
Health care strategies for mental health problems in the prison environment, the Spanish case in a European context

JM Arroyo-Cobo

Prison Health Coordination.
General Secretariat of Penitentiary Institutions. Ministerio de Interior (Spanish Home Office).

ABSTRACT

Introduction: A review was carried out of scientific literature on health care strategies for mental health problems in the prison environment.

Data is given about the main activities put into practice by prison administrations as a response to the worrying information that has come to light in recent epidemiological studies on mental disorders in prison, with figures that, when compared to the general population, give results of double the number of cases of Common Mental Illness (CMI) and four times the number of cases of Severe Mental Illness (SMI) amongst prison inmates.

Materials and methods: A review was made of the most important bibliographical databases containing health care policies for mental health problems in prison published by prison administrations in the last 10 years. This information was completed with other data obtained from an analysis of the indicators available in Health Care Coordination on its health care strategies for mental health in centres run by the Secretary General of Prisons, in Spain.

Results: There is little in the way of scientific literature that clearly states health care policies for mental illness in the prison environment. Those that do tend to agree with a number of affirmations that include the obligation to offer a therapeutic response of equal quality to that received by patients in the community, the need for a multi-disciplinary team responsible for caring for this type of patient, along with a coordinated effort between the medical, social, legal and prison administrations that at a given time have to care for them.

Key Words: mental health; prisons; national strategies; Spain; quality of health care; equity in health; mental disorders; therapeutics.

Text received: 23/06/2011

Text accepted: 10/09/2011

INTRODUCTION

The last annual report by the Mental Health Strategy ¹, approved by the National Health System Interterritorial Board clearly establishes both the social and health care relevance of mental disorders in Spain, and the most basic principles and values are

developed as to properly approach and attend to these problems in the whole public health care system.

Mental disorders are the most common cause of disease burden in Europe, ² they entail a growing challenge due to their health dimension and to their social impact on prosperity, solidarity and respect for fundamental rights and the dignity of mentally

ill people³. At the Ministerial Conference held in Helsinki in 2005, the 52 attending Member States endorsed the Mental Health Declaration for Europe. This Declaration considers mental health as a health care, economic and social priority and therefore, urges European health care systems to deliver mental health strategies which integrate the promotion and prevention of both mental health determinant and risk factors, therapeutic actions, rehabilitation, care and social support, enhancing community care and comprehensive care networks as well as efficiently working to reduce the stigma associated to mental illness, patients and their families⁴.

The WHO estimates that in Western societies, the incidence of psychiatric disorders is up to seven times higher among the imprisoned population than in the general population⁵, just like the Recommendations of the Committee of Ministers of the Council of Europe⁶ depict: throughout recent years and simultaneously to an increase of the imprisoned population, significant growth of some type of mental disorder has been observed among people entering prison. This fact is due to not only a specific effect of prisons on inmates but to an array of reasons among which we can mainly stress the disappearance of asylums -where a great deal of socially problematic people had been hosted for two centuries (personality disorders, oligophrenia), and to the considerable increase of population who lacks all types of resources or who are socially excluded, among which a great deal of mentally ill people and specially chronic psychotic patients need to be considered, who easily somehow end up in prison. Obviously, apart from this, we need to count mental disorders caused by toxic substance abuse^{1,7-9}.

Health care provision services in prison must therefore assist a great number of inmates with mental disorders, either because they already had them prior to imprisonment or because the disorder has been exacerbated due to imprisonment or because the disorder has started after it. The WHO¹⁰⁻¹², UN¹³, the EU⁶ and our country's Department of Health¹ have edited general recommendations to promote, coordinate and guide the efforts of public health institutions so that the same therapeutic opportunities for mental patients are ensured both inside and outside prison.

The objective of this document gives response to the need to reflect on the most efficient ways of using available prison resources as to achieve the appropriate quality standards in the care of mental disorders in prison. All this needs to be done in accordance with the recommendations and strategies promoted by the

aforementioned health authorities, both national and international.

The Spanish Ley Orgánica General Penitenciaria (LOGP), General Penitentiary Organic Law establishes the organization of primary care in prison and even that concerning specialized and hospital care, since its regulations set that, when necessary, "treatments will be provided in centres depending of other public non penitentiary administrations"¹⁴. The Spanish Ley General de Sanidad (General Health Law) ensured that the National Health System provided care to all patients in one healthcare network, and in the case of mental patients, it integrated all psychiatric care services and resources in one public network. Precisely, prison health care, which for now has been set apart from such integration, is specifically contemplated by the 2003 Ley de Cohesión y Calidad (Act on Cohesion and Quality), where the need for prison primary care devices to be definitely transferred to healthcare devices within autonomous communities is stressed, in order to gain coordination, equity, continuity, justice and accessibility for users to health care services. The Spanish Criminal Code, after its 1995 amendment, stipulates that a criminal offender who is hold criminally irresponsible on a plea of insanity can be submitted to ambulatory treatment or to involuntary psychiatric internment in an appropriate institution, for a period of time which will never exceed the duration of the sentence which would have been imposed if held liable. An important flow of severe psychiatric patients in the penitentiary system have this judicial origin and involve an array of medical and legal issues which have an effect on their evolution, diagnosis and rehabilitation.

