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Editorial

EDITORIAL

Mental Health care in different fields within the criminal enforcement system: What model do we need?

The Act 16/2008 as of May 28th, on cohesion and quality of the National Health System advocates the universal nature of the right to the protection of health and the provision of health care in conditions of equality for all beneficiaries. Moreover, it considers the need of transferring prison health services to the general health system as to improve the continuity of care, equity and clinical management.

The principle of equivalent care for people submitted to criminal sentences never implies the suspension of the right to health, although in order to exercise such right the peculiarities of the provision of health care must be adapted to the special features of the penitentiary field, according to the different fields of the criminal enforcement system.

For decades now, the high prevalence of metal disorders and addictions in the penitentiary field has been internationally acknowledged, and recent studies seem to confirm the increasing trend that these are suffering. The study EUPRIS [1] by the European Commission (2007), despite the broad heterogeneity among the 24 European participant countries, seems to confirm this fact. Two recent studies carried out in Spain [2, 3] coincide when concluding that between 25 and 27% of inmates hosted in Spanish prisons present some kind of mental disorder, with or without addiction. The study by Vicens *and cols*. [3] reveals 4.2% of inmates with a diagnosis of psychosis. If we also consider active addiction without any other mental disorder, the overall prevalence approaches 50%. Apart from the aforementioned prevalence rates, 47% of inmates fulfill antisocial personality criteria according to the renowned study by Fazel and Danesh [4], although Vicens *and cols* conclude significant features of personality disorders in almost 80% and suicidal risk in 35%. This data obviously reflect not only the high prevalence of mental disease in prisons, but the great complexity —comorbidity— of cases too.

There are many factors which seem to explain this reality: cultural factors like the emphasis on safety by the population; social factors like the relationship between poverty and crime or mental disorders; health care factors such as the reduction of available psychiatric beds or the lack of a more comprehensive relationship between the mental health network, prison health, forensic psychiatry and the judicial system [5]. Anyway, it does not seem likely that the main factor be attributable to a supposedly higher dangerousness of people with severe mental disorders. Excluding the antisocial disorder, studies such as NESARC [6] and others[7] have proven that the relationship between mental disease and violence is poorly significant. Only the association with substance abuse, stressing life events and a history of violence make a patient with a determined mental pathology more likely of committing a violent crime than the average population.

As far as the care systems are concerned, the aforementioned EUPRIS study also revealed the great heterogeneity within Europe. In fact the authors even complain about the impossibility of agreeing a definition for *prison psychiatric bed*, apropos of which Spain still declares nothing.

In Cataluña, rehabilitation professionals of the penitentiary system assisted during 2009 a total of 2938 different people (29% of the total) under drug-dependency treatment. In some centers, almost 20% of inmates were assisted by mental health specialists throughout the year and 44 interconsultations with Primary Care were pursued per every 100 inmates. Throughout the year 5.8 discharges from psychiatric hospitalization per every 100 inmates took place in the centers in Barcelona with psychiatric beds [8].

In closed educational centers for Young Offenders, with a total of 168 places, the mental health network carried out 1814 interventions, this is almost 11 interventions per year and place, and over 300 young offenders on an open regime were assisted in outpatient facilities.

By the end of that year there were 261 people under an internment security measure, of which only 105 were hosted in a conventional medium or long term stay hospital. The evolution of the number of measures runs parallel to the increase of alternative criminal sentences. In the first semester of 2008 this

figure was 4743 and in the same period in 2009, was 7908 – a 67% increase.

Hence we can see how the reality expressed in the prevalence data also translates a high consumption of health resources: the prevalence assisted can be up to 7 times higher than in the general population and the hospitalization rate is multiplied by 15.

A very hard reality, as we can see which jeopardizes the real compliance with the aforementioned equivalence principle. The project PAIEM, from the Secretary General of Penitentiary institutions (2009) [9] intends to take a step forward, by creating functional multidisciplinary teams in each centre, therefore promoting training initiatives and structuring the rehabilitation programs. In Cataluña too there has been significant progress in the implementation of a health care model with several levels, which remains incomplete in part of the territory. Nevertheless, with the economic crisis and mental health care yet poorly funded in comparison with the rest of the health system, it becomes increasingly difficult to be optimistic about the effective approach of the penitentiary issue. How should that approach be in our opinion?

In the penitentiary field, we consider a *first level* located in each prison, including primary care and specialized care for mental health and addictions. The inter-relation of professionals in both fields must focus, alike the conventional public network, on improving the resolution capability of family clinicians and nurses in regard of mental disorders.

In accordance with the need of adequacy to the specific environment of a prison, the multidisciplinary specialized team must also monitor severe cases (addictions included), create rehabilitation spaces for patients with severe mental disorders and coordinate themselves with the community network of services for the monitoring and management of the case. We believe that the specialized team should also count upon a few crisis beds, included in the general infirmary, for those cases needing special and brief surveillance.

The *second level*, specialized hospital care, must provide service for a group of centres and must count upon a centralized service for psychiatric emergencies, intensive treatment units for acute hospitalizations, detoxification and situations of organic comorbidity. This level should include an expert unit for forensic psychiatry assessments.

Intensive rehabilitation units would integrate the system's *third level*, even if they were not located in each centre, they must be considered alternative health services to the obsolete traditional psychiatric infirmaries. This way safety measures requiring of further contention could also be carried out.

Regarding safety measures, the public network of mental health and addictions is the first care reference, both for internment measures and outpatient control; so that prison health services are only in charge, by means of judicial authorization, of the cases which require very high safety measures.

Contrarily to the rule we hereby find an enormously contradictory reality, because while in the judicial practice they pursue the maximum period of sentences, in the healthcare field they fight to avoid old long term institutionalization periods. In this context, change of direction is needed and an exercise of reality between the judicial power and the healthcare system needs to be accomplished. Greater support and broadening of outpatient treatment as an alternative to long hospitalizations needs to be considered as well as a standardization which will ensure a safer therapeutic process.

It is equally necessary to improve the forensic psychiatric evaluation of patients with a significant mental disorder who have committed a crime.

With these main components, the organization model should be necessarily based on the clinical needs of each patient and on the safety requirements implied by each case. The role of measure execution officers and of the cooperation with judges is essential for the success of the model.

In the field of Young Offenders it is necessary to include the support to consulting services and an appropriate therapeutic offer for teenagers and young offenders on an open regime.

Moreover, the public network of mental health and addictions must support educational centers for young offenders, by means of providing professionals for the necessary interventions.

The Therapeutic Unit must be considered a service of strictly healthcare management and it is essential for the more complex cases that may need care on a temporary residential regimen alike therapeutic communities.

To conclude, it is necessary to further insist in the fact that the materialization of the equivalence principle [10], due to the high morbidity rates in the centers, entails an extraordinary challenge for the penitentiary system and for the health system itself, which should definitely take over responsibility of the situation as soon as possible. Similarly, healthcare providers should be in charge of health care within the centers. We understand that care provided to mental patients

or people with chronic substance dependency eventually intends to integrate the patient in the community and to avoid exclusion, and therefore the coordination with the conventional out-prison network will always be essential. Anyway, with the appropriate judicial guarantees, the management of these patients should be mainly clinical, by incorporating continuing evaluation of the risk and fulfilling a criterion of continuity. Healthcare integration interventions should be encouraged by means of the coordination and articulation of the services which provide care to the imprisoned population. In this aspect, Information and communication technologies (ICT) can also play an important role in the penitentiary field.

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