

Study of the prevalence of severe mental disorders in the penitentiaries Puerto I, II y III of Puerto de Santa Maria (Cadiz): new strategies of psychiatric care in prisons

N Marín-Basallote y C Navarro-Repiso

Acute Mental Health Unit, Puerto Real University Hospital. Mental Health Clinical Management Unit, Carretera Nacional IV, Km 665, CP: 11510. Puerto Real (Cádiz)

ABSTRACT

Introduction: In recent years it has been observed that there is a high level of severe mental disorder within the Spanish prison system.

Methods and Materials: A one year descriptive and transversal study of the psychiatric health care demand in the prisons Puerto I, II and III of Puerto de Santa Maria (Cadiz).

Results: Of the 128 patients studied, the psychiatric diagnostics with highest prevalence were personality disorders (F60-69) at 35.16%, the next group was psychosis (F20-29) at 25.78%, and in third place mental and behaviour disorders due to use of psychotropic substances (F10-19) at 16.41%. 46.09% suffered conditions which are categorized as severe mental disorders.

Discussion: This study confirms the high levels of severe mental disorder in prisons located in the area of the Puerto Real Hospital. We are making efforts to improve on psychiatric health care provided to these patients by working closely with the Prison system.

Keywords: prisons; mental disorders; schizophrenia; mental health; antipsychotic agents; substance-related disorders; social distance; community mental health services

Text received: 14/02/2012

Text accepted: 10/10/2012

INTRODUCTION

The prevalence of mental disorders within prison has increased throughout recent years. This fact has been reflected in the last studies by Penitentiary Institutions in 2006 (1), in the so called PRECA study with results published in the article: Prevalence of psychiatric pathology in Spanish prisons, in December 2011(2), the study carried out by FAISEM (the Andalusian Public Foundation for social integration of people with mental disorders) and even in dissemination articles in the press and on TV. Potential causes for such a high prevalence are (3): an increase and massification of the imprisoned population in Spain, a higher number of people suffering from mental disorders, the disappearance of mental hospitals ever since the psychiatric reform, a higher number of people

with no resources and socially excluded and the abuse of illegal drugs.

Together with this increase of mental illness in prison, a high prevalence of severe mental disorders (SMD) has also been observed, considering as such a care process defined by the ICD-10 psychiatric diagnosis (World Health Organization International Classification of Diseases): F20 schizophrenia, F21 Schizotypal disorder, F22 Persistent delusional disorders, F24 Induced delusional disorder, F25 Schizoaffective disorders, F28-29 Other and unspecified nonorganic psychotic disorders, F31 Bipolar affective disorder, F32-33 Recurrent depressive disorder without and with psychotic symptoms, F60 Paranoid personality disorder, F60.1 Schizoid personality disorder and F60.3 Emotionally unstable personality disorder. Regarding the aforementioned high

prevalence we must consider the limited capacity of mental health services, the changes concerning hospitalization criteria, the difficulty entailed by community assistance to difficult patients and the criminalization of certain behaviours.

For a severe mental patient to enter prison there are three circumstances (4) that the disease goes unnoticed through the whole criminal case, that the disease is noticed but that it is established that the patient is liable to prosecution and that the mental disorder is triggered in prison.

By following this classification we can take the first circumstance and ask ourselves why goes a mental illness unnoticed. These could be some of the possible causes (3): because of a careless attitude of prosecutors and judges due to the backlog of work, the lack of rigour of the duty solicitor, the lack of economic resources of the mental patient, the unawareness of the disease leading to not reporting this fact, or the patient not contacting the solicitor, or on the other hand the solicitor sometimes does not contact the patient until the day of the trial. All these circumstances entail that the disease goes unnoticed or is not accredited. Sometimes summary trials entail speedy pre-trial proceedings, some patients are not being assisted by healthcare services and some have not even been diagnosed.

As far as the second circumstance is considered: the disease may have been noticed but not considered as a cause for immunity from prosecution; other alternatives rather than ordinary imprisonment should be considered.

