Comprehensive Care Program for the Mentally Ill in Spanish Prisons (PAIEM): Assessment after four years operation

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ABSTRACT

Objective: To assess the comprehensive care program for the mentally ill in prisons (PAIEM) which has been implemented for 3 years in Spanish prisons, with the aim of improving processes and results.

Methods: Descriptive study of the data gathered from an anonymous questionnaire completed by members of the PAIEM team in prisons. Frequency distributions were obtained of all the variables relating to facts, attitudes, opinions, experiences, situations and processes of the PAIEM.

Results: 91.2% of the PAIEM teams responded. Psychologists, educators, doctors and social workers were the professionals that collaborated most actively in the PAIEM (73%-84%) and were the ones to act most frequently as tutors. The mentally ill are usually located in ordinary modules (80%). The most commonly used activities for their psycho-social rehabilitation are self care (73%), education for health, preparation for daily life and social skills (more than 60%). Interventions with families are basically by telephone (79%). Bivariate analysis showed that the PAIEMs that operate most effectively are those that coordinate well with other technical teams, that prepare referral more than six months prior to release and ones where the NGOs process the referrals. Over 71% of the professionals observed improvements of disabilities and needs in over half the patients more than half of the professionals involved are satisfied (3.4/5) with their participation, although they acknowledge that there is a greater work load.

Conclusions: The activities of the PAIEM are adequate, especially in the phases of early detection, stabilisation and rehabilitation and less so in the social incorporation phase, which improves when the third sector intervenes in referrals of patients to the social health care network outside prison.

Keywords: Mentally Ill Persons; Prisons; Process Assessment (Health Care); Delivery of Health Care; Continuity of Patient Care; Patient Care Team; Rehabilitation; Personal Autonomy.

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INTRODUCTION

For some years now the main stakeholders of penitentiary facilities in Western countries have continued to highlight the increased number of people suffering from mental disorders hosted in prisons [1-5].

The World Health Organization (WHO) recognizes that the rate of psychiatric disorders among those imprisoned is higher than in the general population [6]. This is due to a series of facts among which we can consider the disappearance of mental hospitals, an increased abuse of toxic substances and an increased rate of population under social exclusion, among which we can find a high number of people with mental disorders who may be eventually imprisoned, and last the specific effect that imprisonment may cause [7-10].

All authors agree that there is no correlation between mental disorder and crime, or between prison and mental decline yet there is a strong connection between marginalization and imprisonment. Frequently mental disorders entail unsuccessful social adaptation which may eventually lead to criminal behavior and thus, criminal sentences [11-13].

The WHO [14-15], United Nations [16], the European Union [17] and the Spanish Ministry of Health, Social Policy and Equality [18] have published general recommendations to promote coordinate and guide the efforts of public healthcare institutions so that prisons grant the same treatment opportunities that mental patients have in outside facilities.

To ensure continuing and equivalent assistance within the penitentiary facility it is of paramount importance to count upon an adapted care program for the mentally ill in such environment [21-22].

In October 2007 the World Health Organization Regional Office for Europe published a statement which established a series of key criteria to improve the assistance provided to mental patients in European prisons [23]. This document raises awareness on the unconventional nature of the situation and the difficulty to grant in prisons the same principles and values that the community model is based on regarding mental health care such as: the autonomy of patients, continuous and accessible care, interdisciplinary approach and equal care, focusing treatment on the social recovery of patients granting that all institutions involved in their rehabilitation are equally responsible. In short, aiming for the maximum quality care within an environment which in the first place, does not foster the assistance of severely mentally ill patients.

In Spain, in all prisons except in those in Cataluña, where the responsibility regarding this issue has been transferred, the needs of these patients have been met by the implementation of a specific assistance program in 2009: the Comprehensive Care Program for the Mentally Ill in Spanish Prisons (PAIEM) [24], which contains all the guidelines agreed by experts on the approach of mental patients in prisons:

An interdisciplinary approach meaning that all prison professionals who are especially interested in this type of patients and with direct access to them may become involved in their assistance.

Equity, meaning that patients in prisons may count upon a series of assistance resources comparable to those available in the community, as to reach the same quality standards.