Imprisoned people are part of the society and their successful rehabilitation will ensure a reduced risk for recidivism of antisocial behaviors. As far as such behaviors are associated to mental disorders, the treatment of the later will largely contribute to avoiding them. The organization of treatment of mental disorders in prison must secure an equivalent and continuous opportunity with that provided for the same disorder in the community¹⁵⁻¹⁷. Disorders commonly observed within the prison environment are characterized by their complexity, chronicity and their association with social and physical factors jeopardizing their prognosis and management, such as for example their involvement with drug abuse or learning disabilities. This is why, along with the opportunity of a joint approach of all the issues concerning the disorder, it is very convenient that a multidisciplinary team coordinately leads the treatment of this type of patients¹⁸.

The complex organization of life within a prison, lead by control and discipline, all types of restrictions and forced cohabitation, strict scheduling and monotony, emotional isolation and frustration; handicap the building of appropriate therapeutic spaces for the treatment of some mental patients. Nevertheless, there are such spaces, in some wards within prison, in the infirmary, in occupation workshops, in devices where the company of mediators or voluntary therapists is enabled. The promotion of such spaces, along with the training of all prison officers as far as the management of mentally ill people is concerned, is a key point in the building of positive environments, where respect, safety and empathy among inmates are encouraged. It is essential to build the necessary ambience to cultivate the disease's protective resilience and where specific strategies for the rehabilitation and autonomy of patients may be developed. These spaces must be available for patients without them turning into ghettos to group and separate them from the rest of inmates so that they do not "hinder" the facility's normal life.

In 1998, in the United Kingdom, one of the most complete studies until then on psychiatric morbidity among prisoners in England and Wales was published¹⁹. This report was a consequence of an article which Lord Ramsbotham, Chief Inspector of Prisons, had pu-

blished two years before denouncing a discriminatory treatment by the British administration to patients due to the fact of being imprisoned²⁰. This article generated in England and Wales a current of opinion between different lobbies which eventually entailed the initiation of the transfer process of health care depending from HM Prison Service to the Public Health System, a process which was attained in April 2006²¹.

As it has been already mentioned, the countries in our environment have experienced since the 1980s an increase of inmates with psychiatric disorders. Between 1989 and 1990, in Netherlands, research on the prevalence of psychic disorders among offenders on short custodial sentences, between 18 and 24 years old in the prison of Nieuw Vossenveld was carried out. Inmates were interviewed short after their admission to prison. This report reveals that 79.9% of inmates, throughout the one year study period or the year before that, fulfill the criteria for axis I or axis III DSM-III diagnosis (axis-I disorders include drug or alcohol abuse). 32% have suffered from an axis-I disorder one year before or during the study (addiction problems excluded), 10% from an affective disorder, 17% from anxiety disorder and 8% from schizophrenia or schizophreniform disorder. Such prevalence is clearly higher than that of the general population²².

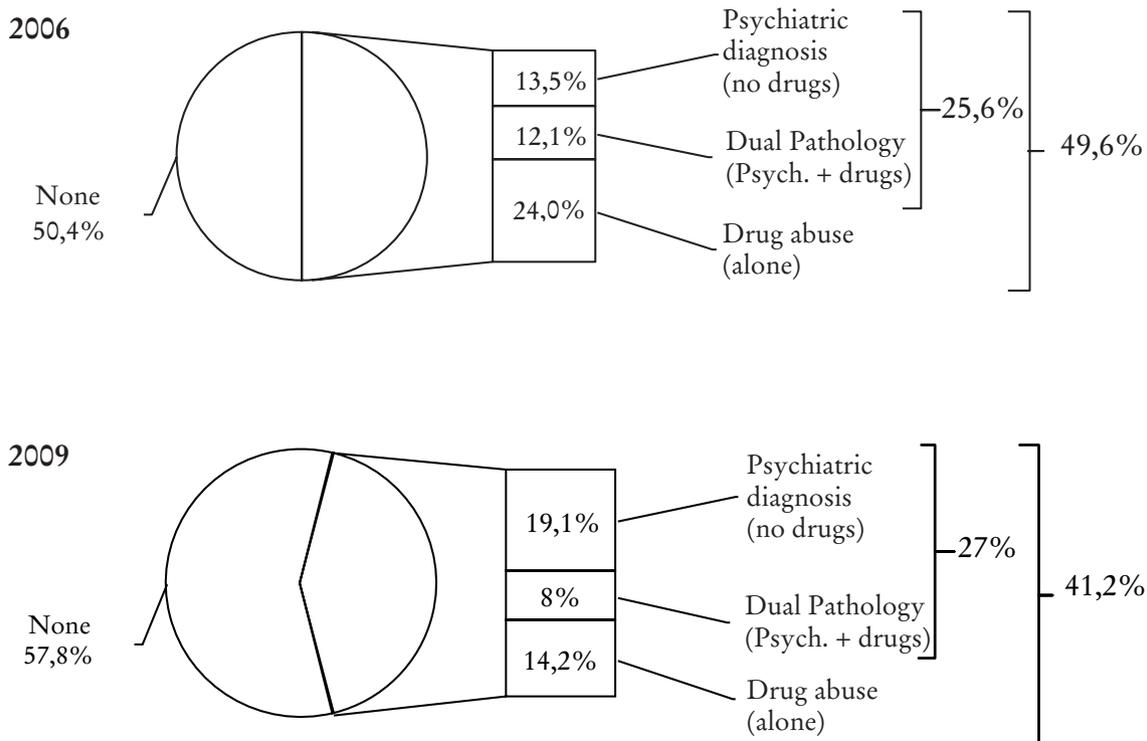


Figure 1: Comparison of the two epidemiological studies carried out in Spanish prisons.

