. (Gallego, 2015)

The inimputability excludes liability, but not the possibility of imposing custodial security measures, as a psychological 'abnormality' can divert to a “dangerous” behaviour or generating alarm. (*Op. cit.*)

The presence of psychopathological disorder may or may not confirm the existence of a serious mental disorder. However, what matters is the psychological effect of the disease that occurs in the functionality and quality of life of the person. This effect can disturb the mental faculties so that the subject can carry out a non-adapted behaviour (until commit some kind of crime). (*Op. cit.*)

Among the mental illnesses that involve inimputability when commits an offense they are mental retardation, delirium, dementia, drug addiction -always if result in full intoxication-, schizophrenia and some cases of severe disorders of mood. (*Op. cit.*)

It is true to say that prison is an institution that can create or aggravate mental illness, and in prison the person can get sick, develop adaptive frames (anxiety, depression), behavioural disorders, addictive disorder, and psychosis inclusive. Early detection of mental disorders in prisons and treatment priorities are remarkably observed by several studies (Capdevila, Ferrer, 2007: 30).

At the aforementioned Recommendation R(2006)2 of the Committee of Ministers to Member States on the European Prison Rules establishing the guiding principles of the work in prisons, there are a range of recommendations that regulate explicitly what should be the care of the mentally ill in prisons. Thus, the Recommendation 12.1. ("People who suffer from mental illness which mental health condition is incompatible with detention in prison should be detained in an establishment designed for this purpose."); Recommendation 12.2. ("However, if these people are exceptionally detained in jail, their situation and their needs should be governed by special rules."); Recommendation 40.4. ("The prison medical services should strive to continue and treat mental illnesses or mental deficiencies and patients eventually suffer."); Recommendation 42.3.e. ("When examining a prisoner, the doctor, or / nurse / qualified depending on the physician should put special attention: (...) to the identification of any psychological pressure (...) to a high-stress due to deprivation of liberty. "); Recommendation 42.3.h. ("(...) The identification of physical or mental health problems that can hamper the reintegration of the inmate after his release."); Recommendation 42.3.j. ("(...) to the conclusion of agreements with the community services so that all necessary medical and psychiatric treatment for the person concerned can continue after his release if the prisoner consents this agreement. "); and Recommendation 47.1 ("The institutions or specialized sections located under medical supervision should be organized for observation and treatment of prisoners suffering from mental disorders or conditions that are not necessarily provided in the provisions of Rule 12.") (*Op. cit.*: 31-32)

As for the figures for the prevalence of suffering from some kind of mental disorder in our prison population, throughout his life, is 84.4%. It means, five times more in relation to civilian population (PRECA Study, 2011):

- Substance abuse disorders (76.2%)
- Anxiety disorders (45.3%)
- Mood disorders (affective) (41%)
- Psychotic disorders (10.7%)

3. RESEARCH METHODOLOGY IN CATALONIA

3.1. Introduction, purpose and objectives

The extraction and data analysis focused exclusively on models of written questionnaires aimed at professional and designed by the Italian developers of the Project ME.D.I.C.S. However, there were questions that, although not modified, were took into account when analysing data; for example, by no distinction between Project promoters of self-harm and attempted suicide. Indeed, professionals working in Catalonia on the subject of mental health in prisons make the appropriate distinction: actions or self-harm attempts also called "manipulators"[11] (manipulation attempts) "must be viewed as more expressive episodes as intentional, that is, as a dysfunctional way of communicating a problem. These little finalists' actions, of low lethality, therefore not seek the death and are highly vindictive; according to some studies that character reaches 80% of the events. (Direction General of Penitentiary Services, s/s: 1).

Another thing different are the actions or self-harming behaviours with suicidal intent, which have much higher rates in prisons than in the general population. They are associated with people who abuse alcohol and / or substances which have been involved and committed suicide attempts before, who have psychotic mental disorders (such as schizophrenia, organic or toxic psychosis and maniac outbreaks) and depression, that are for the first time in a prison -being more common during the first few days in the establishment- and the population shocked by the imprisonment sentence or long daily stress related to life prison. (*Op. cit.*: 2)

Other questions contained in the questionnaires were neither modified nor be taken into account when analysing data; for example, when asked to the group of physicians how long does the inmate initiates the chosen protocol after an attempted suicide or self-harm. The appropriate response would be

[11] Also the WHO defines and supports this concept ("manipulation attempts") into WHO-IASP, 2007: 24-25

“immediately”, but it is not stated in the questionnaire being the closer one “less than a week.”

The objectives of this report are:

1. Provide an overview of the features of the collective groups participating in our research.
2. Show the answers given by different groups as described in section 3.3. of this chapter.
3. Point out the improvement proposals of the groups of participants in the research.

3.2. Technical details for the operation and data analysis[12]

Fieldwork: was developed between 23rd February 2015 and 23rd May 2015 (with a prior task of presenting the Project to the management teams of the three prison centres selected - the first of men, the second of women and third of young- before the end of December 2014).

Sample: 174 participants (23,4%).

Population: 744 employees in the three centres

Methodology: Self filled paper questionnaire (6 different models for 6 professional groups + 1 group of volunteers) and emptied through the spread sheet Excel and SPSS. There have been various tests Chi-square statistics to know the differences that are significant in the first part of the study (profile / characteristics of participants).

Sampling procedure: from the Directorate General of Penitentiary Services was to get the questionnaires to the management team of prisons Brians Homes, Brians Women and Youth Prison Centre. From the direction of each prison were

[12] Sources: La-Roca (2006), Luque (2000), Santesmases (2003), Visauta (1997).

distributed and collected the questionnaires of the individuals of the 7 groups which are objects of study. The management of each prison sent all completed questionnaires to the Directorate General of Penitentiary Services from which it was forwarded to the statistical analysis team for operating data.

Sampling error: for a confidence level of 95% and P = Q, the error is ± 6.5% for the whole of the global sample. A as the sampling error is ± 6.5% for a total participation of 23,4% of the population. However, the results for each group are scientifically valid with stakes exceeding 30% except for the groups of Surveillance officers and Volunteers. This latter group, which can also develop activities outside prisons on the basis of the penitentiary status of the person in prison (criminal measures and alternative compliance period in open environment), was chosen as a source of information for developing tasks essential not only in legal assistance, socio-cultural and educational support issues, etc., but also in health promotion.

Calculation of sampling error **(ε)**: $\varepsilon = \pm K * \sqrt{\frac{p*q}{n}} * \sqrt{\frac{N-n}{N-1}}$

K: constant related to the level of confidence. It has taken 95% confidence level, this corresponds to a value of K=1.96.

p: Proportion of the feature analysed (either the population or sample) When is unknown, use the value of 50% and is said to be the case of maximum uncertainty.

q: the complementary proportion of the feature under study, as appropriate to the population or the sample.

Weaknesses of the study: low participation in two of the seven groups (surveillance officers and volunteers). However, volunteers in prisons:

- They do not attend the prison every day (mostly during weekends).
- They only see inmates on given situations.

- There are not sufficient resources available to communicate with them (intranet ...).
- The registry has not been updating for sometime.
- Their number has been decreasing during the last four years (retirement, reduced financial support ...).

Strengths of the study: the population was bounded; direct access to all individuals (except volunteers); very reliable results in most groups.

4. RESULTS

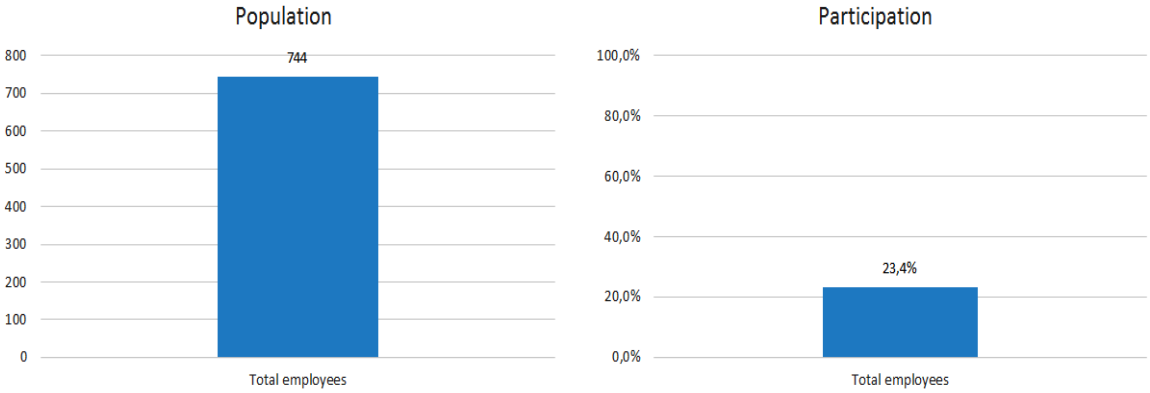
4.1. Characteristics of the participants

4.1.1. Participation

The total number of workers in the three selected prisons (the first for men, the second for women and the third for youth inmates), were 744 plus 376 volunteers. Volunteers have been excluded due to a methodological problem, as it has already been mentioned at the end of Chapter 3. However, we enclose the answers given for the 15 volunteers who filled the questionnaires. The distribution for employees and centres were as follow:

Professionals[13]	CP Brians 1-Men	CP Brians 1-Women	CP Youth	Total
Directors	1	1	1	3
Correctional Officers	360	89	119	568
Treatment area	60	17	27	104
Teachers	16	6	15	37
Doctors	6	3	4	13
Nursing staff	9	5	5	19
Total employees	452	121	171	744

Chart 1



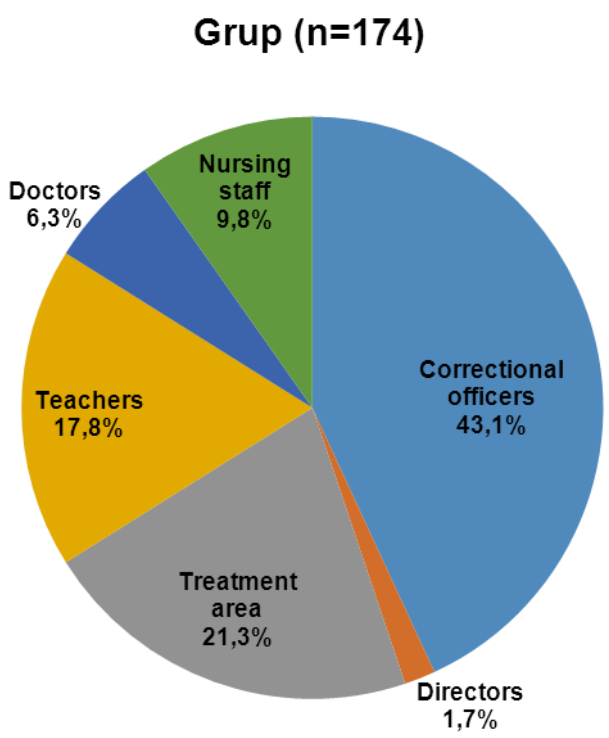
[13] The prison centre B1 for men and for women have a steady number of professionals each one, but both centers are gathering the school and the volunteer's program.

Of the total (744), there were received **174** questionnaires filled plus 15 from the volunteers. The distribution was as follow:

Employees Participants	Total
Directors	3
Correctional Officers	75
Treatment area	37
Teachers	31
Doctors	11
Nursing staff the following chart	17
Total	174

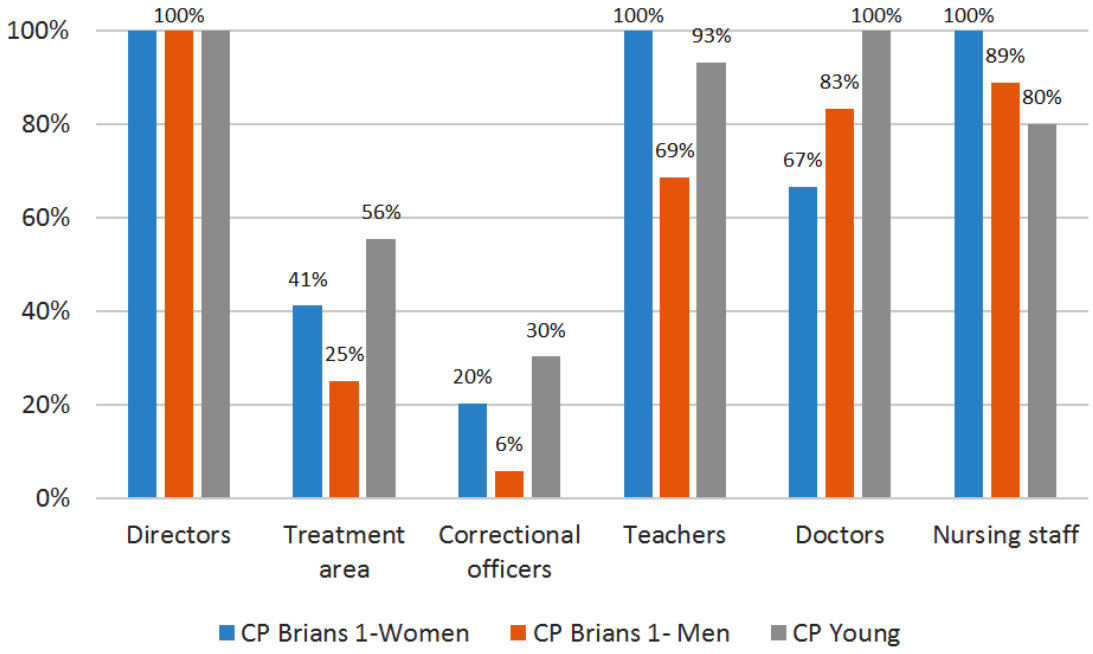
The sample, according to groups was:

Chart 2



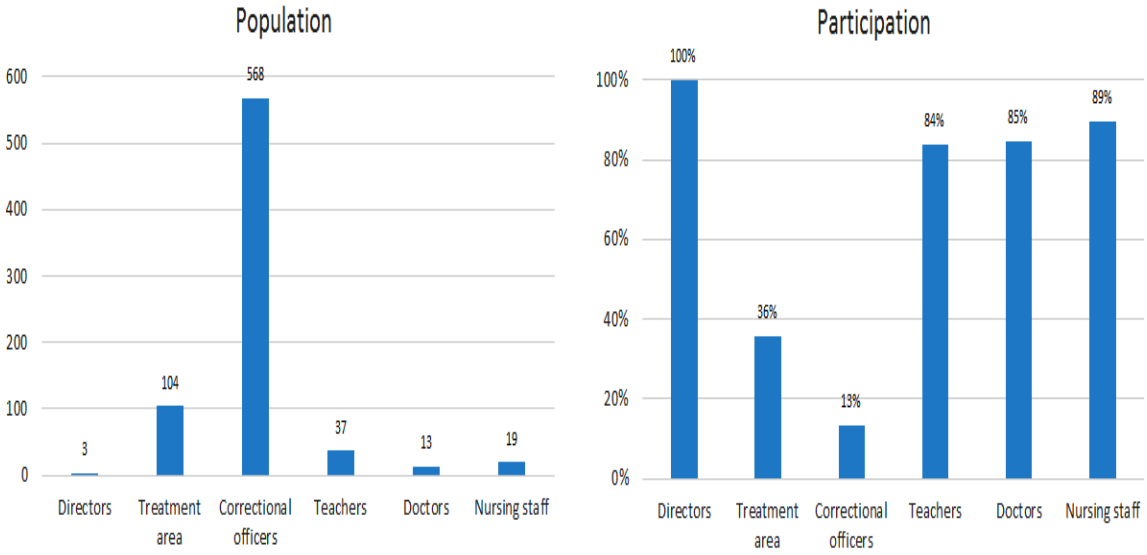
In the following chart we can appreciate the participation in percentages according to the centres.