Continuous assistance both at the time of entrance and release therefore enabling liaison with the community's specialized services for psychiatric patients. Likewise, NGOs and Third Sector Organizations play a relevant role both in the psychosocial rehabilitation of these patients and as irreplaceable mediators in their social rehabilitation.

The flexibility and availability of the resources provided to these patients with a long-term integration goal, as well as of all the facilities comprised in prisons such as workshops, the room for respect program, support groups for drug users, disability support groups, sports, specific therapists, social skills, etc.

The development of individual treatment and rehabilitation programs, so that a directed follow-up of each patient's rehabilitation process is enabled.

The co-responsibility of all management authorities involved in the operation of the institutions, from directors to top stakeholders regarding healthcare and treatment in each prison.

The PAIEM comprises three stages. The first pursues the diagnosis and stabilization of patients, the second, psychosocial rehabilitation and the third, appropriate derivation and reintegration upon release. It specifically targets mental patients deprived of liberty hosted in ordinary facilities, this is, that were found accountable for the crime committed by the court that rendered the sentence. It also includes patients that suffer from a mental illness initiated once they have been imprisoned. Nevertheless, the clinical situation of these patients does not match that described by Article 60 of the Spanish Criminal Code, which depicts a mental patient who is not capable of acknowledging the sense of his/her reclusion and hence the execution of that sentence must be suspended. The patients to whom PAIEM applies serve a sentence and although they suffer from mental disorders which may severely impair their lifestyle in prison they do not fulfill the requirements to apply the aforementioned Article, since they are not permanently disconnected from reality and their ability to know and feel are preserved. Those found immune from prosecution at the time of trial are therefore sentenced to other types of security measures comprised in specific programs in Prison Psychiatric Units.

In all cases, the prison itself uses the recommendations of the Strategy on Mental Health drafted by the National Health System for their treatment[25].

This paper intends to describe the assessment carried out to know the perception of PAIEM members on the improvement of quality care provided to mental patients hosted in prisons through the implementation of this program.

METHODOLOGY

Data was collected by means of a questionnaire developed by a professional workgroup including members of the Sub Directorate General for Coordination of Prison Health (SGCSP in Spanish), the Sub Directorate General for Treatment and Management and several NGOs which develop their work with mental patients in prison. The questionnaire initially included 45 questions which mostly targeted a qualitative assessment, but which also included by means of specific data and objectives, other variables whose results could be assessed numerically both on activities carried out and on the efficiency of the program. For its "validation" the questionnaires were provided by videoconferencing to PAIEM members included in the five facilities where the program is considered to work better, according to the data periodically gathered on this issue. With the information collected, the group reprocessed the questionnaire 26 which finally included 34 anonymous questions both close and open-ended, including items on facts, attitudes, opinions, experiences, situations and processes within the PAIEM. The objective was to assess both the operation and outcome of the program.

The questionnaire was provided to the 68 penitentiary facilities dependent on Penitentiary Institutions (all except those located in Cataluña): the program is not developed in Psychiatric Hospitals or in open regime facilities. Once fulfilled by PAEIM members, all the information was gathered in an ad hoc database.

Absolute frequencies and percentage distributions were used for qualitative variables while means, medians and percentiles were calculated for quantitative variables. The denominator included "all the prisons", so that the answers of professionals were grouped according to what prison they develop their jobs in. For the items regarding the multidisciplinary team and the assessment of specific facts of the program the denominator included "all the professionals who answered the questionnaire". Some of the results are compared with those collected in the 2012 second semester Assessment Cards, which are periodically gathered by the SGCSP. A bivariate analysis has also been carried out by means of contingency tables to depict the relationship between the "degree of satisfaction" and other variables collected in the assessment. The Chi-square test has been used to look for statistically significant correlation between chosen variables.

Specific software was developed by the SGCSP to create the database in Access and SPSS was used for bivariate analysis.

RESULTS

The questionnaire has been answered by 331 professionals belonging to 62 out 0f the 68 prisons where PAIEM has been implemented. Among those who answered the questionnaire there are mainly psychologists, educators, physicians and social workers. Most of them have been part of the PAIEM multidisciplinary team for over 2 years (see Table I).

According to the information gathered, the professionals who most actively participate in the development of this program are psychologists, physicians, social workers, educators, nurses and those belonging to social entities (see Table I).