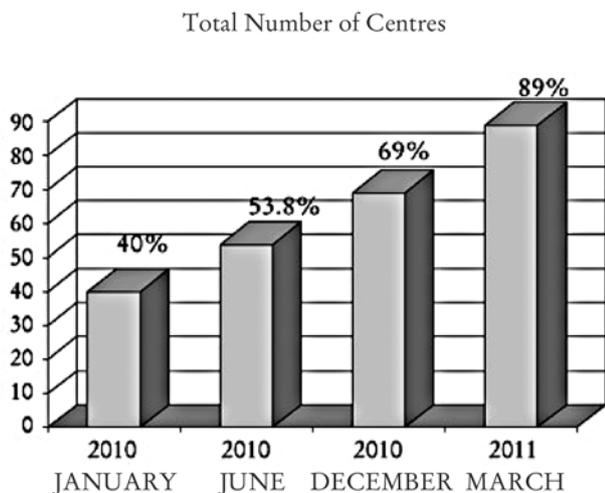


Figure 2: Total number of centres where PAIEM is established in different time periods until now

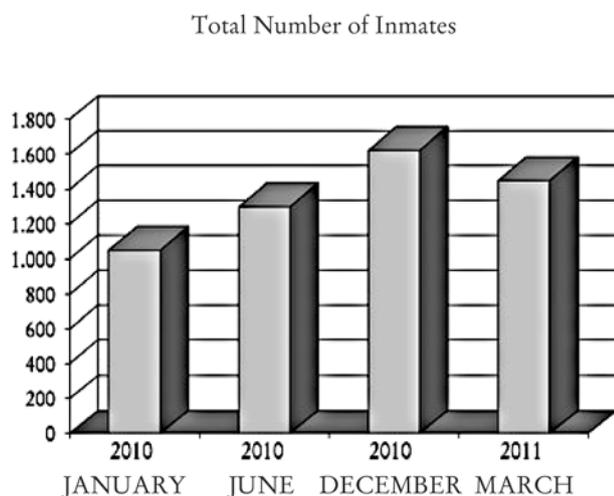


Figure 3: Total number of inmates included in PAIEM in different time periods until now

In the last 2007 European Commission report on mentally disordered persons in European prison systems²³, it was informed that about 12% of inmates need specialized psychiatric treatment, and that figure is growing. Facing the needs that such patients entail in prison is a problem which is not properly solved in none of the European countries. For the report's authors, the basis of this problem lays on deficient interaction between community psychiatry, forensic psychiatry and prison health authorities. Even the community psychiatry suffers from the lack of resources. According to the World Health Organization (WHO) mental and behavior disorders represent 12% of the global burden of

disease. However, budgetary provisions for mental health issues in most countries, is less than 1% of total health expenditure. The relationship between burden of disease and health expenditure is therefore clearly disproportionate²⁴.

In Spain, two different studies have been carried out to understand the number and type of mental patients in prison. The first one was carried out in 2006, by means of 1000 clinical histories, randomly chosen in all the prisons in the country and the other epidemiological study was carried out in 2009 on a 707 large sample by means of specifically trained interviewers and the same methodology used by the most prestigious studies on mental pathology in the general population²⁵. Results have been very similar in both studies: the later revealed a previous history of common mental disorder in 84.4% of inmates, drug abuse or dependency disorders in 76.2%. At the time of interview, 41.2% of inmates presented some kind of mental disorder, specifically Anxiety Disorder in 23.3%, Drug Abuse or Dependency Disorder in 17.5%, Affective Disorder, generally depressive, in 14.9% and Psychotic Disorder in 4.2%²⁶ (see Figure 1).

The response given by the Spanish prison administration to this situation at a national level was focused on the PAIEM action protocol (Comprehensive care program for mental health problems in prison²⁷.)

MATERIAL AND METHODS

A bibliographical revision of the main databases (PubMed, Scielo, CoChrane) has been carried out together with other resources such as online bibliographic indexes belonging to the Spanish Health Department, Home Office or the general search engine Google, to review all documents on health care policies on mental health issues in prisons, published by prison administrations throughout the last 15 years. Bibliographical search has included the terms: Prisons (and) mental health (and) programmes (or) strategies, both in English and Spanish. Other papers describing treatments and/or specific results of a sample submitted to the jurisdiction of courts have been discarded. Papers included in the revision had to describe and / or evaluate programmes or strategies implemented on the whole imprisoned population to provide mental health care.

This data has been completed with the analysis of the documents of the General Secretary of Penitentiary Institutions on health care strategies for mental health issues^{27,28}.

The available indicators on Health Coordination on the development of the PAIEM have also been gathered together with available information on the situation of Psychiatric Hospitals depending from Penitentiary Institutions. Therefore, this paper has been conducted as a systematic revision of available scientific evidence, published in the most specific and acknowledged databases, on the strategies implemented by public administrations to approach the needs of mental patients in the prison system.

RESULTS

As far as the systematic revision of available bibliography on health care policies involving mental health in the prison system is concerned, there is few literature published (see Table 1). Apart from the recommendations of international agencies such as the European Union ^{3, 6}, the WHO ^{4, 18} or health departments ¹, most of the available documents correspond to Europe, especially to the United Kingdom.