Chart 3



So, the total participation of workers was 23,4%. Groups most involved: managers, doctors, nursing staff, teachers and treatment area.

Chart 4

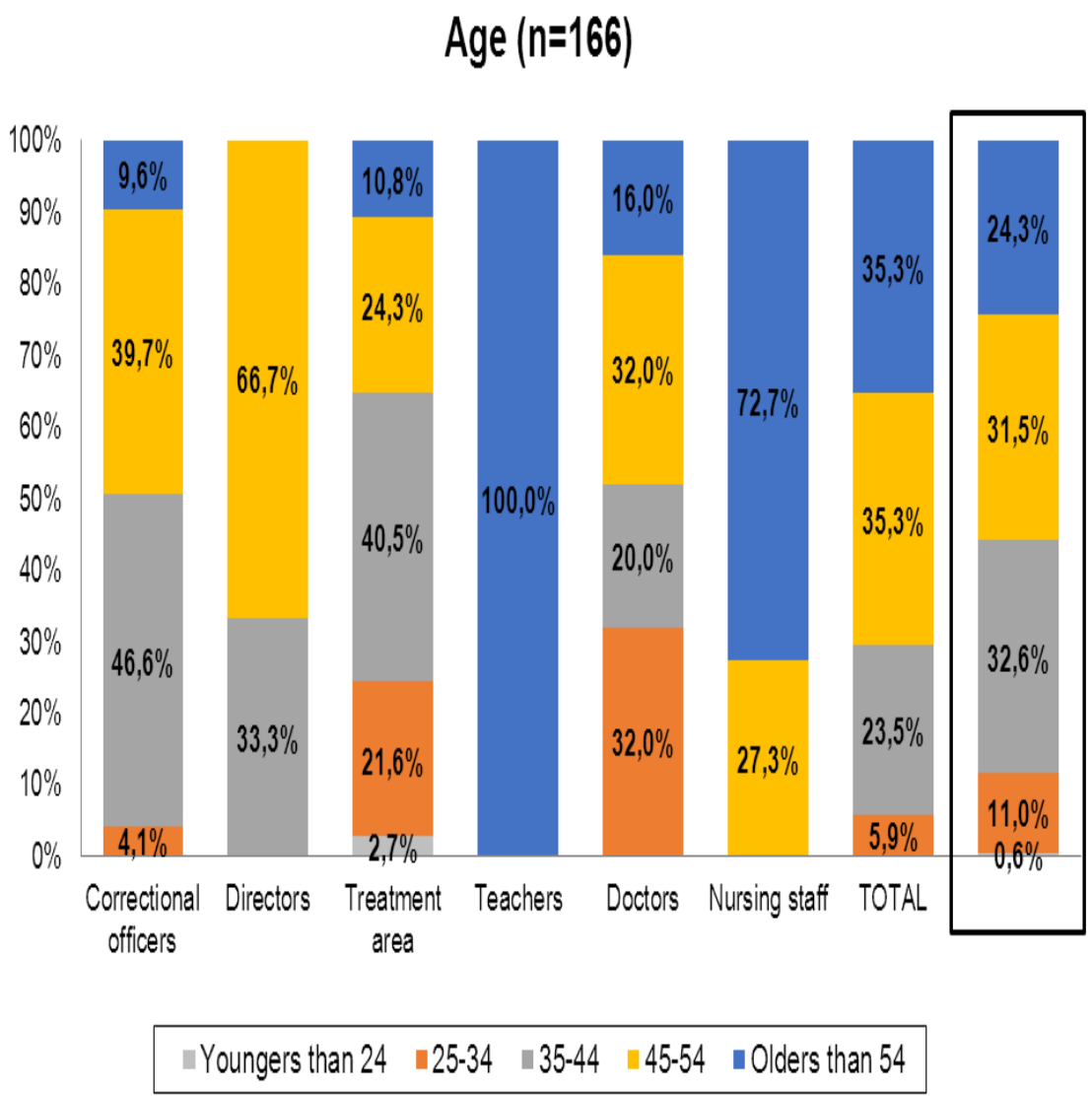


4.1.2. Age

About the age of participants, on the one hand doctors are the most senior group of staff in Catalan prisons and the group of the treatment area is much younger (some of them less than 24 years old), and, on the other hand, 100% of volunteers are more than 54 years old.

55,8% of participants are more than 45 years old. It is supposed to be more personal and professional experience:

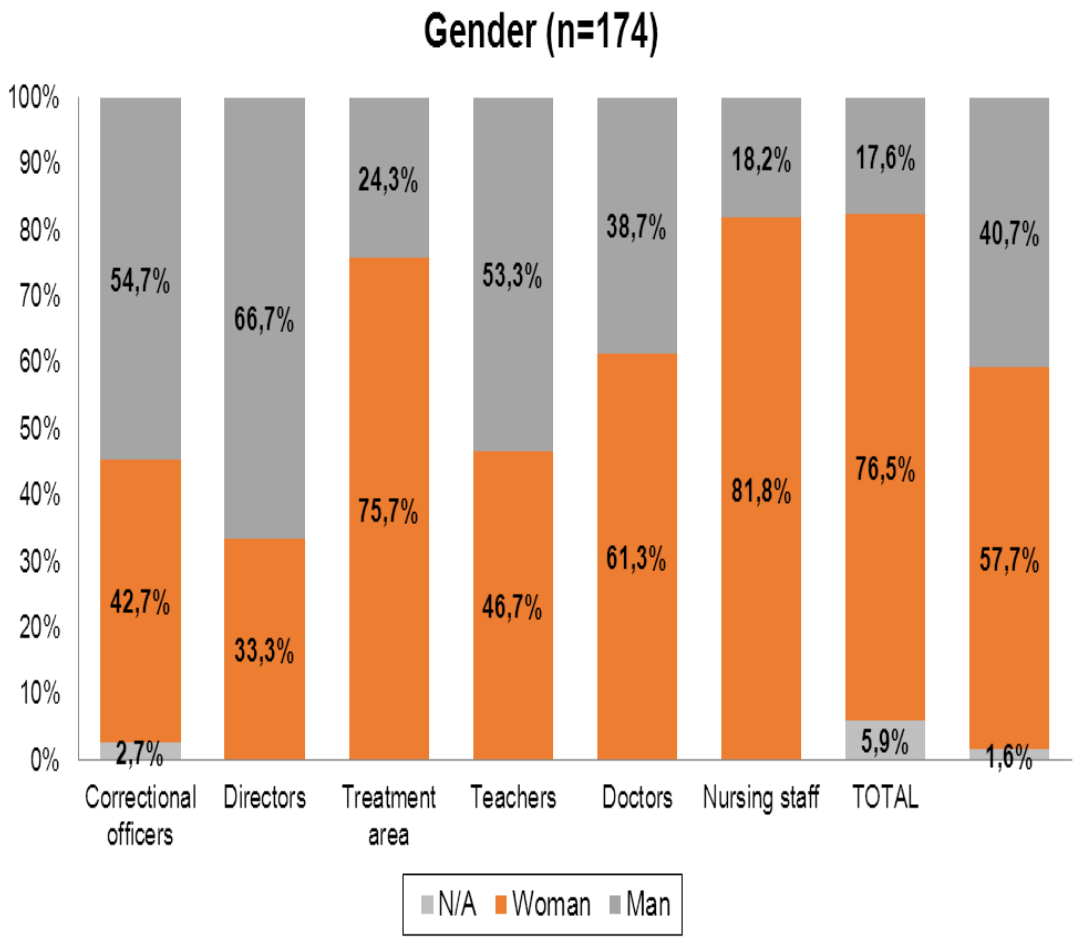
Chart 5



4.1.3. Gender

Most of the participants were females because there are more women in treatment area group, teachers, doctors and nursing staff:

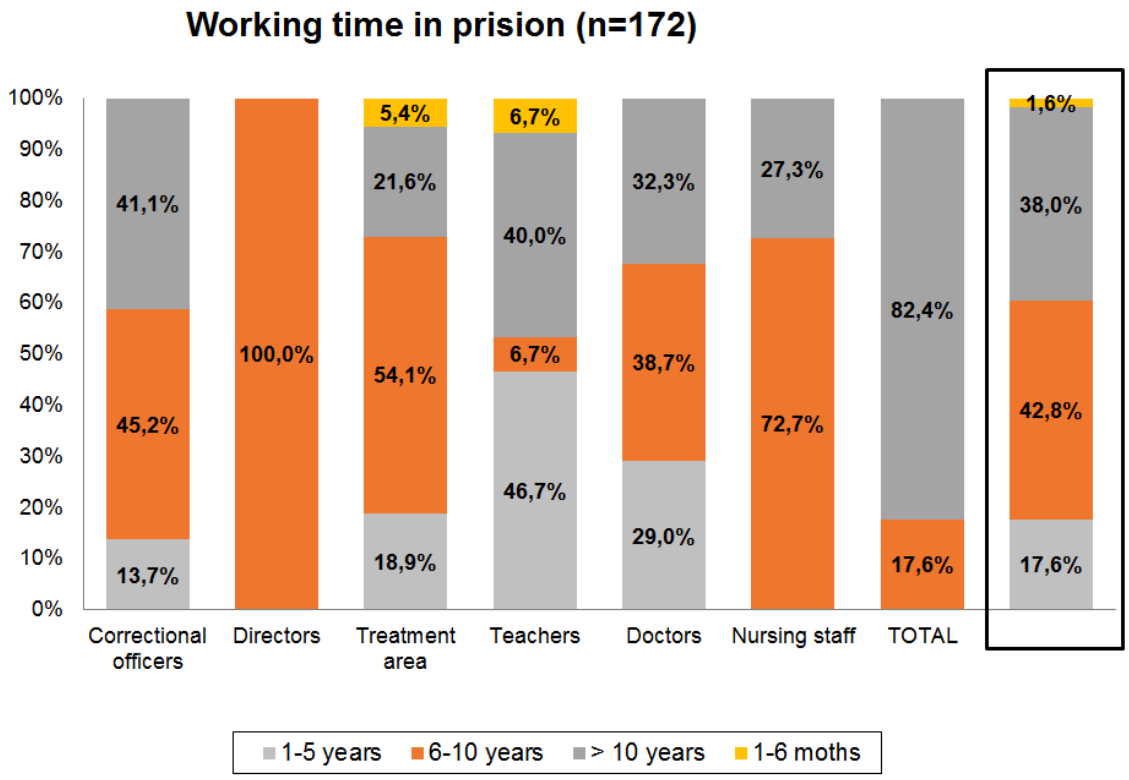
Chart 6



4.1.4. Working time in prison

In total it can be appreciated that a big majority of the personnel have more than 6 years' experience in prison. In those with more than 10 years, it can be emphasized, on the one hand, the specific incidence of the nursing staff, volunteers and correctional officers.

Chart 7



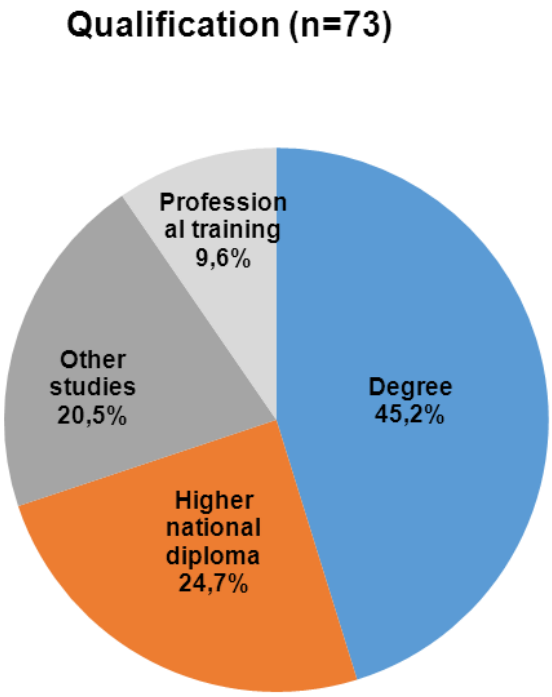
4.1.5. Qualifications

4.1.5.1. Officials surveillance qualification

Tis group is especially relevant because having any kind of university qualification is not compulsory in order to be a prison civil servant. Nevertheless 80% of the participants in our survey have such qualification.

So, in general, we can see a high degree of academic level, training and motivation among the participants (45,2% degree, 24,7% higher national diploma -3 years training-, and, 20,5% other studies).

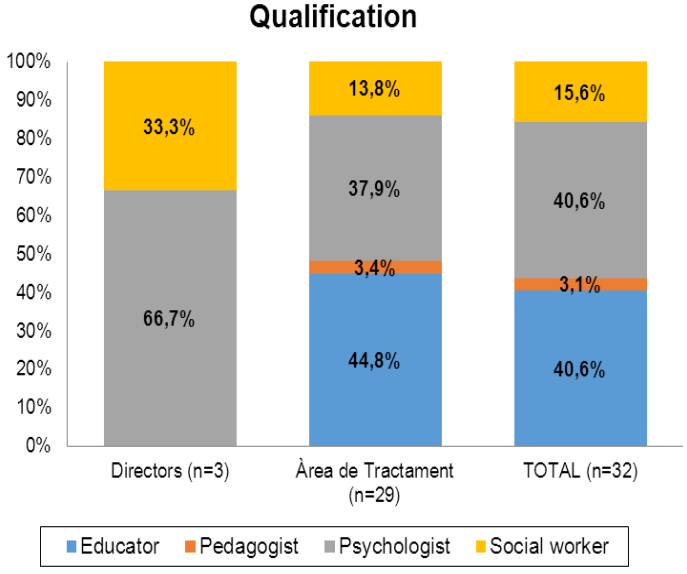
Chart 8



4.1.5.2. Directors and Treatment area group. Qualifications

Mostly, there are educators and psychologist.