And finally in the third circumstance: unforeseeable disease. We should think of two possibilities: that the disease is noticed in the enforcement of the order and that frequently psychic disturbances are developed when submitted to a long deprivation of freedom. In both cases the disease would be treated in ordinary penitentiary facilities. In this case Article 60 of the Criminal Code amended by Organic Law 15/2003 could be implemented, by deferring the enforcement proceedings and the judge would enforce a safety measure to grant the patient's healthcare in an appropriate facility (5).

So that safety measures could be implemented Prison Psychiatric Hospitals were created and these have remained as the sole modality of special facility where the penitentiary activity is developed. On one hand, the Prison Psychiatric Hospital works as a facility for the implementation of safety measures, diagnosis and care facility for patients immune from prosecution and on the other hand, for prisoners for whom Article 60 is applicable and for inmates whose

psychic decompensation can't be managed in an ordinary prison (6).

In this context we have carried out a study to establish the profile of the patients being attended in prisons and to verify the prevalence of SMD in the prisons within our area: to analyze the demand of psychiatric care in such facilities. The prisons included in our area are: Puerto I, a first degree facility including almost 120 inmates at the time of study; Puerto II: mainly a preventive facility with about 700 inmates and Puerto III, an ordinary prison hosting about 1700 inmates, male and female (preventive and convicted).

MATERIAL AND METHODS

The study that we have carried out is a descriptive and transversal study throughout the period June 2009- May 2010 (both inclusive). It has been carried out in the three penitentiary facilities of Puerto de Santa Maria (Cadiz).

The sample under study includes a total of 128 patients (n=128) corresponding to both initial consultation and revisions comprised in the aforementioned period. Data has been collected from consultation request forms used in the prison psychiatric assistance and the reference psychiatrist has been responsible of recruiting all the patients that he has assisted in such period.

The variables analyzed have been: age, gender, psychiatric history, main diagnosis according to ICD-10 and if according to such classification it could be considered a severe mental disorder, number of revisions after initial consultation, drug abuse and type, treatments, somatic diagnosis, methadone maintenance program (MMP) and mental retardation. Moreover, we have worked out the percentage of severe mental disorder exclusively according to the main ICD-10 diagnosis.

When we designed the study we thought that it would be interesting to include how we were medicating our patients, so we selected 16 different variables, including both monotherapy and multiple therapies.

Data has been analyzed with the SPSS 12.0 statistic software.

RESULTS

In our sample (n=128) 92.19% were male inmates and only 7.81% female. We found a mean age of 36.52. Regarding the most prevalent psychiatric diagnosis according to ICD-10, we first observed perso-

nality disorders (F60-69) 35.16%, followed by schizophrenia, schizotypal disorder and delusional disorder (F20-29) 25.78% and third behaviour and mental disorders due to psychoactive substance abuse (F10-19) 16.41% (See Figure 1). It is also worth noting that 77.34% of the sample (99 patients) comorbidly abused of some type of drug at the time of the study. Such abuse is depicted in Figure II.

The percentage of severe mental disorder is 46.09% (n=59) with proportions as follow: 55.93% (n=33) corresponding to ICD-10 blocks F20-29, 37.28% (n=22) to blocks F60-69 and the third would be the block F30-39 (mood disorders) with 6.78% (n=4).

The percentage of toxic substance abuse in this last variable under study (SMD) is slightly higher than in the general sample, 77.97% opposite 77.34%. Moreover it is worth noting that all SMD correspond to male inmates.

All the 16 variables regarding the psychopharmacological treatment are depicted in Table 1.