Table 1: Documents included in the revision, original country and database where found

Number of reports	Country it refers to	Database
7	England and Wales	Medline
2	Spain	Medline
1	New Zealand	Medline
1	Canada	Medline
1	Europe	Medline
1	USA	Medline
2	Spain	Scielo
1	England and Wales	Scielo
1	England and Wales	Cochrane
5	England and Wales	Other database
2	USA	Other database
7	Spain	Other database
11	European Union	Other database
1	Kenya	Other database
43	TOTAL	

All stated policies lead off the analysis of needs whose description is repeatedly emphasized in all consulted documents:

- The first data concerning a higher prevalence of mental patients among inmates than in the general community go back to over two centuries ago ²⁹. This fact is preserved and gains momentum today. There are several reasons to explain this:
 - Some are cultural reasons, such as the influence or a current of thought in today's society which stresses the relevance of protection and safety and disregards care and healing ³⁰, partly caused by the alarmist treatment that the media provides of crimes committed by mental patients ³¹.
 - Others concern health care management, such as the closure of psychiatric hospitals with no alternatives to patients who need this resource. There is a consistent inverse relationship between the reduction of hospital psychiatric beds and the increase of the number of inmates with mental disorders ²⁹.
 - Another reason lays on inappropriate management of public policies which do not promote the coordination between different administrations in charge of these patients ^{32, 33}, which leads to an apparently irreconcilable relationship between different points of view belonging to justice administration, which pursues the strict compliance with law, and health administration, whose main objectives are healing and rehabilitation. This would entail the main argument to explain the administration's erratic actions towards these patients, who should be in charge of specialized therapists to enable their social rehabilitation and whose guardianship should lay in courts, something which still today is extraordinarily rare.
 - The relationship between crime and social exclusion partly explains a higher percentage of mental disorders traditionally associated with social exclusion in prison. The relationship between crime and drug abuse adds yet another relevant factor for mental health to imprisoned people- psychoactive substance abuse disorders. All these factors, considered as a whole, can explain a great deal of the high percentages of a previous history of mental disorder among people admitted to prison, when compared to the general population.
- All observed syndromes generally need a simultaneous combined approach, due to implied chronicity and comorbidity issues ³³.

- The prison environment is not the most appropriate for the treatment of severe mental disorders, since its main aims are control and security, not resilience and rehabilitation³³.
- As far as the coverage of these needs is concerned, the proposals implied in strategies have a common denominator in all published documents:
- The quality of therapeutic responses must be the same as that provided in the community^{6, 18, 30 and 33}. Since the right to health is not influenced by the custodial sentence, it must be executed in all its force (principle of health care equivalence)³⁴. As far as the methodology to ensure equal health care, opinions among authors greatly vary. On one hand, the need for one same institution providing health care both inside and outside prison is supported, something which would obviously ensure equivalent treatment and therefore, the transfer of healthcare staff from prison administrations to the community's health administration is considered the ideal method to secure equity in the provision of this fundamental right^{29, 31}. This is so in countries like France, England, Wales or Norway and is still in process in Scotland and in our country, it is well advanced in Cataluña. On the other hand, the action of specialized health care teams in prisons is defended, since they work with socially excluded groups and complex situations in the community, such as assertive community psychiatry teams. Anyway the need of one same public health specialized organization managing mental health issues both in free and imprisoned patients, is emphasized³⁰.
- This must be a multidisciplinary team in charge of assisting this type of patients with complex treatment needs together with a lack of social support. The diagnosis of different combined mental disorders is also observed, with an evolution through time without appropriate treatment of even without any disease awareness: almost in 100% of these cases a drug abuse disorder is associated. It is necessary to find therapeutic spaces within prison to treat these addictions: the most acknowledged model is the Therapeutic Community model, which can be modified where needed to be adapted to the functioning of the prison environment^{31, 35-37}.
- The utility of prison care resources are considered to be the only ones able of efficiently fighting social inequality in health. These are devices able to early detect pathologies associated with social exclusion, therefore rescuing chronic patients from a downward spiral of deterioration and conflicts with justice. Patients are identified and stabilized in prison and they have the opportunity to return to the society with an improved health, by being derived to community care devices which will treat their disorder therefore reducing the risk of relapse and of recidivist antisocial behaviors caused by their illnesses^{28, 38}.
- The need for mutual understanding between justice, social, healthcare and prison administrations along with the commitment to consider the user's and the society's point of view, entails a continuing repetition in all consulted documents that all institutions and social stakeholders need to understand each other and coordinate their efforts^{30, 31}. Only organized and lively efforts from all stakeholders will enable the provision of necessary resources for patients, at the correct time within the evolution of their mental processes.
- It is relevant to develop a campaign to raise social awareness aimed at the public opinion, professionals: both social and healthcare, and judicial stakeholders, to counteract the effects of the double stigma suffered by mental patients submitted to judicial procedures. This stigma is partly responsible for people thinking of them more as criminals than as ill people and this severely discriminates them when accessing to necessary rehabilitation treatments³⁹. This is especially serious when patients have been held irresponsible for the committed crime and custodial measures are imposed more as a punishment than as a treatment³⁰.
- Economic reasons can lay at the basis of the lack of resources for these patients. Although it could seem that the stay per person in a prison is cheaper than in a healthcare resource, it is relevant to show public economic managers that early derivation of these patients to the appropriate social health resource greatly reduces the risk of antisocial behaviors, and therefore costs derived from arrests and police investigations, judicial processes, prison stays as well as the social cost of victims of possible crimes, the patient's family members and the patient him/herself³⁴.
- It is necessary to solve controversy and both ethic and legal dilemma arising from clinical actions in specific cases, such as, the conditions under which involuntary treatment may be initiated, urgent transfer protocols from detention and custodial facilities for mental patients, such as police stations or prisons, to social healthcare