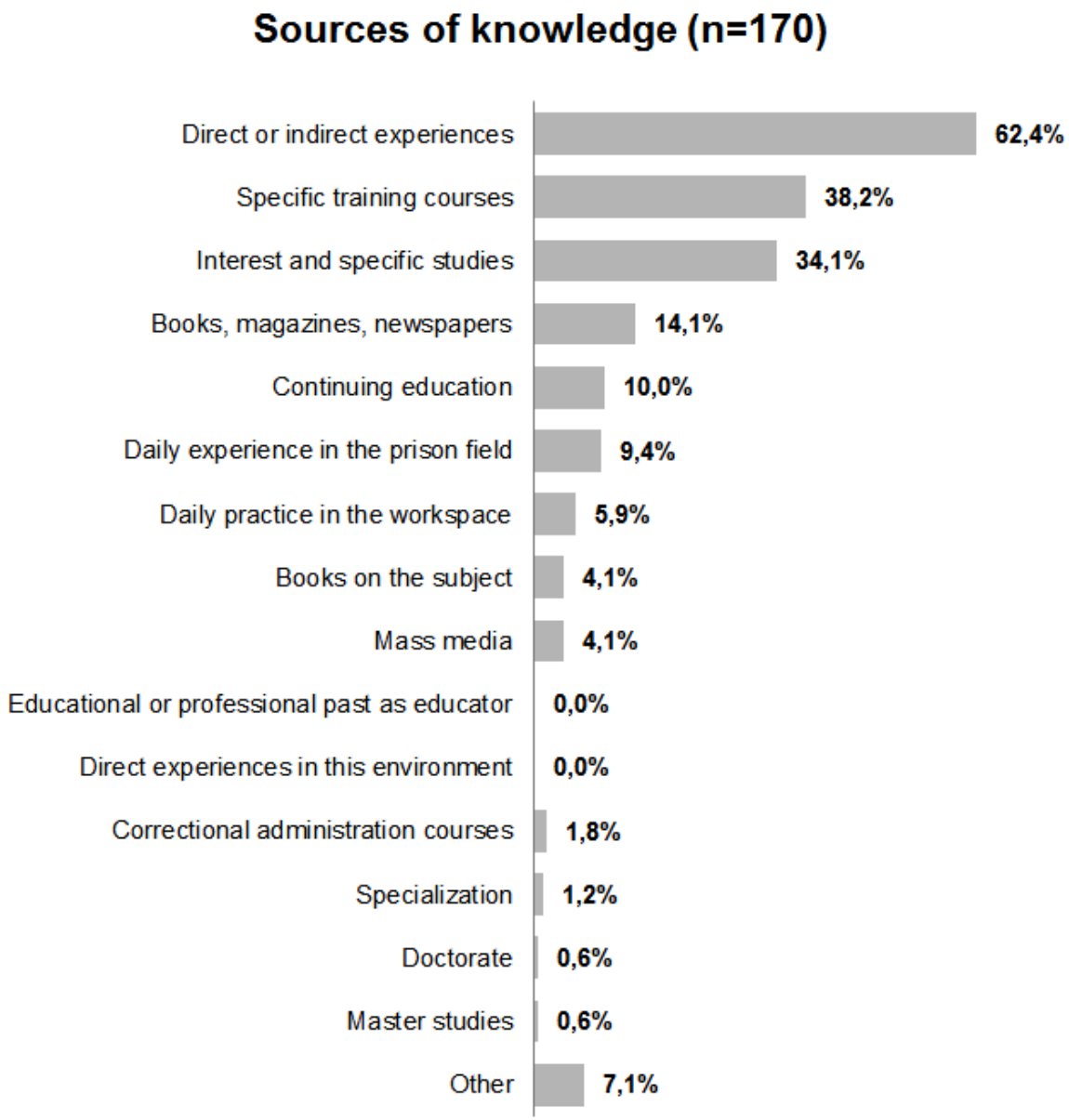
Chart 9



4.1.6. Sources of knowledge about mental health among the workers

In the following chart we can appreciate the global data in the sources of knowledge about mental health among the overall participation. It is important to stress that most of them answered the importance in the direct or indirect experiences in their resources of knowledge although are also meaningful the resources associated at formal training.

Chart 10

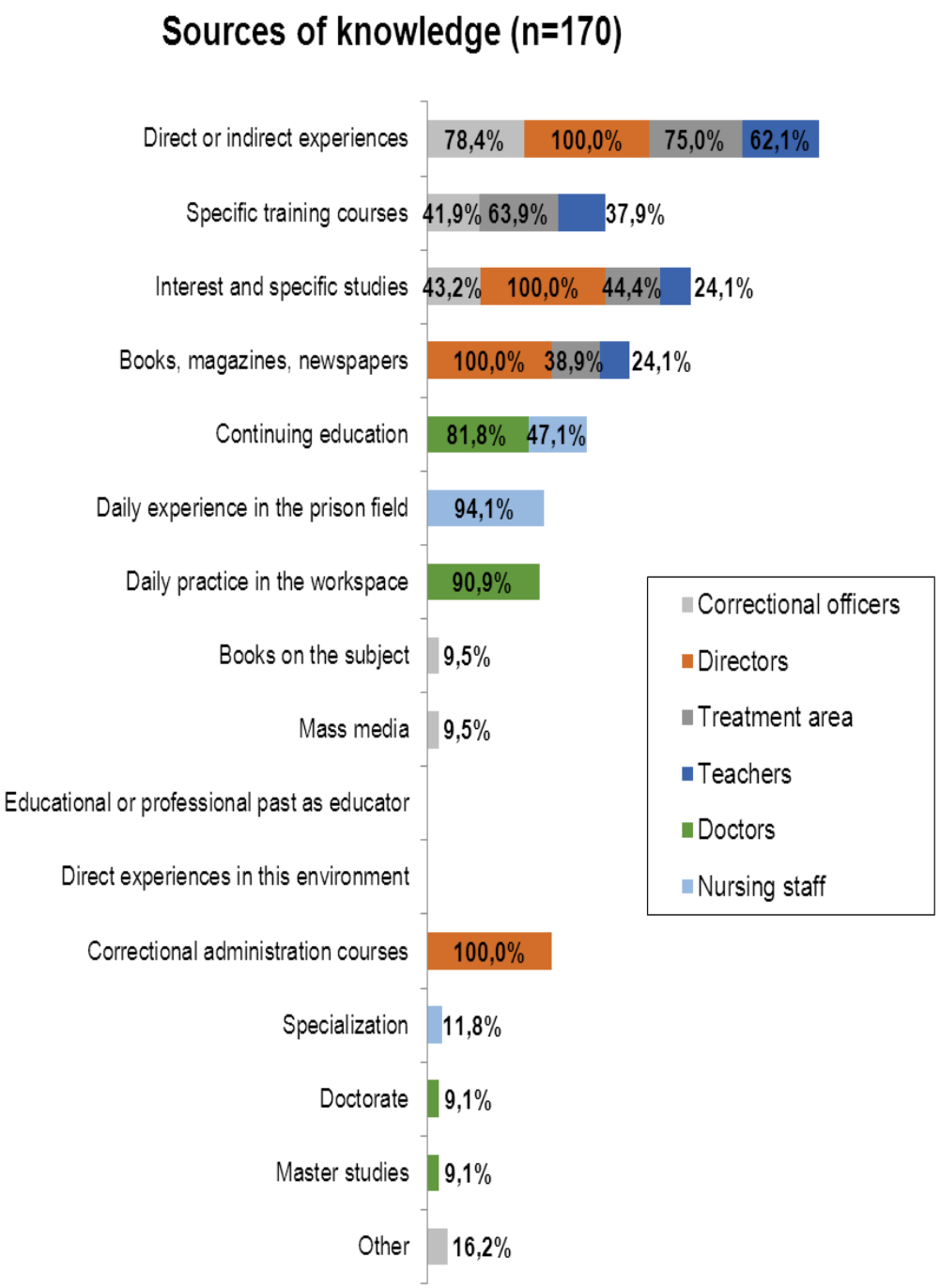


The following chart shows the resources of knowledge about mental health among the participants for groups. Nursing staff is the group that give more

importance to the daily experience in their job description about continues training.

It is important too that 45% of teachers have previous experience in our system and almost 50% have more than 5 years of experience in prisons.

Chart 11



4.2. Descriptive features about the contents of the given answers

4.2.1. Results collective group “governors”

The three directors of the centre, two men and a woman, have an experience of between 6 and 10 years. Two of them are psychologists and one is a social worker.

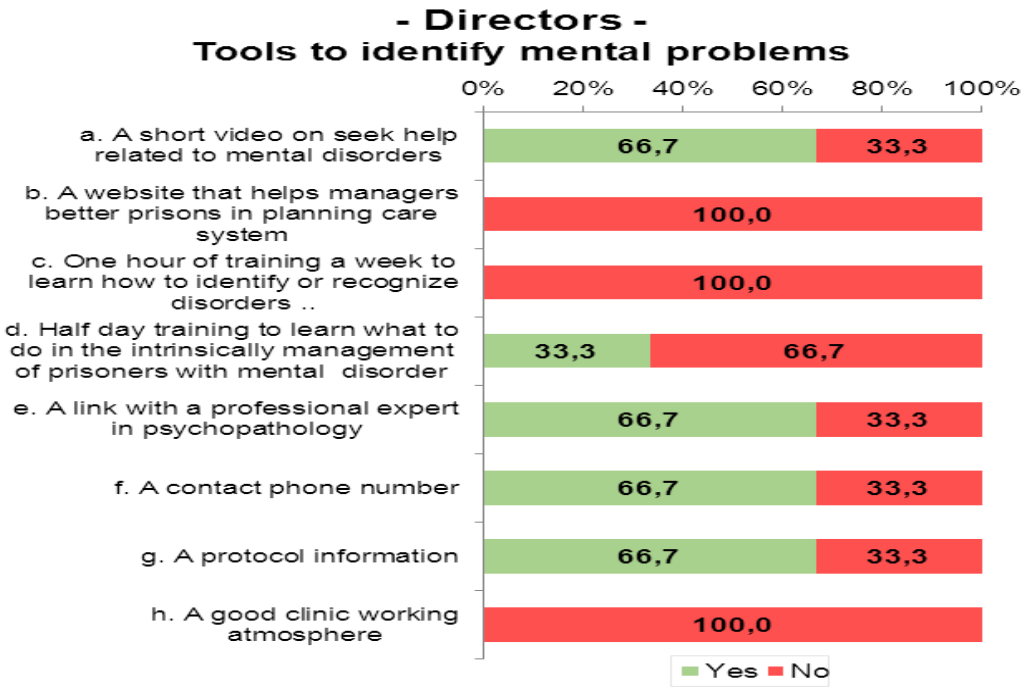
To the question “can your centre ensure adequate care to inmates suffering psychological problems?” governors have answered (100%), “yes, in cooperation with our health staff and national health system”.

To the question “what is your best option if someone tell you that an inmate is developing an important psychopathological problem?” was considered for one of them. The other two chose “contact with the specialist in psychiatry”.

About the answers: “it is not my job”, “no, I already have the information I need”, “it is useful to be updated about the evolution of inmates suffering from serious problems”, one governor chose the answer “yes, but I do not have time” and two of them answer “yes, I would like to learn more about this issue”.

To the question “a strategic plan to address territorial dysfunctions or psychological problems, including the introduction of tools to identify early mental problems. “what would be useful to introduce?” the answer by two professionals was: “protocol information” the remaining options available are detailed in the chart below:

Chart 12



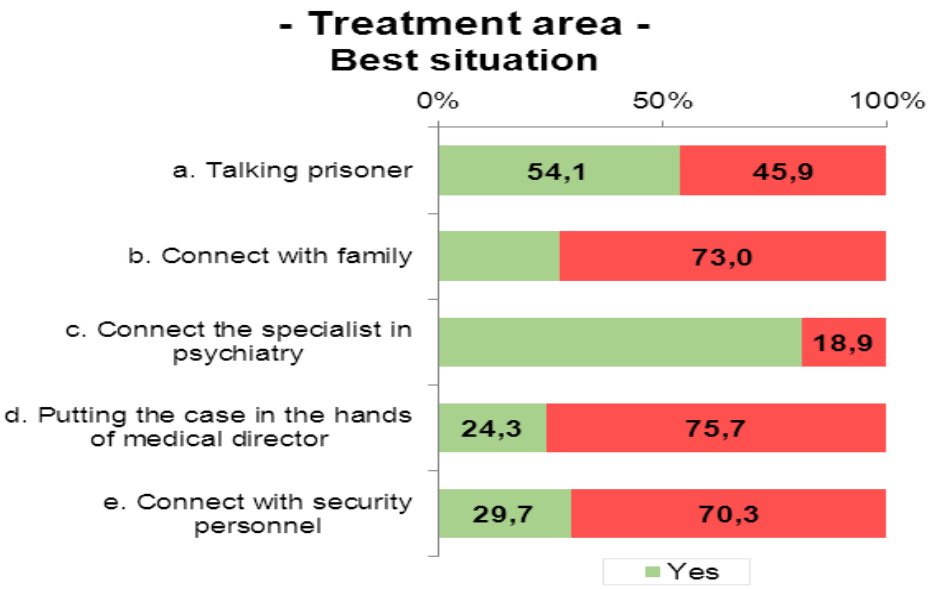
Regarding the question “can some professionals in your prison find this type of information and training, particularly useful?” all three answered “Psychologist”, two added medical director and educators”

4.2.2. Results collective group “treatment area”

45% of them are educators, 40% psychologist, and the rest social workers. It should be noted in particular that 92% of this group has defended the need of training on the subject.

To the question “does the prison where you work assure attention, care and proper treatment to inmates with psychological problems?” the answers given by the professionals were: “if it falls within my responsibility, although it is not my direct task but it is the duty of other professionals with more experience and skill as physicians” (33.3 %) and “if it falls within my responsibility, although it is not my direct task but it is the duty of other professionals with more experience and skill, such as psychiatrists and clinical psychologists” (37%).

Chart 13

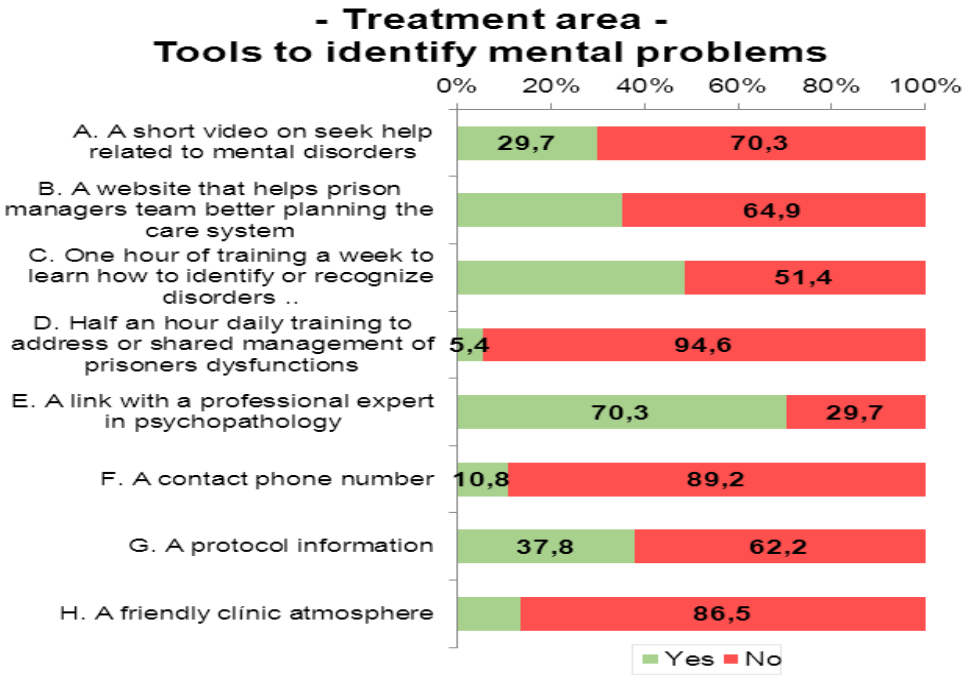


The answer “connect with a specialist in psychiatry”, 81.1 % was valued to the question: “what is the best option when you communicate that an inmate is developing a severe psychopathological situation?”

To the question “would it be useful to update their knowledge to identify and manage inmates who suffer serious problems?” 91.9 % of professionals answered “yes, I would know more about it.”