As far as the rest of variables considered we must note that the most frequently observed somatic disease was the infection by hepatitis C virus (9.38%, n=12). Out of the patients with substance abuse (n=99) 19 were under methadone maintenance pro-

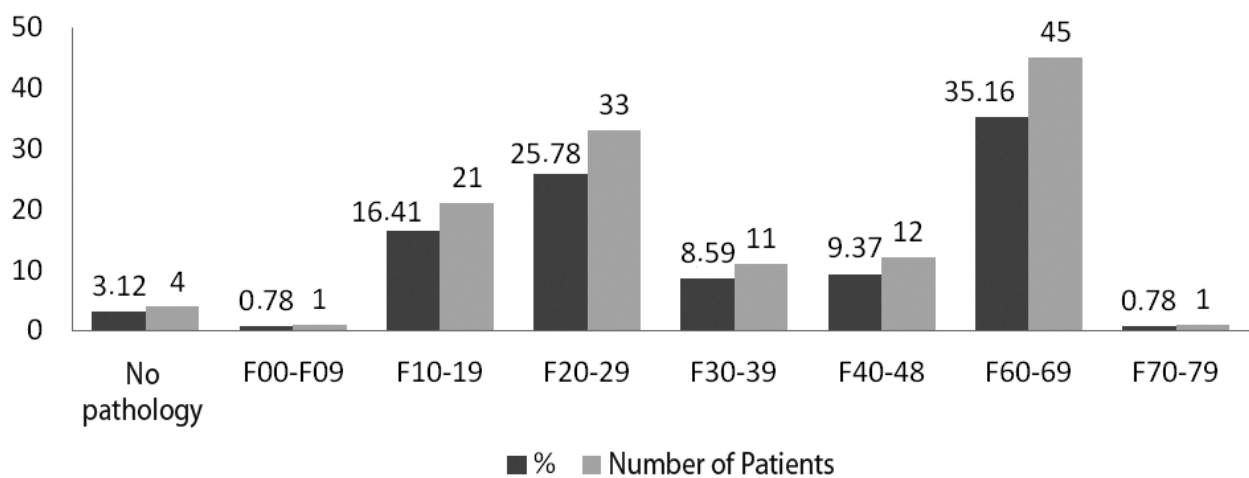
grams. We observed mild mental retardation in 7.81% of the sample. Last, we must note that 60.94% (n=78) presented a history of psychiatric disorders and the mean of revisions after initial consultation was 1.5 per patient.

DISCUSSION

The profile observed corresponds to a male patient of a mean age of 36.52 years, with a history of psychiatric disease in 60.94% of cases (n=78), with a diagnosis of severe mental disorder in almost 50% of cases, a total of 94 inmates mainly under antipsychotic treatment and drug abuse in 77.34% (n=99) of cases.

The study confirms the high prevalence of SMD, as expected, with 46.09% of the sample, which corresponds to 59 patients.

We believe it is interesting to mention the study carried out in our area throughout 11 years (2989-2000) by Dr. Espinosa Nogales and Dr. Herrera Valencia (5) in the facilities of Puerto I and II. The clinical profile of inmates then observed were mainly male, single, Spanish and original from the province of Cadiz inmates who had primary studies. With regard to somatic pathology, the most frequently obser-



F00-09: Organic, including symptomatic, mental disorders.
 F10-19: Mental and behavioural disorders due to psychoactive substance use.
 F20-29: Schizophrenia, schizotypal and delusional disorders.
 F30-39: Mood (affective) disorders.
 F40-48: Neurotic, stress-related and somatoform disorders.
 F50-59: Behavioural syndromes associated with physiological disturbances and physical factors.
 F60-69: Disorders of adult personality and behaviour.
 F70-79: Mental retardation.

Figure 1: Most prevalent psychiatric diagnosis (n=28).