resources for the diagnosis of acute symptoms and monitoring upon release^{31, 33, 40 and 41}. An analysis on the situation of hospitals depending from the prison system where this issue is thoughtfully evaluated has just been published²⁸. The ombudsman *Justicia de Aragon* has disclosed a report where several solutions to this controversy are debated, between what is strictly judicial and what is strictly clinical, when deciding upon the future of treatment delivered to mental patients who contact the judicial system³⁵.

- It is relevant to establish a continuous education program, aimed at surveillance officers and professionals in charge of therapeutic interventions in prisons. Improved abilities will enable them to raise awareness on the situation of these patients in prison and on the impact of all prison staff in the creation of therapeutic spaces within prison⁴². It will also enhance their roles in avoiding stigma and discrimination of these patients in prison³⁵.

As far as the strategy implemented by the Secretary General of PI to approach mental health issues in the prison system is concerned, the analysis of needs is mostly shared with the premises already stated in the bibliography. Response to such needs began to be set in June 2007, when the "Plan on Mental Health in Prisons" was published. After a piloting period of proposed action and after the evaluation of results, the Application Protocol of the Comprehensive Care Program for Mental Health problems in Prison (PAIEM) was reached and published in September 2009²⁷. This paper summarizes the guidelines provided by the Secretary General on the attention to mental health problems within the prison environment, which are basically the following:

- Since specialized and hospital care depend from health authorities of autonomous communities, their cooperation is essential to ensure equal provision of services, as long as the Act on Cohesion and Quality- which establishes the transfer of primary care in prisons, covered by the Home Office until now, to health institutions in each Autonomous Community- is not obeyed.
- The PAIEM establishes the creation of multidisciplinary teams within centres, promoted by treatment and health directors and deputy directors, including all the professionals who can develop a role in care actions aimed at these patients during their daily activities: healthcare staff, psychologists, staff from Associations or

NGOs, jurists, teachers, sport or occupation monitors and surveillance officers.

- The whole Strategy on Mental Health of the Secretary General would not be developed without the improvement of continuing training among professionals developing more health care related tasks with these patients: doctors, nurses and psychologists. For them, a 60-hour course has been held every six months for four years now. From this year on, there are also official announcements on online training about the functioning and objectives of the PAIEM for all officers included in multidisciplinary teams.
- The PAIEM sets a basis for the approach of mental health problems, often complex and changing issues observed among inmates serving a sentence in prison or awaiting trial. It serves as a link to other specific treatment programs, such as the addiction program in prison, which provides an Attention Group for Drug users, or the Program for Intellectually Impaired inmates. The PAIEM enables early diagnosis, a personalized therapeutic plan and tutored monitoring for adaptive impairments. In a similar way, it is possible to see how the patient evolves within the rehabilitation program. The activity developed by external professionals such as psychiatrists, therapists and social workers from NGOs, is guided and coordinated with the rest of activities provided by the multidisciplinary team, in PAIEM team meetings²⁷.
- Controversy concerning strictly judicial approaches and those based on clinical criteria on the derivation, treatment and custody of some mentally ill patients under the guardianship of courts, is still preserved in our country, just like documents considered in the bibliography also revealed in surrounding countries. In Spain, the problem concerning patients submitted to security measure, therefore held irresponsible for their crimes, is specially pronounced. Courts intend, through these measures, to ensure a correct treatment and therefore, achieve the rehabilitation of these patients, who end nevertheless serving the custodial sentence in low rehabilitator profile facilities such as Psychiatric Hospitals.
- Psychiatric hospitals depending from prison systems are overcrowded because they are burdened with an excessive derivation of patients who have entered the judicial system but who do not comply with the clinical profile of mental patients needing hospital care. There are several causes to explain such inadequate derivation:

incoordination concerning judicial, criminal, social and assistance administrations, stigmatization, which entails rejection in community resources from which they could benefit; social pressure concerning mental diseases for safety to prevail over rehabilitation; the lack of prevention and control policies concerning mental illnesses in chronic patients with impaired social support resources, which entails worsening and antisocial behaviors, sometimes repeatedly and eventually severe.

- A series of reflections have been gathered by different experts working for two years in multidisciplinary teams which held multicentric periodic meetings in some autonomous communities to discuss the situation of mental patients submitted to security measures and admitted to psychiatric hospitals in their communities. These have been called "Case Analysis Commissions":
 - No data have been collected showing an increased risk for security in the community when acting through the derivation of mental patients submitted to security measures to high care potential resources instead of high control resources, if the adequate profile of patient is chosen.
 - Appropriate derivation reduces recidivism.
 - Appropriate derivation saves social and economic costs.
 - Appropriate derivation needs from the creation of stable coordination mechanisms between administrations for them to be able to flexibly and lively face different health care needs implied by the somewhat chaotic psychosocial career of a complex mental patient throughout his/her life. An efficient response will allow the judicial system to back off.
 - Appropriate derivation entails, at least, the correct understanding of two complex administrations: judicial and health. Both work on different missions, views and values and have a different culture and therefore agreement between their representatives is usually a laborious task.
 - According to the evidence published, 81% of patients submitted to security measures are recidivists in the commission of crimes, generally minor, and therefore the "revolving door" phenomenon of patients entering and exiting the prison system is common.
 - High recidivism rates are associated with

the presence of mental illness together with Psychoactive Drug Use disorder (dual pathology).