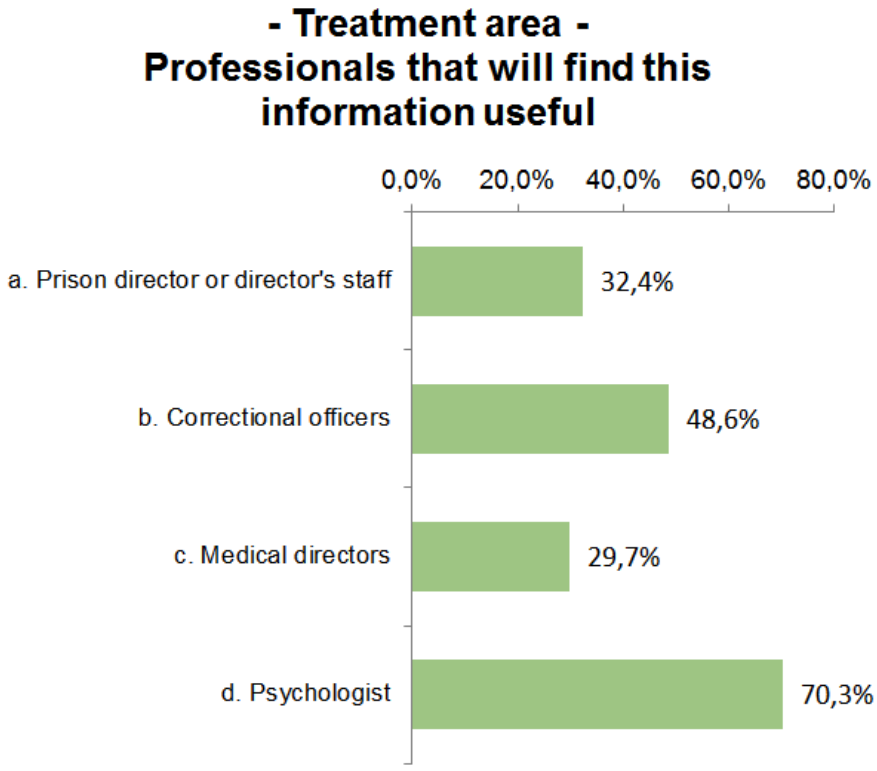
To the question: “a local mental health strategic plan includes the use of instruments to detect mental disorders early. So, “what kind of options would be useful to include?” the answer most valued by professionals was: “a link with a professional expert in psychopathology” (70.3%) , “one hour of training a week to learn how to recognize psychiatric disorders related to aggressive and violent acts” (48.6%) and “a protocol information” (37.8 %).

Chart 14



To the question “is there anyone in your prison who would find this type of information/training useful?” 48.6% consider that they would be useful for correctional officers and 70,3% for psychologist.

Chart 15

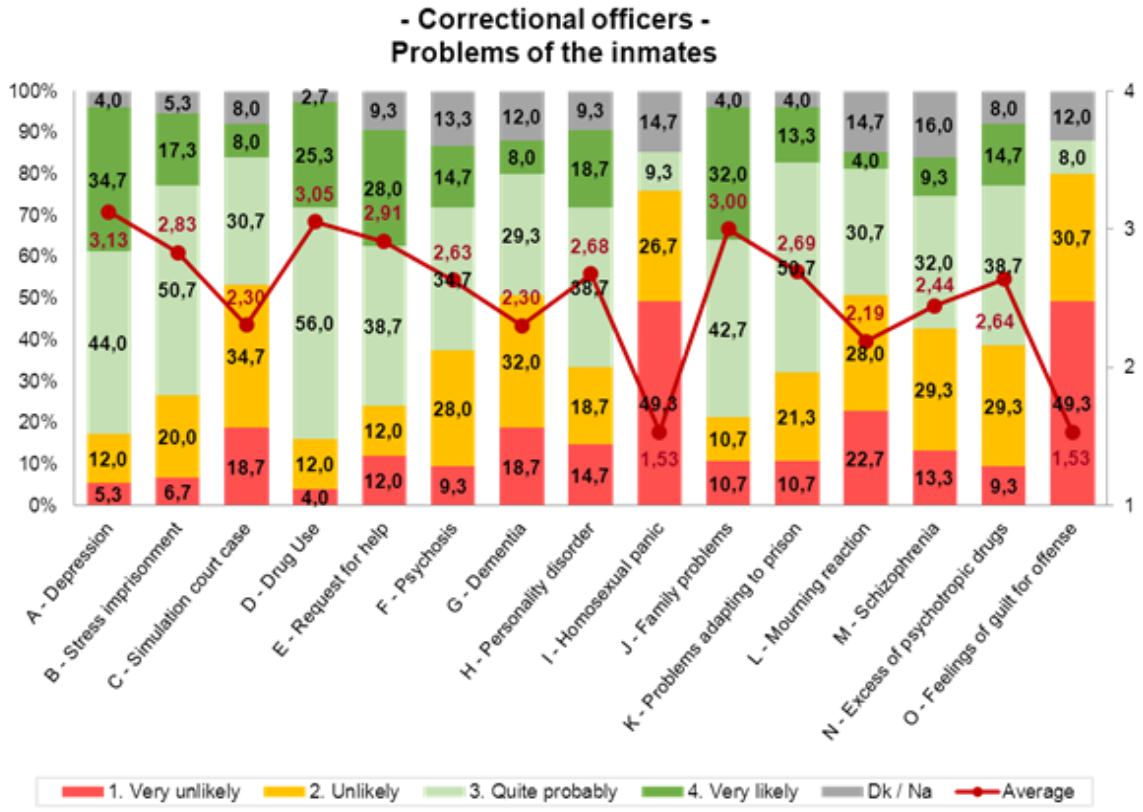


4.2.3. Results collective group “Correctional Officers”

56,9% of their participants work in a rota system, 29,2% are permanent staff and 13,9% answered “others”. 41,1% have been working in prison system for more than 10 years, 45,2% from 6 to 10 years and 13,7% from 1 to 5 years. Almost 40% of them have some kind of training about mental health issues and 9,3% do not have any kind of experience in mental disorders (do not answer, 1,3%).

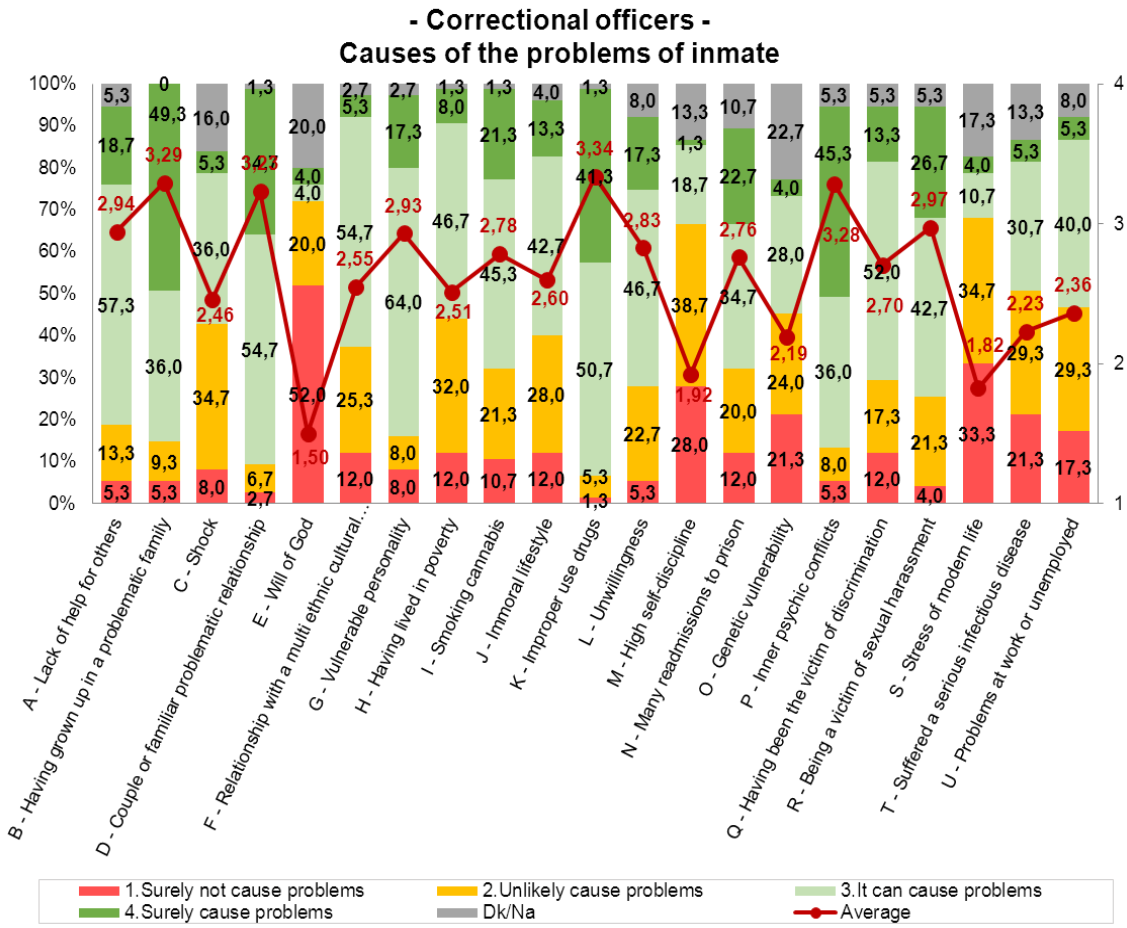
To the question “what could explain self-harms, hunger strikes, suicide attempts?” The main answers given were: “use of drugs”, “depression” and “family problems”.

Chart 16



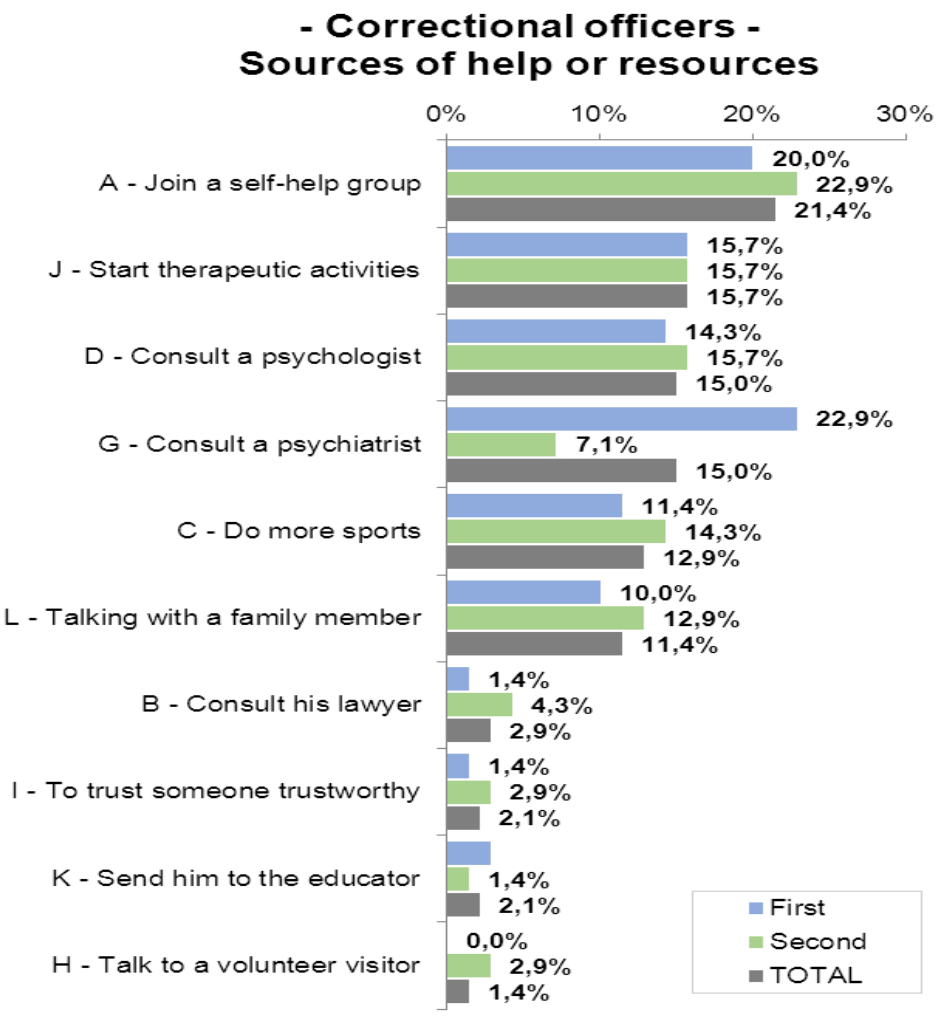
To the question “what could be the cause of a great uneasiness?, the most valued answer was “misuse of drugs”, “lack of help”, “to grow up in a family with many problems” and “inner-psychic conflicts”.

Chart 17



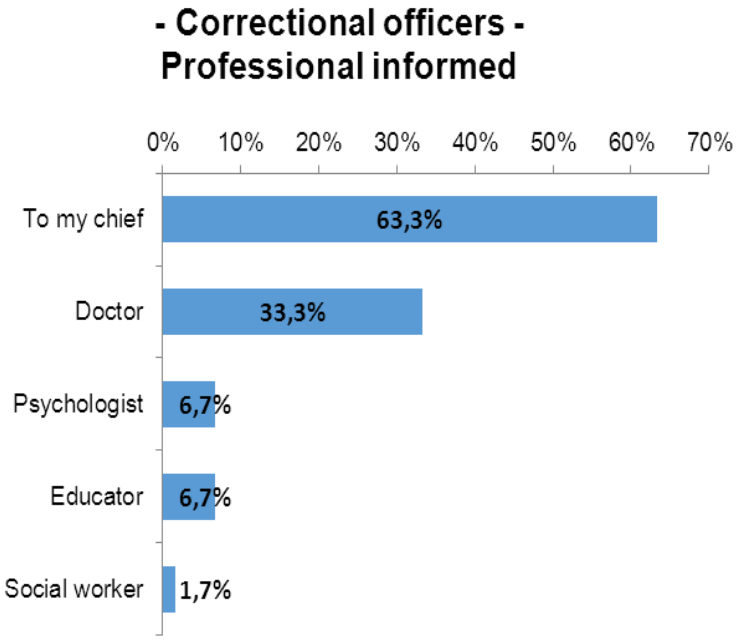
About the question “what kind of possible sources of help can be activated in prison?” the most valued answer of correctional officers was “to join a self-help group” (22,9%), while “to start therapeutic activities” and “to rely on someone” are valued in 15,7% and in 2,9% respectively

Chart 18



To the question made to the correctional officers “do you perceive any sign of problems in the inmate, before he/she did any sort of mild or serious self-harm?” The most outstanding answer was “yes” (80%). The 63,3% report their boss and 33,3% to the doctor.