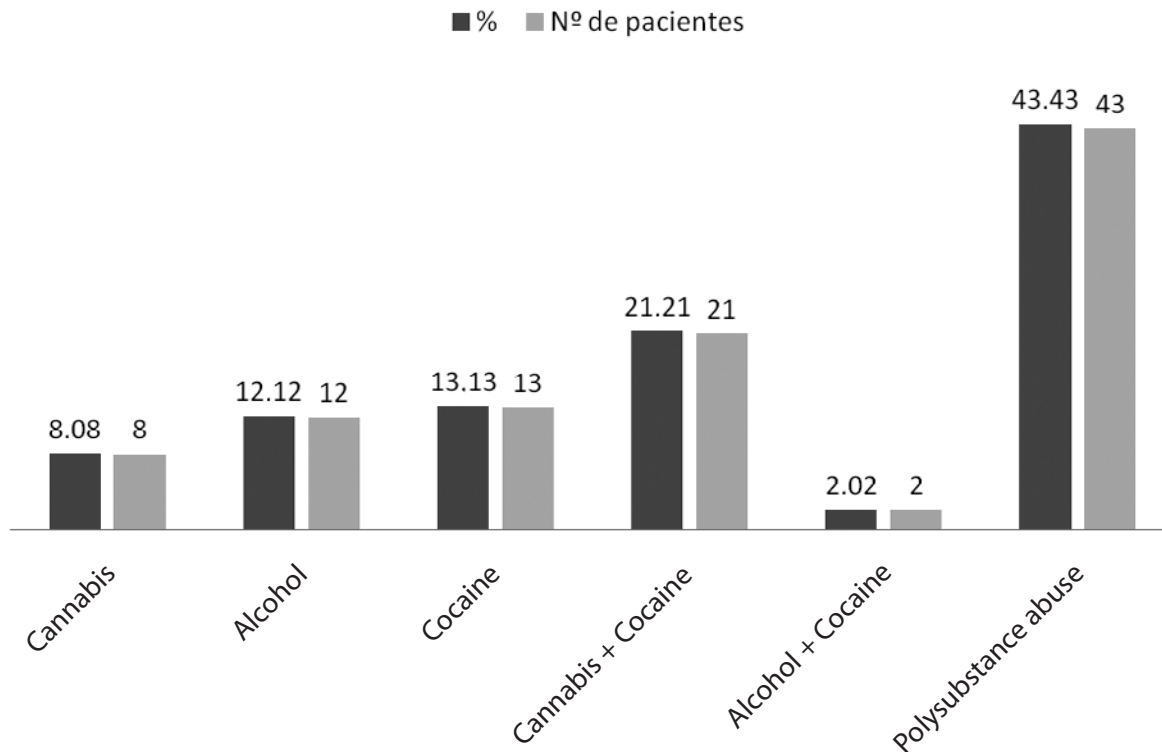


Figure 2: Substance abuse throughout the study.

ved was HIV infection. On general terms, a pattern of multi-substance abuse was observed. Last, the diagnosis comprised within blocks F20-29 and F60-69 of the ICD-10 represented a great deal of the pathologies observed among inmates, alike our study.

In 2007 a psychiatrist from the Mental Health Area of Puerto Real (Dr. Gallego) brings psychiatric care to the prison. Since then we go to each of the facilities once every month, therefore offering a broader accessibility and an economic saving from transferring inmates to outpatient psychiatric consultation.

We are hereby fulfilling the public health cooperation agreements established between prison and healthcare authorities. We are also following the action strategy 12 of the second Comprehensive Mental Health Plan of Andalusia 2008-2012 which deals with mental health care provided to people at risk of social exclusion (7).

Besides, we have offered our assistance to prison health services which are currently implementing the PAIEM (Spanish for Comprehensive Care Program for Mental Patients) (8) and we believe that taking part in the identification, diagnosis and treatment of SMD is one of our main objectives in the way to prepare the release from prison. As to improve the identification of SMD we are implementing a training

program for physicians and nurses within prison and we have also emphasized on the criteria for psychiatric consultation derivation. Therefore, whenever psychotic symptoms are detected, or if there is a history of SMD or doubts concerning the diagnosis of a SMD psychiatric consultation will be pursued.

Moreover we would like to work for the release of SMD patients by means of the analysis of their social and familiar situation and by granting a FAISEM resource if needed. If the patient belongs to our healthcare area (Puerto Real- Cadiz) he/she will be brought to the SMD Commission where, together with the reference psychiatrist and social worker, his/her situation upon release will be analyzed. If the patient does not belong to our area we expect the prison social worker assigned to the PAIEM to contact the social worker of the Community Mental Health Unit and thereby coordinate the inmate's release.