- Crimes committed by severe mental patients are associated to medication discontinuation. There is no recidivism in this type of patients.
- Successful reduction of recidivism is clearly associated with an appropriate derivation ensuring continuous treatment of patients in healthcare resources. Such continuity is secured by a mechanism which entails active search of the individual within his/her environment and enables therapeutic adherence.
- Healthcare resources coordinated with prison and judicial authorities for patients under security measures or who have already served a sentence and need monitoring, play a relevant role in appropriate derivation and therefore avoiding recidivism.
- There is no evidence of a relationship between mental illness and criminality. Mental illness can cause criminal behaviors as far as it contributes to chaotic lifestyles, social vulnerability, stigmatization and exclusion. In other cases the pernicious individual influence of a severe or chronic mental process precedes an incomprehensible, impulsive and unpredictable act which leads to criminal behavior.

DISCUSSION

For some years now, those responsible for the prison system in western countries and especially in Europe have drawn the society's attention to the high number of people with mental disorders hosted in the prison system. The most reliable data multiplies by four the presence of severe mental illnesses among inmates if compared with the general population, by two if the comparison concerns any mental disorder and by fifteen or even by one hundred if we consider drug abuse upon admission with substances such as cocaine and heroin respectively. The fact of a rising proportion of mentally ill people within prisons must not lead to the correlation between mental illness and delinquency, or prison and mental deterioration. We are talking about chronic mental patients, whose processes have evolved for several years, whose deterioration finally leads to failure to socially adapt and therefore to criminal behaviors typically associated with social exclusion: drug abuse,

theft, lesions, robbery^{43, 44}. In exceptional cases of mental illness, generally with clear premonitory signs, extremely violent and irrational crimes are committed, with deaths involved. The prison system in our country has reorganized itself to face the challenge of dealing with this contingent of patients within prisons. Prisons all over the country, except in Cataluña where prison competences have been transferred, have implemented a specific action program, known as PAIEM, which includes all guidelines agreed by experts when providing care to mental patients in prison: multidisciplinary teams, with the participation of all prison professionals interested in patients and who directly treat with them; equity, serving as a link with specialized psychiatry services in the community so that they can act within prisons from the start, as well as with NGOs and third sector agencies who play an irreplaceable mediation role concerning social rehabilitation tasks, all of which find within the PAIEM the necessary support for their work in centres. The PAIEM provides patients with all therapeutic spaces within the facility: workshops, respect modules, drug abuse groups, programs for disabled inmates, sports, specific therapists, social abilities, etc and does so by means of an individualized treatment and rehabilitation program. Such program allows tutored monitoring of the rehabilitation process of each inmate and gives the responsibility for its functioning to the higher managing authorities within the centre: from the board of directors itself to the chief healthcare and treatment authorities. Most probably, complete equity would have been achieved if the same institution providing care outside prison for these patients did so within prison this is, if the execution of the 2003 Act on Cohesion and Quality had already been put into force. Unfortunately, still today primary care services provided by prison health, set apart from the rest of the structure from which it depends to provide comprehensive care: specialized and hospital care, must face the problems concerning the organization structure and coordination issues with that alien institution-in charge of healthcare provision in each community- to ensure that imprisoned patients are provided with the same quality services than the outside community.

Therefore, the Secretary General of Penitentiary Institutions is making an effort to follow the strategies accepted by most of the experts on the approach of mental health issues among inmates, even if doing so entails serious structural problems since it is not

a healthcare institution and therefore depends on the cooperation of the rest of public health stakeholders to achieve such objectives.

Nevertheless, the relationship with the judicial administration may be what definitely establishes the specificity of prison health services in comparison to other healthcare services. When treating patients in prison, and specially mental patients, judges' opinions are especially necessary and most frequently controversy arises when discussing the management of non-liable patients submitted to security measures. We must not forget that psychiatry originated from the need to establish the responsibility of criminal acts, by setting the responsibility of patients apart from that of criminals.

Court guardianship on the evolution of mental illness among inmates and specifically on patients held criminally irresponsible and submitted to alternative security measures entails a delicate part of healthcare actions in the prison system. Understanding between judicial and health instances need to be promoted by means of the establishment of communication between different point of views and the building of necessary bridges to establish mutual understanding of two universes with very different thought schemes and objectives. One: the compliance with what is legally established, and the other: the patient's benefit. We must be able to reach both objectives.

As far as the actions of public administrations concerning mental patients held criminally irresponsible for the crimes committed, sometimes serious, and submitted to treatment to achieve resilience and avoid any risk of recidivism, the general impression concluded by this report is that results achieved until now are greatly improvable. Pending the definite conclusions of the six Case Analysis Commissions, until now it is worth stating that coordination spaces need to be set between administrations which at some point are responsible for these patients. The efficiency of the response given to these situations by public stakeholders needs to be enhanced through an attitude of sincere co-responsibility and collaboration.