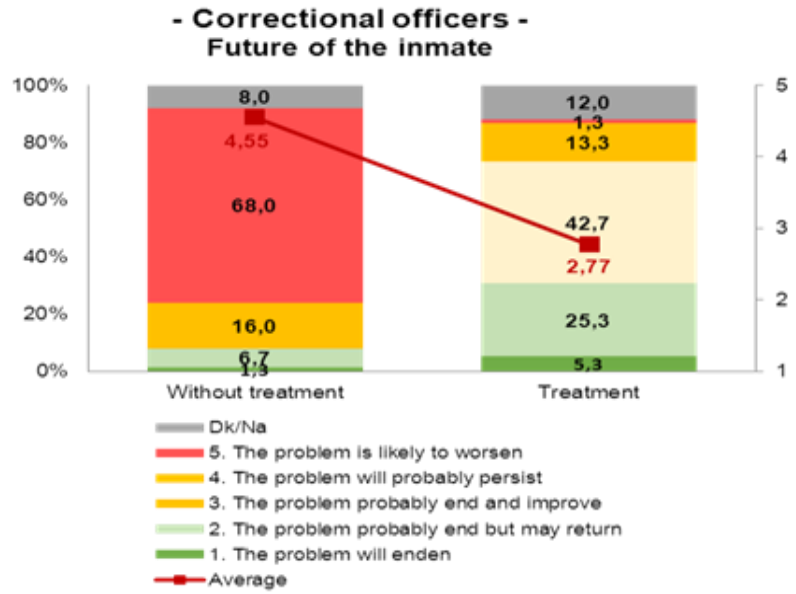
Chart 19



Regarding the question “do you feel you are a part of a network aimed at reducing trouble?, 75% answered yes.

Concerning the question “what is the future of the inmate suffering from psycho-pathological disorders”, it stands out their pessimistic point of view, because they thought the trouble will probably persist in those undergoing treatment or the trouble will probably get worse and worse in those without treatment.

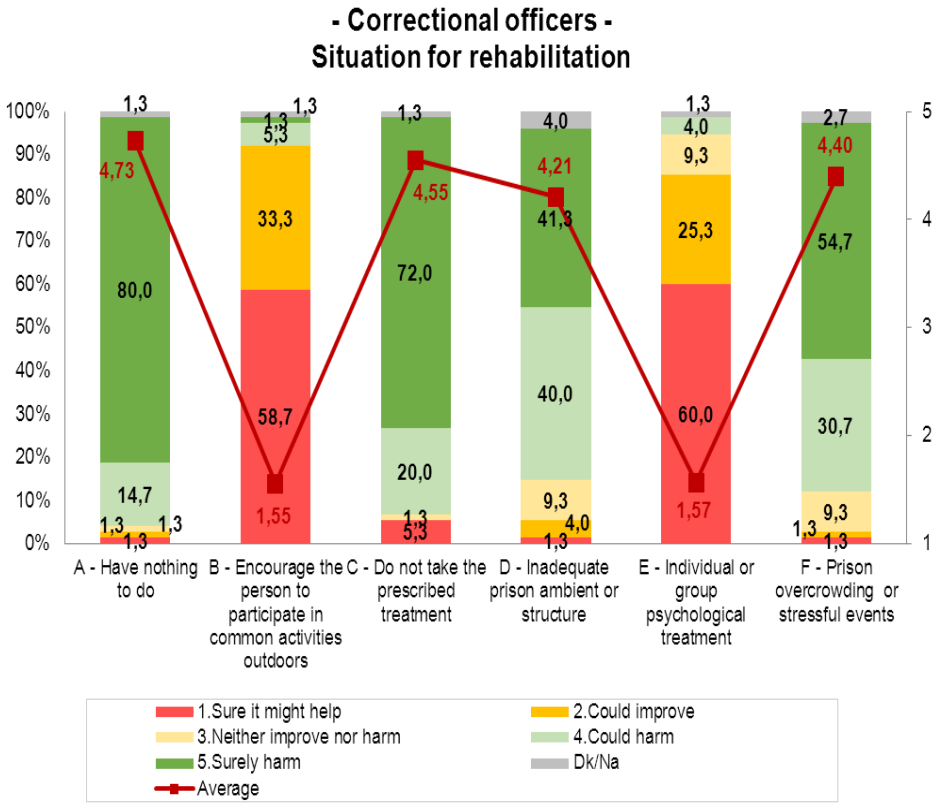
Chart 20



On the question “what situation could facilitate or be an obstacle in the rehabilitation of an inmate who suffers from psychological problems?” the most relevant answer given was “individual/group psychological treatment” (60%).

As a factor that could be an obstacle in the rehab “not taking the prescribed treatment” was answered by 72%, while the most valued option was “not having anything to do” with 80**% .**

Chart 21



4.2.4. Results collective group “teachers”

19,4% of teachers have a degree and 84% of them are permanent staff. 29% of them have been working in prisons from 1 to 5 years, 38,7% from 6 to 10 years and 32,3% more than 10 years.

62% of their students are male and 38% are female. 60% are over 30 and each teacher attends on average 38 students per class. 59% of students are basically school leavers and 53.5% hold a primary school certificate.

The attitude towards teaching staff was 58% favourable and 25% very favourable among the students. Teachers point out that 29% of the students do not pay enough attention during the classes and 61% indicate that it is feasible to start classes within the first 10 minutes.

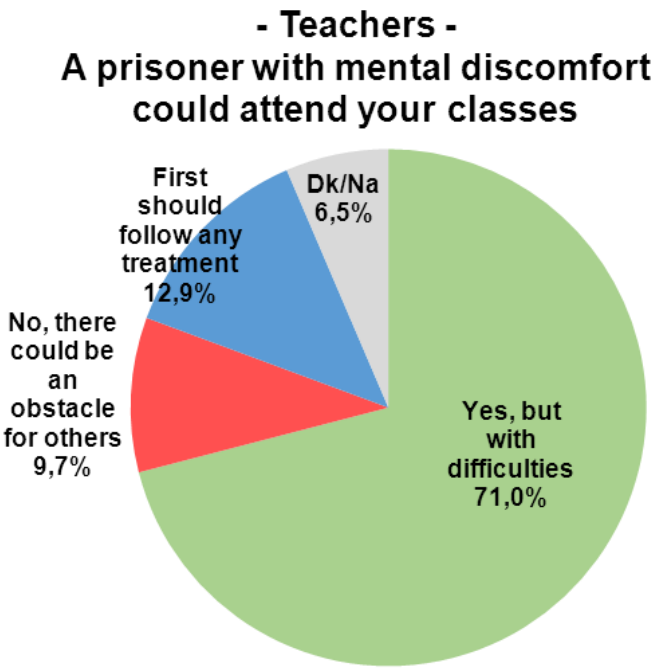
Teachers are satisfied of the support they receive from other field professionals. 84% reckon to be satisfied or very satisfied with the teamwork of teachers. On the other hand, it is worth considering that 87% of them think that school is a tool that helps reducing the discomfort of inmates, and it should be noted that only 10% of the students displays a low attention attitude during the studies.

Confidence in the management team of the school is very high as this is indicated by 97% of teachers. Any problem is communicated by teachers to educators in 50% of cases and in 25% of them to the prison governor.

To the question “what would you change from the education system?” teachers, among other interesting suggestions, have pointed out strengthening the support to the students who need more help than others with initiatives such as the inclusion of French language lessons (for inmates from Maghreb) and carrying out more outdoor activities.

Almost all questions to the group were not relation with the objective of the Project (number of students, other teacher’s satisfaction, quality of care of the students, etc.); only one question was refers directly on the issue of mental health of their students. It is valued graphically to show the rest of answers and to show that a significant majority of professionals (71 %) would accept students with mental discomfort, being assessed the following answer also positive “first should follow any treatment”, (12.9%).

Chart 22



4.2.5. Results collective group of "doctors"

About qualification, 4% of doctors are specialist and only 18% general practitioners (family doctors).

It is important to point out the answers given about the strategies of intervention chosen in inmates with recently self-harming or suicidal attempt who are **under** the control and follow up of Local Mental Health Service, or, the inmates with mental disorder **without** control and follow up of specialised service.

The Catalan psychiatric penitentiary system distinguishes between a self-harming gesture episode or an action which entails a real intention of committing suicide. However, the questionnaires did not point out that difference.

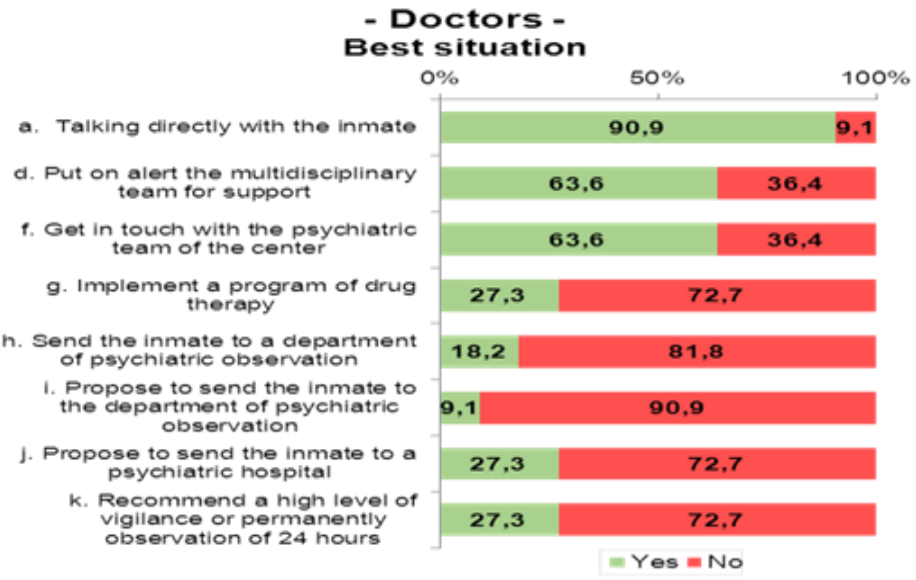
4.2.5.1. Results: inmate under control/supervision

For this reason, only 9,1% of doctors chose the answer “to propose to send the inmate to a special department of 24 hours psychiatric observation” in case of attempting suicide.

About the self-harming gestures, the main answer given was “to talk directly to the inmate” (90,9%).

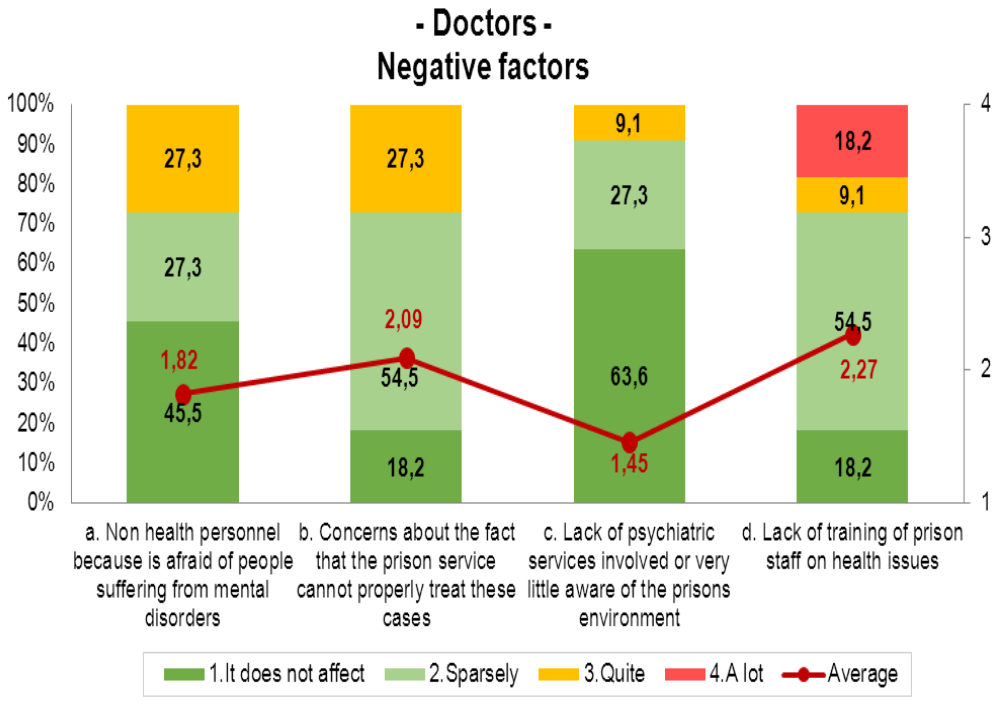
As it has been said earlier, to the question “how long does it take until the inmate starts the procedure?”, 100% of answers were less than a week in both of cases: in a self-harming gesture episode or an action of committing suicide. Obviously, the attention is immediately.

Chart 23



About the most negative factors affecting doctor’s intervention, the majority option chosen was “lack of trained staff in health care”.

Chart 24



4.2.5.2. Results: inmate without control/supervision

To the question “which strategies of intervention are chosen in inmates who are not under the control of the Local Mental Health Service, for recent self-harming or suicidal attempt?” the option “to get in contact with the psychiatrist”, got 91% of answers.

The most negative factors affecting doctors intervention were the lack of trained staff in health care 27,3%.

Charts 25 and 26 show the global criteria:

Chart 25

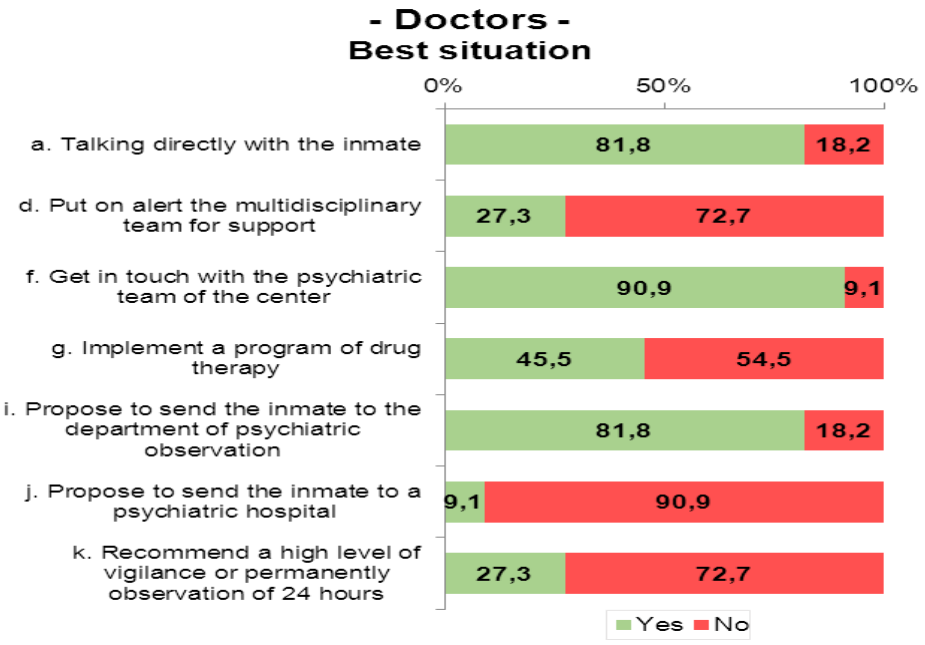
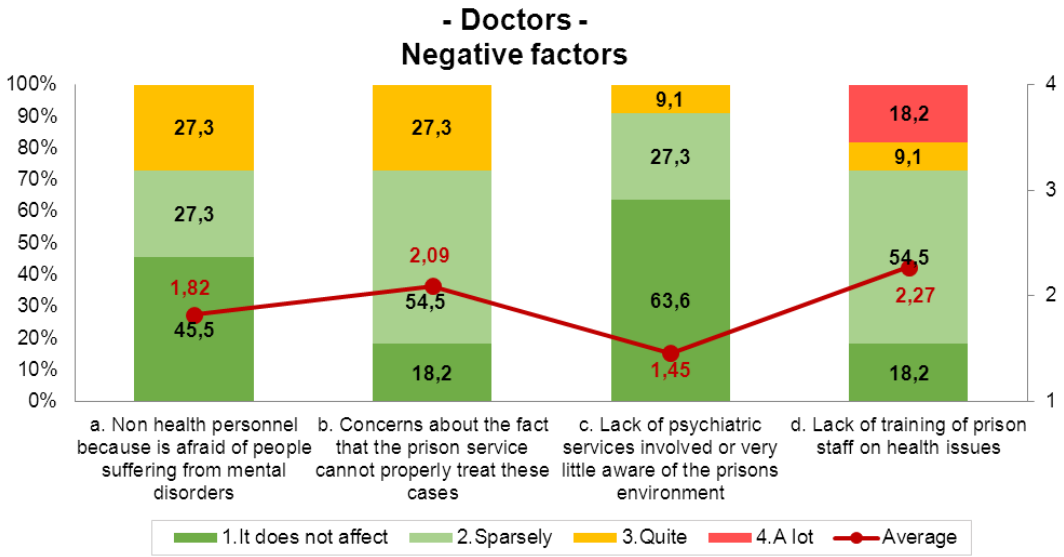