It would be interesting to further research as to assess, in the future, the new way of psychiatric assistance implemented in prisons.

As in any other descriptive study our main aim has been to establish the prevalence of SMD in prison, as well as to provide a general approach on the features of mental patients hosted in ordinary prisons. All ethical aspects have strictly been observed in the development of this study.

Table 1: Psychopharmacological treatments.

	Number of patients	Percentage
BZD (BENZODIAZEPINES)	3	2.34
APS (ANTIPSYHOTICS)	10	7.81
AD (ANTIDEPRESSANTS)	2	1.56
BZD+APS	14	10.94
BZD+AD	14	10.94
AD+APS	4	3.12
AD+APS+BZD	11	8.60
AD+APS+BZD+MS (MOOD STABILIZER)	9	7.03
AD+APS+MS	3	2.34
BZD+APS+MS	10	7.81
BZD+MS	1	0.78
BZD+AD+MS	10	7.81
AD+MS	4	3.12
APS+MS	8	6.25
DEPOT	4	3.12
DEPOT+OTHERS	21	16.40

CORRESPONDENCE

N. Marín Basallote
 Unidad de Salud Mental de Agudos,
 Hospital Universitario de Puerto Real.
 UGC Salud Mental. Ctra. Nacional IV, Km 665,
 CP: 11510. Puerto Real (Cádiz)

BIBLIOGRAPHICAL REFERENCE

1. Estudio sobre la salud mental en el medio penitenciario, diciembre 2006 [Internet]. Madrid: Dirección General de Instituciones Penitenciarias; 2007 [citado 22 En 2012]. Disponible en: http://www.msc.es/organizacion/sns/planCalidadSNS/boletinAgencia/boletin10/estudio_saludMental_medio_penitenciario.pdf.pdf
2. Vicens E, Tort V, Dueñas RM, Muro A, Pérez-Arnau F, Arroyo J.M, et al. The prevalence of mental disorders in Spanish prisons. *Criminal Behav. Ment. Health.* 2011 Dec 21;5: 321-32.
3. Mora MI. Enfermos mentales en las prisiones ordinarias: un fracaso de la sociedad del bienestar. Informe febrero 2007[Internet]. Sevilla: Asociación Proderechos Humanos de Andalucía; 2007 [citado 14 En 2012]. Disponible en: <http://www.apdha.org/media/saludmental07.pdf>
4. Espinosa M, Herrera R. Análisis de la demanda y respuesta terapéutica en la relación asistencial establecida entre los centros penitenciarios Puerto-I y Puerto II con el ESM Bahía en el período 1989-2000. En: Hernández M, Herrera R, coords. *La atención a la salud mental de la población reclusa.* Madrid: AEN Estudios/30; 2003.
5. Vizueta-Fernández J. El trastorno mental grave apreciado después de dictarse sentencia firme: el art. 60 del Código Penal. *Revista electrónica de ciencia penal y criminología* [Internet]. 2007 [citado 12 En 2012];09(04):[sobre 15 p.]. Disponible en: <http://criminnet.ugr.es/recpc/09/recpc09-04.pdf>
6. Barrios-Flores LF. Origen, evolución y crisis de la institución psiquiátrico penitenciaria. *Rev Asoc Esp Neuropsiq* [Internet]. 2007 [citado 08 En

- 2012]; 27(2): 201-28. Disponible en: <http://scielo.isciii.es/pdf/neuropsiq/v27n2/v27n2a16.pdf>
7. Valmisa Gómez de Lara E, coordinador. II Plan integral de salud mental de Andalucía. 2008-2012 [Internet]. Sevilla: Consejería de Salud; 2008 [citado 18 dic 2011]. Disponible en: http://www.juntadeandalucia.es/servicioandaluzdesalud/library/plantillas/externa.asp?pag=../../publicaciones/datos/473/pdf/PISMA_2008_2012.pdf
 8. 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 dic 29]. Disponible en: http://www.iipp.es/web/export/sites/default/datos/descargables/descargas/Protocolo_PAIEM.pdf