CORRESPONDENCE

JM Arroyo-Cobo
Talleres Editoriales Cometa, S.A.
Ctra. Castellón, Km. 3,400
50013 Zaragoza

BIBLIOGRAPHIC REFERENCES

1. Estrategia en Salud Mental del Sistema Nacional de Salud 2009-2013 [Internet]. Madrid: Ministerio de Sanidad, Política social e Igualdad. Centro de publicaciones; 2011 [citado 2011 abr 15]. Available at: <http://www.msps.es/organizacion/sns/planCalidadSNS/docs/saludmental/Salud-Mental2009-2013.pdf>.
2. Andlin-Sobocki P, Rössler W. Cost of psychotic disorders in Europe. *Eur J Neurol*. 2005; 12: 74-7.
3. Green Paper. Improving the mental health of the population: towards a strategy on mental health for the European Union. [Internet] Brussels: European Communities; 2005 [citado 2007 mar 17]. Available at: http://eurlex.europa.eu/LexUriServ/site/es/com/2005/com2005_0484es01.pdf.
4. Mental health: facing the challenges, building solutions: report from the WHO European Ministerial Conference [Internet]. Helsinki: WHO; 2005 [citado 2007 marzo 18]. Available at: http://www.euro.who.int/_data/assets/pdf_file/0008/96452/E87301.pdf.
5. Mendelson EF. A survey of practice a regional Forensic Service: what do Forensic Psychiatrists do? Part I-II: Characteristics of cases and distribution of work. *Br J Psychiatry*. 1992; 160: 769-776.
6. Recommendation No. R (98) of the Committee of Ministers to members states concerning the ethical and organisational aspects of health care in prison. [Internet]. Strasbourg: Council of Europe Committee of Ministers. 1998 [citado 2011feb 28]. Available at: <https://wcd.coe.int/wcd/ViewDoc.jsp?id=475927&Site=CM>.
7. Hernández-Monsalve M, Espinosa-Iborra J. La atención a pacientes con trastornos mentales en las prisiones. [Ponencia]. Estrasburgo: Asociación Española de Neuropsiquiatría; 1999.
8. Hills H, Siegfried C, Ickowitz A. Effective Prison Mental Health Services: Guidelines to expand and improve treatment. [Internet]. Washington: National Institute of Corrections; 2004 [citado 2011 en 22]. Available at: <http://static.nicic.gov/Library/018604.pdf>.
9. Muñoz M, Vázquez C, Bermejo M, Vázquez JJ, Sanz J. Trastornos mentales (DSMIII- R) de las personas sin hogar en Madrid: un estudio utilizando la CIDI. (Composite International Diagnostic Interview). *Arch. Neurobiol*. 1996; 59:270-282.
10. Mental health : facing the challenges, building solutions: report from the WHO European Ministerial Conference of Helsinki.[Internet]. Copenhagen: WHO; 2005 [citado 2007 marzo 18]. Available at: http://www.euro.who.int/_data/assets/pdf_file/0008/96452/E87301.pdf.
11. Mental Health Promotion in Prisons: Report on a WHO Meeting; 1998 nov 18-21; The Hague, Netherlands. Copenhagen: WHO, Regional Office for Europe; 1998.
12. Icrc.org[Internet]. Ginebra: Comité Internacional de la Cruz Roja; c2000-01 [actualizado 2007 feb 16; citado 2007 mar 27]. Available at: www.icrc.org.
13. United Nations. Basic Principles for the Treatment of Prisoners 45/111: Genebre: General Assembly; 1998.
14. Gamir-Meade R. Los facultativos de sanidad penitenciaria: evolución perspectivas y notas sobre su régimen jurídico. Madrid: Dykinson; 1995.
15. Wilson S. The principle of equivalence and the future of mental health care in prisons. *Br J Psychiatry*. 2004;184: 5-7.
16. Penal reform international: making standards work: an international handbook on good prison practice. The Hague: United Nations; 1995.
17. Declaration. Prison health as part of public health [Internet]. Moscow: WHO; 2003 [citado 2011 abr 10]. Available at : http://www.euro.who.int/_data/assets/pdf_file/0007/98971/E94242.pdf.
18. Background paper for Trecin statement on prisons and mental health [Internet]. Trecin: WHO; 2007 [citado 2011 abr 11]. Available at: http://www.centreformentalhealth.org.uk/pdfs/Background_paper_Trecin_Statement.pdf.
19. Singleton N, Meltzer H, Gatward R, Coid J, Deasy D. Psychiatric morbidity among prisoners: summary report. London: Stationery Office; 1998.
20. Her Majesty's Inspectorate of Prisons, patient or prisoner? A new strategy for health care in prisons. London: Home Office; 1996.
21. Joint Prison Service and National Health Service Executive, Working Group. The future organization of prison health care [Internet]. London: Home Secretary and the Secretary of State for Health; 1999 [citado 2011 abr 12]. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006944
22. Van 't Hoff G, De Loeff J, Latooij H. Asistencia de los reclusos con problemas de salud mental en Holanda. *Rev Esp Sanid Penit*. 2009; 11: 35-41.
23. Salize H J, Drefling H, Kief C. Mentally Disordered Persons in European Prison Systems: needs, programmes and outcome (EUPRIS). [Internet]. Mannheim: European Commission. Central Institute of Mental Health; 2007 [citado 2010 ag 10].