Chart 26

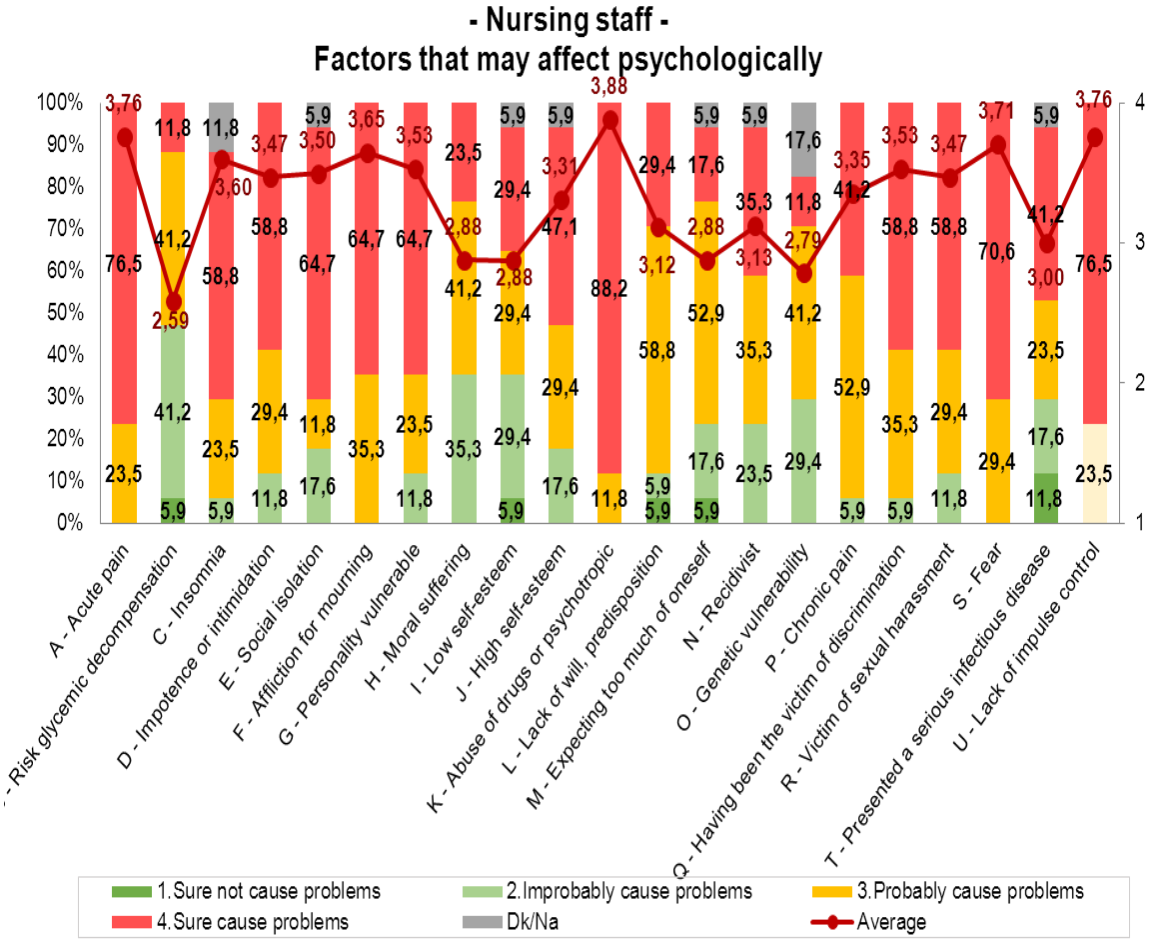


4.2.6. Results collective group “nursing/nursing assistants”

This group consists of 52,9% of nursing assistants, 41.2% of professional nurses, 5,9% do not give an answer. Regarding the time that they have been working in prison, 18% less than 10 years, and 82%, over 10 years.

To the question “what can greatly affect the psychic balance of the inmates”. The most relevant answers were “Drug abuse” (88,2%), “acute pain” (76,5%) and “lack of impulse control” (76,5%).

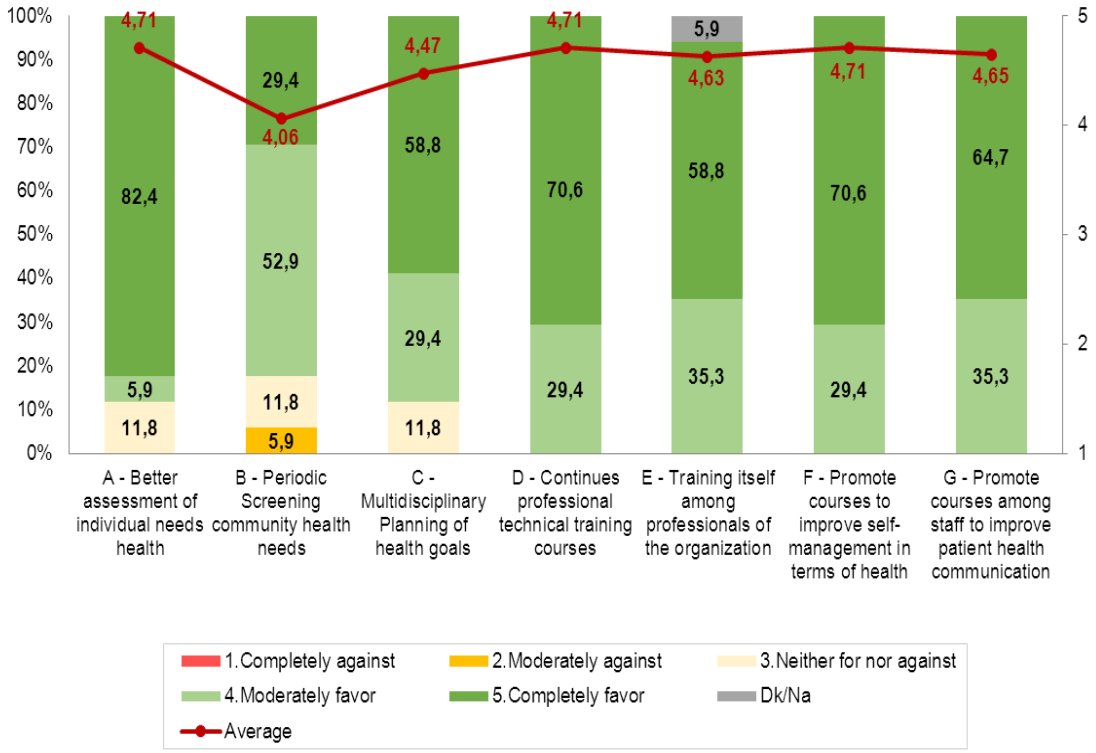
Chart 27



About the question “what possible sources of help can be activated in prison”, the answer “better evaluation of the individual health needs” has meant 82,4% and promoting continues professional technical courses for a better self-management of mental disorders, 70,6%.

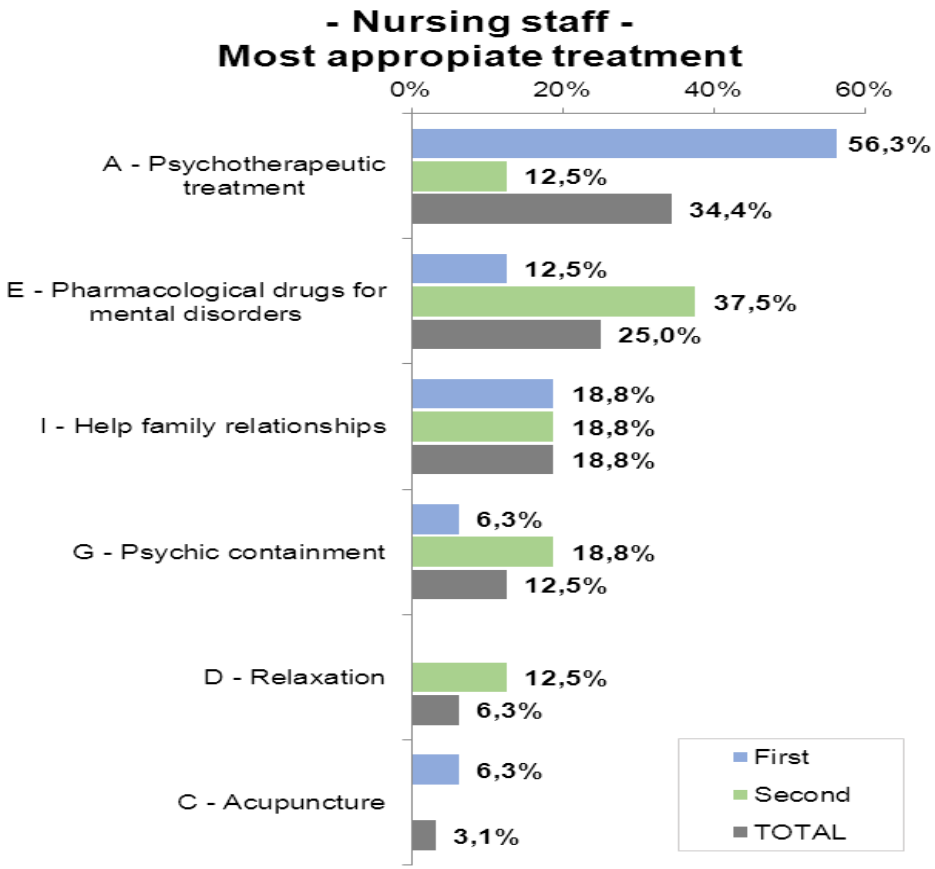
Chart 28

- Nursing staff -
Sources of help



To the question “which treatments might be the best?”, 56,3% of professionals chose “psychotherapeutic treatment” and 18% of them chose “family support”, while “relaxation treatment” was not the first choice in any of the answers.

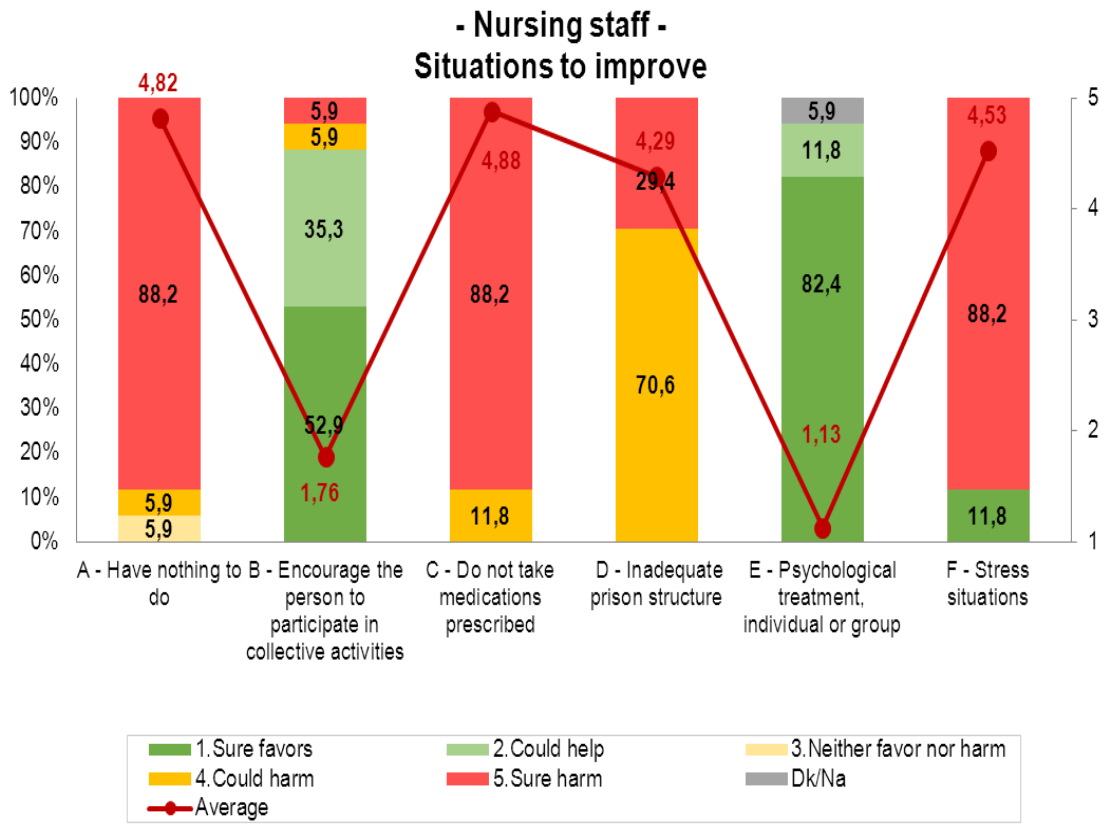
Chart 29



As for the question “which situations could favour or not the recovery of inmates with mental disorders?” the first factor was the “individual or group psychotherapeutic treatment” (82,4%) while “encouraging the person to participate in collective or outdoor activities” is considered by 52.9%.

As a factor that is against the recovery 29,4% answer “inadequate prison structure”. The most recurring options were “having nothing to do” (88.2%), “stressful events” (88.2%) and “not taking the prescribed treatment” (88.2%).

Chart 30



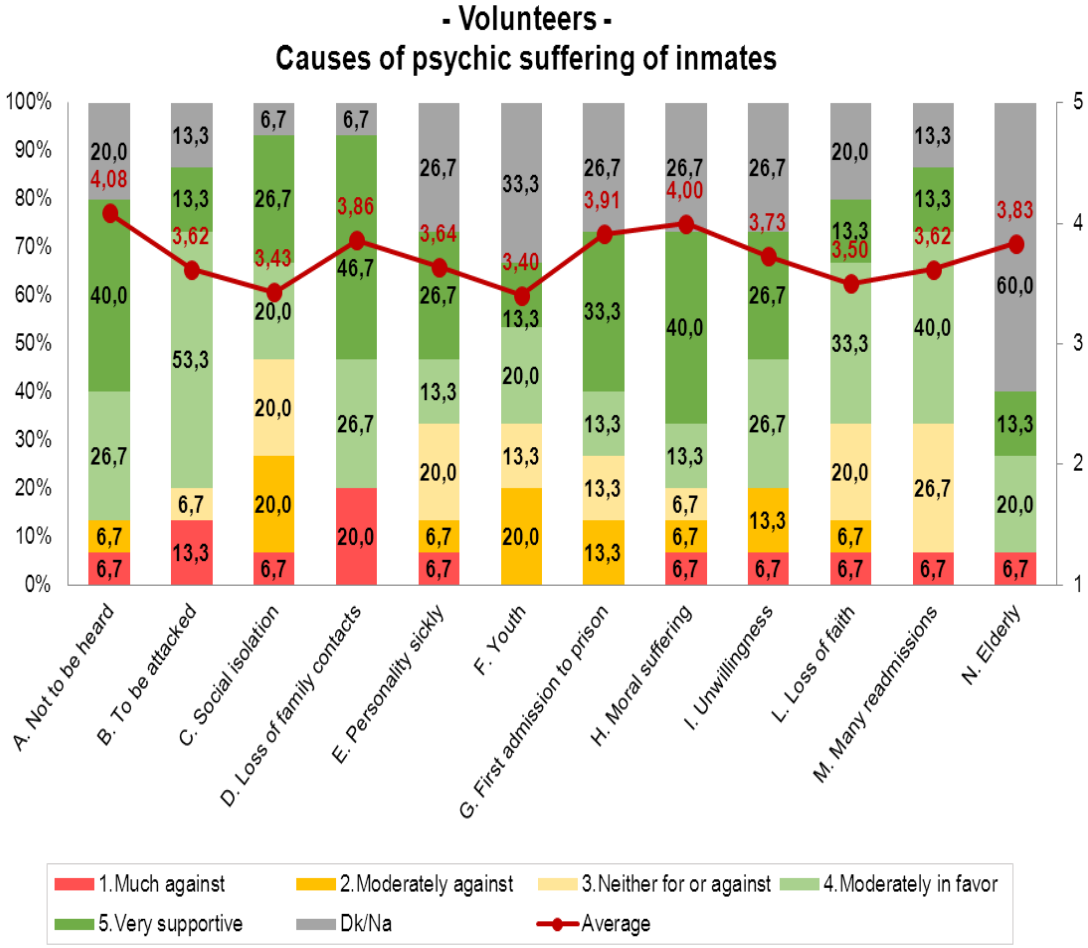
4.2.7. Results collective group “volunteers”

As mentioned above, this group has not participated in a sufficiently representative way because of the problems mentioned earlier. This has been excluded because it affects the work methodology.

However, we provide the same information for this small group: they are either graduates or they hold a diploma 6.7%. 86,6% of them are retired. All are over 54 years old. 7% of them have been working in prison for less than 6 months, 46% from 1 to 5 years, 7% from 6 to 10 years and 40% over 10 years.

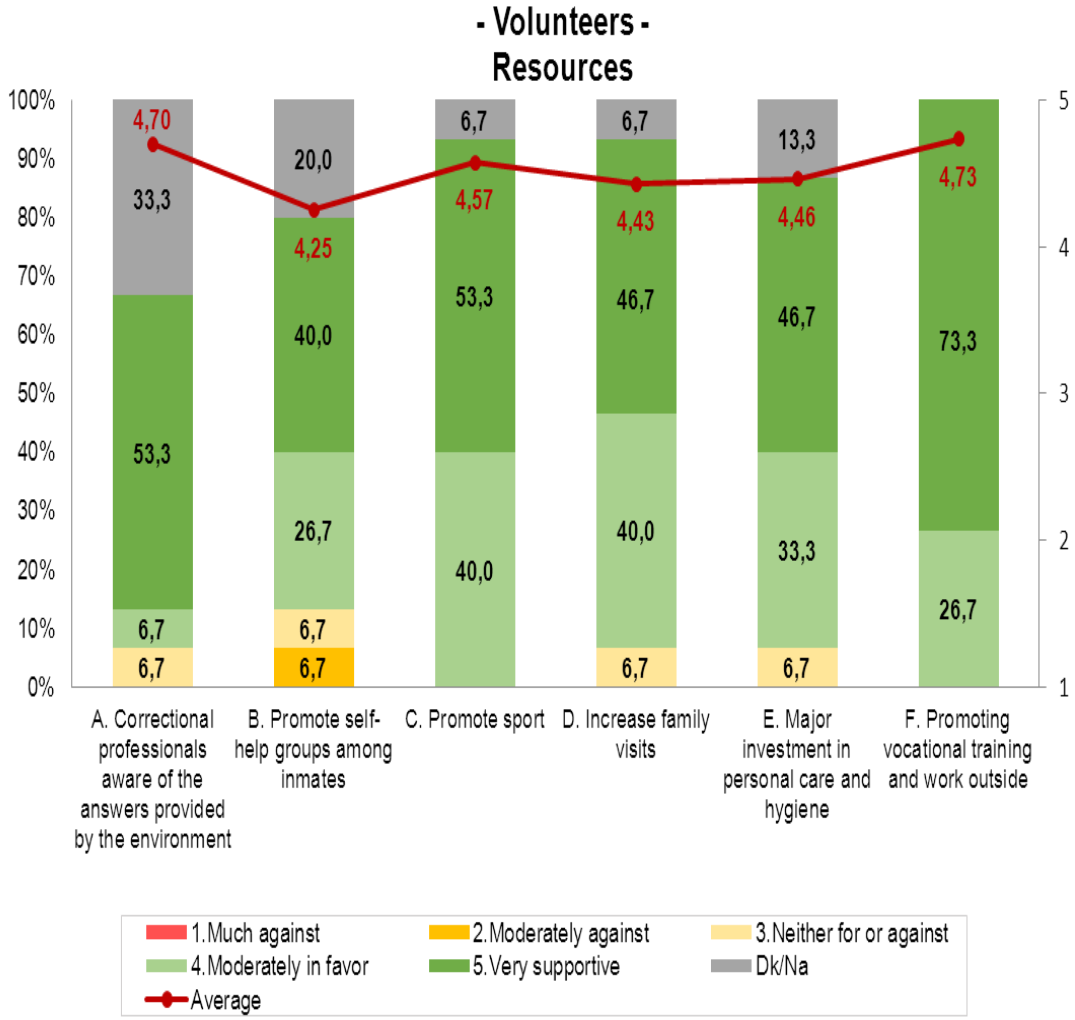
To the question “what situations could affect the stability of intra-psychic”, the answers were: 26,7% “social isolation” and 26,7% “unhealthy personality”. However, the most frequent answers were: “loss of family contacts” (40%) and “moral suffering” (40%).

Chart 31



To the question “what resources can be activated in prison?” the answer “promote self-help groups among inmates” has been the first choice in 40% and “promoting vocational training and work outside” 73.3%.

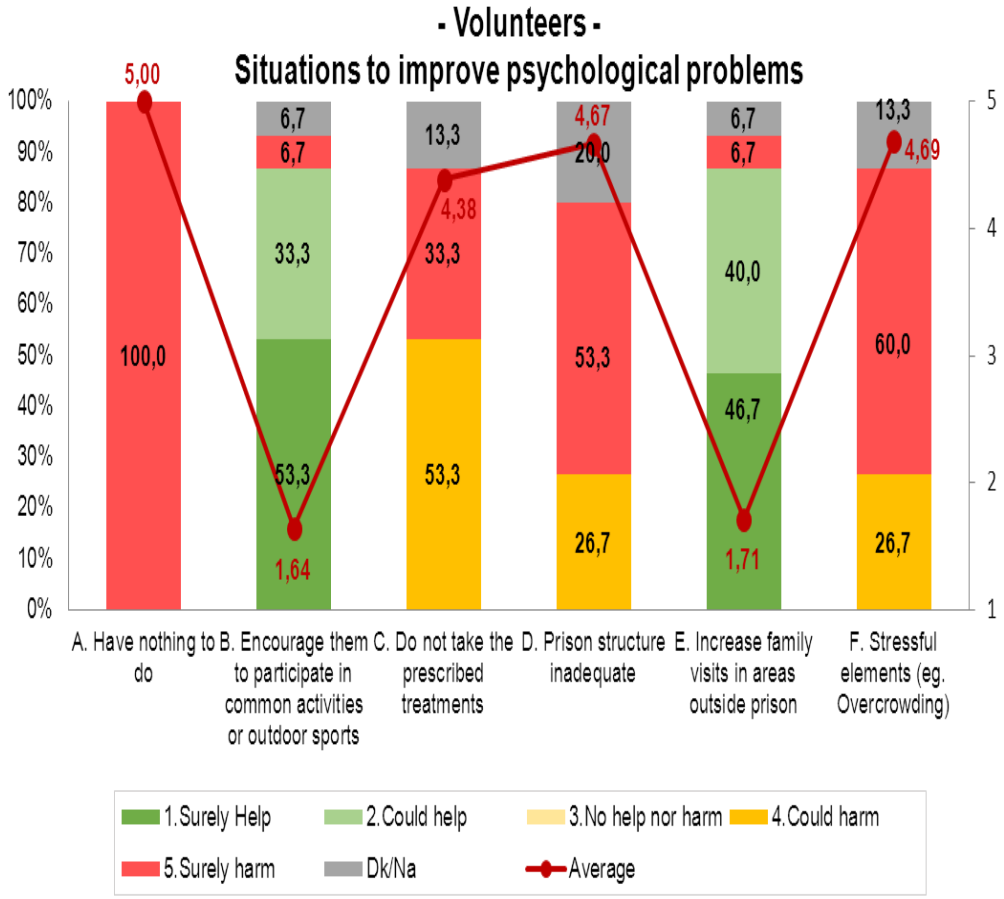
Chart 32



To the question “which situations could favour or unfavour the recovery of an inmate with mental disorders?” volunteers have considered as first choice of facilitating situations “to encourage common activities or participate in outdoor sports” (53.3%) and “increasing family visits in areas outside the prison” (46.7%).

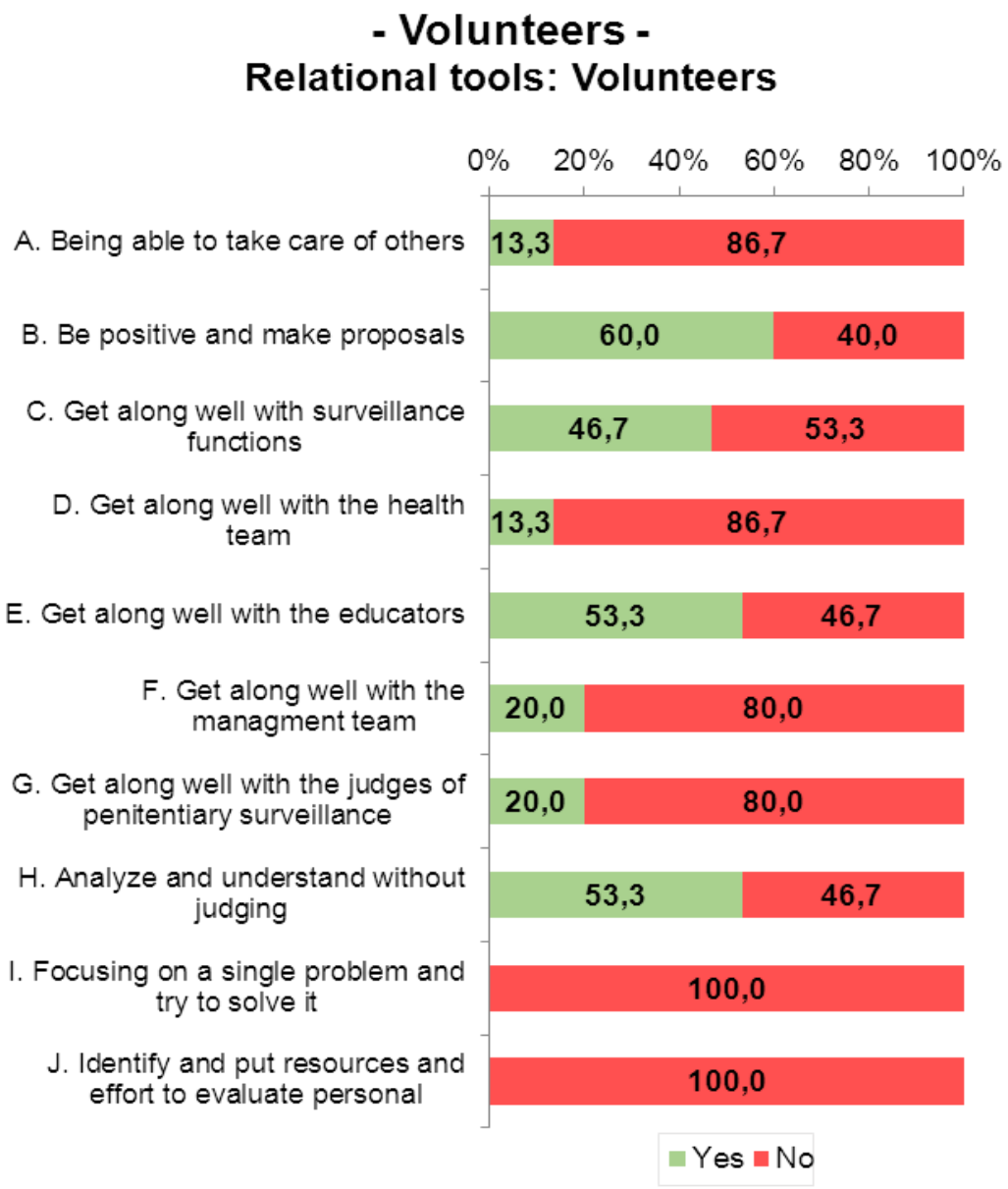
As for the factors that do not favour, presented in order of importance: “having nothing to do” (100%), “stressing factors -overcrowding in prisons-“ 60%, “inadequate structure of the prison” (53.3%) and “not taking the prescribed treatment” (33.3%).