- Available at: http://ec.europa.eu/health/ph_projects/2004/action1/docs/action1_2004_frep_17_en.pdf.
24. Gómez-Tato I. Atención sociosanitaria y atención mental *Rev Adm Sanit.* 2005; 3 (2): 273-86.
 25. Haro J. Prevalencia de los trastornos mentales y factores asociados: resultados del estudio ESEMeDEspaña. *Med Clin.* 2006; 126 (12): 445-451.
 26. Vicens E, Tort V, Dueñas RM, Muro A, Pérez-Arnau F, Arroyo JM, et al. The prevalence of mental disorders in Spanish prisons. *Criminal Behaviour and Mental Health. Crim Behav Ment Health.* 2011 jun 15. doi: 10.1002/cbm.815.
 27. Protocolo de aplicación del programa marco de atención integral a enfermos mentales en centros penitenciarios (PAIEM) [Internet]. Madrid: Secretaría General de Instituciones Penitenciarias. Dirección General de Coordinación Territorial y Medio Abierto. 2009 [citado 2011 may 29]. Available at: http://www.iipp.es/web/export/sites/default/datos/descargables/descargas/Protocolo_PAEM.pdf.
 28. Hospitales psiquiátricos dependientes de la administración penitenciaria: propuesta de acción [Internet]. Madrid: Secretaría General de Instituciones Penitenciarias. Dirección General de Coordinación Territorial y Medio Abierto. 2011 [citado 2011 may 30]. Available at: http://www.institucionpenitenciaria.es/web/export/sites/default/datos/descargables/bEpidemiologicos/PROPUESTA_DE_ACCIxn_HOSPITALES_PSIQUIxTRICOS_PENITENCIARIOS.pdf.
 29. Reed J. Mental health care in prisons. *Br J Psychiatry.* 2003; 182: 287-8.
 30. Wilson AB, Draine J. Collaborations Between Criminal Justice and Mental Health Systems for Prisoner Reentry. *Psychiatr Serv.* 2006 jun; 57(6): 875-8.
 31. Gunn J. Future directions for treatment in forensic psychiatry. *Br J Psychiatry.* 2000; 176: 332-8.
 32. Steel J, Thornicroft G, Birmingham L, Brooker C, Mills A, Harty M, et al. Prison mental health in-reach services. *Br J Psychiatry.* 2007; 190: 373-4.
 33. Coid J, Bebbington P, Jenkins R, Brugha T, Lewis G, Farrell M, et al. The National Survey of Psychiatric Morbidity among prisoners and the future of prison healthcare. *Med Sci Law.* 2002 Jul; 42 (3): 245-250.
 34. Earthrwl M, O'Grady J, Birmingham L. Selective literature review and expert consultation exercise. *Br J Psychiatry.* 2003 Apr; 182: 299-302.
 35. Bradley K. Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system [Internet]. London: COI for the Department of Health; 2009 [citado 2011 abr 15]. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf.
 36. Kiima D, Jenkins R. Mental health policy in Kenya: an integrated approach to scaling up equitable care for poor populations. *Int J Ment Health Syst.* 2010; 4:19. doi: 10.1186/1752-4458-4-19
 37. Walker H. Using psychosocial interventions within a high-security hospital. *Nurs Times.* 2004; 100 (31): 36-9.
 38. Diversion. A better way for criminal justice and mental health. [Internet]. London: Sainsbury Centre for Mental Health; 2009 [citado 2011 may 29]. Available at: <http://www.centreformentalhealth.org.uk/pdfs/Diversion.pdf>.
 39. Blank-Wilson A, Draine J. Collaborations Between Criminal Justice and Mental Health Systems for Prisoner Reentry. *Psychiatr Serv* [Internet]. 2006 jun [citado 2011 jun 26]; 57: [3 p.]. Available at: <http://ps.psychiatryonline.org/cgi/content/full/57/6/875#top#top>.
 40. Civeira Murillo JM, Dolado Pérez A, Querol Nasarre P. Necesidades asistenciales de la población con alto riesgo de delincuencia en Aragón. Problemas y alternativas en el cumplimiento penitenciario: Aspectos judiciales, forenses y sanitarios. Informe especial 2010 El Justicia de Aragón. [Internet]. Zaragoza: El Justicia de Aragón; 2011 [citado 2011 may 28]. Available at: http://www.eljusticiadearagon.com/gestor/ficheros/_n004630_INFORME%20%20NECESIDADES%20ASISTENCIALES%20POBLACION%20RECLUSA.pdf.
 41. Campbell LA, Kisely SR. Directivas terapéuticas por adelantado para pacientes con enfermedades mentales graves. *Biblioteca Cochrane Plus* [Internet]. 2009 [citado 2011 may 31]; 2: [sobre 20 p.]. Available at: <http://www.biblioteca-cochrane.com/BCPGetDocument.asp?SessionID=%202185708&DocumentID=C005963>.
 42. Arroyo JM, Ortega E. Un programa de mejora de la calidad asistencial de los problemas de salud mental en prisión. Evaluación de resultados después de 6 años (2000-2005). *Rev. Esp. Sanid. Penit.* 2007; 9: 11-20.
 43. Hernandez-Monsalve M, Herrera-Valencia R.†. La atención a la salud mental de la población reclusa. Madrid: AEN. Estudios; 2003.
 44. Davis S. An overview: are mentally ill people really more dangerous? *Soc Work.* 1991 Mar; 36 (2): 174-80.