Chart 33



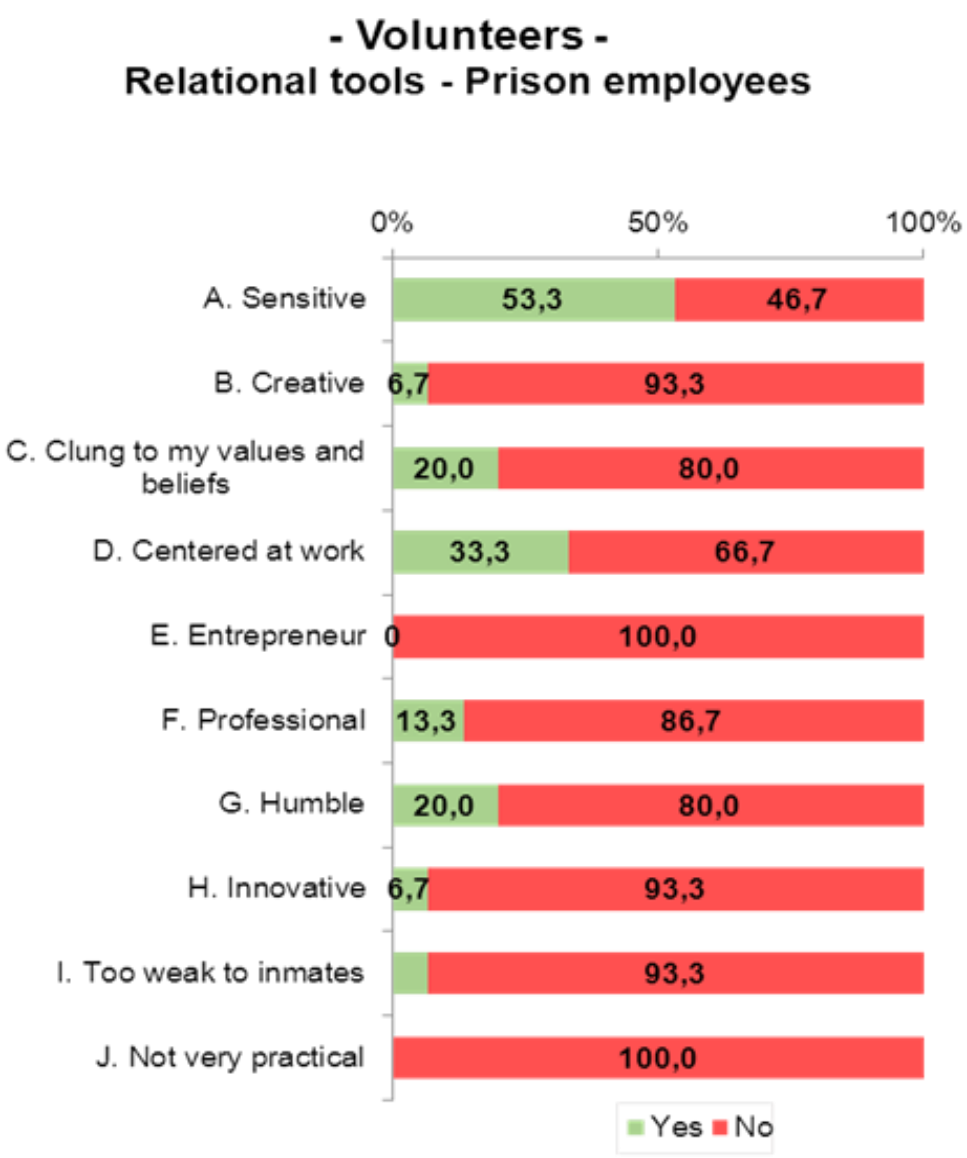
To the question “what are the most important things for a prison volunteer?” the answer “to identify the resources and to provide personal efforts in order to evaluate and properly assess opportunities” was completed a 100% as well as “focusing on a single problem and try to solve it”. There are other interesting criteria:

Chart 34



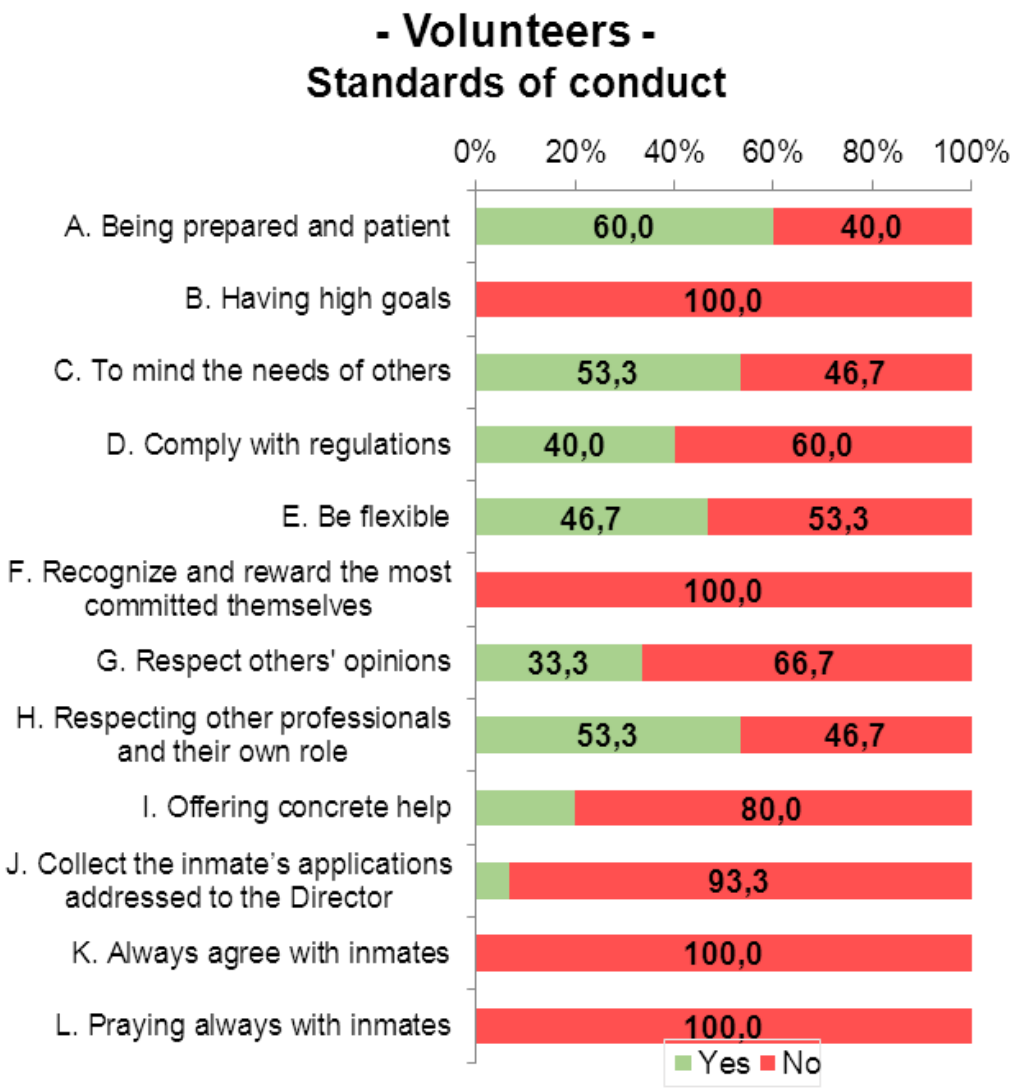
To the question “how could prison staff define the work of the volunteer?” the most frequent answers were “sensitive” (53.3%), “focussed on the job” (33.3%) and “faithful to my values and beliefs” (20%).

Chart 35



To the question “what should the rules of conduct by the volunteer be?” the answer “respect the role of other professionals and to demand respect in return” was the first choice 53.3%, while the most frequent response was “to be properly trained and patient” (60%).

Chart 36


- Volunteers -
Standards of conduct
0%
20%
40%
60%
80%
100%
A. Being prepared and patient
60,0
40,0
B. Having high goals
100,0
C. To mind the needs of others
53,3
46,7
D. Comply with regulations
40,0
60,0
E. Be flexible
46,7
53,3
F. Recognize and reward the most committed themselves
100,0
G. Respect others' opinions
33,3
66,7
H. Respecting other professionals and their own role
53,3
46,7
I. Offering concrete help
80,0
J. Collect the inmate's applications addressed to the Director
93,3
K. Always agree with inmates
100,0
L. Praying always with inmates
100,0
Yes
No

5. CONCLUSIONS AND PROPOSALS FOR IMPROVEMENT

5.1. Conclusions about the characteristics of the participants

- Doctors, nursing and treatment staff are the most committed with the subject.
- Gender. The women presence is a relevant factor to be taken into consideration (education, health and social work).
- Age. The doctors are the oldest.
- Job experience. Very experienced staff.
- Correctional officers. Very high level of qualification of the guards (70% with a degree).
- Main source of knowledge. 67% of the staff has their professional experience as the main source of knowledge about mental health issues.
- Almost 90% state that they are interested in specific training on mental health.

5.2. Conclusions about the contents of the answers given

- Directors. They all consider that their centres can provide adequate care with the cooperation of their NHS health team -Treatment area. El 92% agrees with the need of mental health training.
- Correctional officers. Civil servants, even though that their tasks are not in the health care field, are aware that they can also contribute to decreasing general unrest.
- Teachers. 71% of the teaching staff would accept students with some kind of mental upset.
- Doctors. They point out that increasing mental health training, provided to all staff that takes care of the inmates, especially those with surveillance tasks.

- Nursing staff 82,4% nursing staff considers that the factor that best contributes to the recovery of an inmate with psychopathic problems is the individual or group psychological treatment as well as schedule activities.

The volunteers who answered the questionnaires think that the loss of contact of inmates with their families is one of the factors which affect most of their psychic wellbeing. We recommend the need of outdoor activities as well as the increase of the family visits.

5.3. Proposals of Improvement

Reflecting on the criteria already examined, obviously, in order to extract information specifically focused on the writing of this chapter to achieve the main objective of this report, involves an overview of some of the criteria, both the previously agreed as those of the participants who have contributed as displayed before.

Always taking into account that the subject matter of the Project ME.D.I.C.S. and this report focuses on the issue of mental disorders in the prison environment, there are several criteria provided by participants particularly relevant. Such is the case, for example, the collective group of physicians: asked by the factors that negatively affect their professional intervention, not wary of non-health personnel but the prison itself because it may not be able to guarantee their adequate treatment services. Contrasts with the absolute certainty, by the directors of the centres, that prison can ensure adequate care to inmates suffering from psychological problems or dysfunctions because of the co-operation of the health team and of the national health system.

Another interesting contrast has to do with the perception of the causes of the states of stress that can affect inmates: their most frequent answers do no refers to the prison itself, but to the inmate to have born into a family “with problems” or because of drug use. This opinion would be shared by the nursing

staff, but contrasts with the group of volunteers, which look at the penitentiary institution when asked for situations that might favour or disfavour the recovery of inmates with mental disorders.

Associated with mental health problems are a significant number of fears and stereotypes that associate mental disorder and violence, mainly transmitted by the media (Capdevila, Ferrer, 2007: 43). In this regard, it is noteworthy that the group in the area of treatment, while demonstrating their interest to know more about the problem on the identification and management of inmates suffering from serious problems ask for one hour training per week to learn how to recognize psychiatric disorders related to aggressive and violent acts.

It seems not so concerned about the mental disorder itself but its physical extreme manifestation, while recognizing that the prison environment is a hostile and exceptional environment. This could be one of the reasons that helped to understand the significant frequency of responses of the participants in this work when, asked about the factors that affect mental stability of inmates, are contrary to the fact that the inmates do not take the drugs prescribed with a greater prevalence than to support the use of, for example, relaxation techniques. You can also understand the collective group of teachers when asked whether any inmate with “obvious signs” of mental discomfort could enjoy assistance in the classroom, the answer is that first they should receive treatment.

The improvement proposals presented below are derived from the exploitation of data from the questionnaires filled out by the groups of participants and also of ideas, information, and sources consulted and quoted throughout this work.

When it comes to propose how such a system could be improved, or a state of affairs which is considered inappropriate, you can run the risk of thinking that necessity and diagnosis are widely accepted. However, in many cases, working to promote changes from within or from outside an institution, it is easily detectable the human adaptability to the specific circumstances in which he lives, works, etc. As much as he deems unfair/improvable. In the previous

section have read a few examples, but there are also important professional groups who argue that the system works.

In this chapter proposals are also suggestions for improvement actions. These should be conceived, designed and should be verified with the involvement of professionals from various fields aware that it is not about making a specific proposal but to participate in discussions and projects to develop consistent proposals.

We propose here a change in national legislation, at least to advocate for the States to adapt their national legislation to international standards recommended, some of them for decades, that we have shown throughout this work. But it will not be feasible if is not approached from a multidisciplinary perspective.

It is proposed also the need to generate policies of empowerment of this issue addressed towards changing the social perspective.

The priority of a multidisciplinary training is proposed, ad hoc and continuous, of the whole professionals working in prisons. To work in training it is an important factor. Health is everybody's concern. We don't only want inmates to go through their sentence but helping them to deal with the disorder, the work carried out should be a multidisciplinary one.

It is essential that psychiatric staff work together with other prison professionals. Psychiatrists in Catalan Prisons prioritize the training of our correctional officers, psychologists, social workers, nurses, educators, who work or especially interact with mental patients. All the staff working in prison should have an appropriate level of training.

Since 2007 until 2010, mental health training courses had been offered to our professionals. Those courses were not only aimed to prison professionals but also to magistrates, police force and the penitentiary experts of our prisons

headquarters. Nowadays, suitable training for the professionals who work in prison has been cancelled out due to the recession.

About our courses, information has to be provided and the objectives, the method and contents of the course to be discussed. So, participants have to be provided with written material about the topic.

The contents of our courses had both a practical and a theoretical side. The theoretical side dealt with one section about basic mental health concepts, mental health disorders and security measures, the most prevalent mental health disorders in our penitentiary population. Another section was about special contents: for instance, about professional experiences within the psychiatry sphere, or how professionals act in special cases, about the communication as key factor in the dairy relationship with mental patients, and, basic safety aspects dealing with mental patients in prison…, as, for example, the last but not least: how professionals can cope with their emotions.

So, it is especially important to work in these areas:

First

The computerized medical report with encrypted data should be shared among the medical staff of the national health system (within and outside the penitentiary system)

Second

It is necessary to improve the flow of in imputable cases of security measures among our prison psychiatric units and among these units and the external centres.

Third

To create or setup a specialized team made up by forensic doctors, specialists in legal medicine and expert psychiatrists, in order to carry out:

a) The examination of the most serious cases.
b) The evidence test before trial and to suggest to the magistrate or judge which centre is more suitable if the offender is in imputable.
c) To advice and assess the Community Mental Health Centres.

Fourth

To implement a network of psychiatric outpatient's service. The outpatient's network could have one or more headquarters, depending on the extension on the territory.

These centres will have to develop specifics treatment programs for the most important pathologies, as for instance the Limit Disorder of Personality or the intellectual disabilities.

Professionals working there would have to visit the reference mental health centre where the offender lives. Keeping visits in the headquarters only for the very high risk cases. Low and medium security units must be in the community.

To invest in adequate professionals and expertise, offering a suitable treatment which diminishes the reoffending risk. Everybody knows that reclusion is very expensive for our society and this is one more reason to start up outpatients programs out of prison, in low and medium security units under forensic control.

Fifth

Give power or empower the Criminal Justice technicians, so they can decide to which centre is most suitable for the offender.

Sixth

More outdoor activities should be offered as well as increasing the possibility of family visits.

Seventh

Improve the psychiatric evaluation and expertise in the judicial procedures.

Eight

Implement a special program of attention and intervention aimed to the intellectually disable patients in prison.

Ninth

Improve the control and follow up of the people with security measures with incidence in mental health area.

Tenth

It is fundamental to improve the multidisciplinary intervention and the coordination between all professionals involved working in the prison system with special attention to the contributions of correctional officers in order to inform and prevent conflicts and self-harming attempts.

Mental pathologies are increasing in our system, partly because of the shortage of long stay beds in our ordinary hospitals. The situation is similar in other European prisons systems and the disorders are increasing, also in the US. So, we have to stand that inmates with petty crimes and short sentences, who are clinically compensated, psychopathological balanced, and with a caring family (who gives them support and take over) they shouldn't come into prison. We

should provide them other kind of establishments: Community centres with low and medium security units.

Mental health recovery is not the same as a clinical recovery. It is much more about social recovery and support. Other more social problems will need to be addressed to.

Finally, it is important to adapt the legal framework and reverse the trend to prioritize the concept of dangerousness, and go back to the risk management concept. As we know, dangerousness is a static concept and risk management means a periodical and dynamic evaluation, carrying out some measures to diminish the risk of prison recidivism.

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