The members of the multidisciplinary teams developing tutorship tasks are mainly educators, psychologists, social workers, physicians and nurses, while 15.7% refer that there are no assigned tutors within their facilities (see Table I).

The degree of coordination between the PAIEM multidisciplinary team and other groups within the prison is satisfactory since most of the professionals consider that such degree ranges between high and very high (see Table I).

The bivariate analysis between the variable "members considering that the inmates have improved their impairment and disability" and "coordination between PAIEM and other technical teams" shows a statistically significant correlation, hence the conclusion that the teams with a greater degree of coordination are those with better outcome in the intervention with inmates (Chi2=28.8; p=0) (See Table III).

Most of the professionals refer that patients included in the PAIEM are hosted in ordinary modules, respect modules [27] or Therapeutic Educational Units (TEU) [28]as well as in the infirmary when needed. 9% have reported that these patients are hosted in modules exclusively for mental patients and only 0.3% refer that they are hosted permanently in the infirmary (see Table II).

The information regarding the PAIEM inmate is mostly gathered in their clinical record or in the treatment protocol (See Table II). Yet, when inmates previously included in the program are transferred from one prison to another there are problems in accessing this information in 59.7% of the cases.

Whenever PAIEM inmates become involved in regimental incidents, surveillance officers usually draft a disciplinary report in most prisons; rarely do Disciplinary Commissions require a report specifically created by the PAIEM Team or by officers themselves (See Table II).

Table 1. Result of the assessment of variables regarding professionals involved in the PAIEM.

Variables	Number	Percentage
Occupation		
Psychologist	64	19
Educator	60	18
Physicial	53	16
Social Worker	46	14
Treatment Deputy Director	37	11
Nurse	25	8
Other	46	13
Duration of participation in PAIEM		
<1 year	68	21
Between 1 and 2 years	103	32
>2 years	154	47
*Professionals more involved in PAIEM		
Psychologist	278	84
Social worker	245	74
Physician	245	74
Educator	243	73
NGOs	205	62
Nurse	169	52
Psychiatrist	94	28
PAIEM members who work as tutors	215	65.5
Educator	208	62.8
Psychologist	196	59.2
Social worker	177	53.5
Physician	156	47.1
Nurse	52	15.7
Coordination of PAIEM team with other teams within the center		
Very High	64	19
High	102	31
Average	120	36
Low	30	9
None	10	3
No opinion/no reply	5	2
Action taken before incident of PAIEM patient		
Disciplinary report	213	64.5
Officer's specific report	59	17.7
PAIEM's specific report	59	17.7
TOTAL	331	100

Non exclusive answers. Addition >100

According to what it has been reported the activities aimed at psychosocial rehabilitation which are most frequently implemented are: "program on self care, neatness and cell cleanliness", "health education programs", "daily activities program", "social skills training programs", "cognitive skills training programs" and "coping with illness and autonomous intake of medication". All of them have been reported by around 60% (see Table II).

Group interventions with PAIEM inmates are carried out by professionals belonging to different areas both inside and outside prison. In 40.3% of all the facilities, such activities are carried out by workers of social entities. Among prison professionals we can

Table 2: Result of the assessment of variables regarding PAIEM's activities.

Variables	Number	Percentage
Location of PAIEM patients		
Ordinary modules	264	80
Respect modules or TEUs	195	59
Therapeutic modules	34	10
Modules for mental patients	26	9
Only infirmary	4	0.3
Document including information on the PAIEM		
Clinical record and treatment protocol	141	43
Clinical record	41	12
Treatment protocol	75	23
Others	43	13
Information not collected	14	4
No opinion/No reply	17	5
*More frequent psychosocial rehabilitation activities within PAIEM		
Selfcare	243	73
Health education programs	215	65
Preparation for daily activities	204	62
Social skills training	203	61
Cognitive skills training	197	60
Acceptance of the disease	194	59
Self control techniques	165	50
Preparation for release	163	49
Psychomotricity	89	27
Others	66	20
Family intervention activities		
Scheduled meetings	106	32
Personally upon *vis a vis*	36	11
On the phone	262	79
No activities	56	18
TOTAL	331	100

Non exclusive answers. Addition >100

Table 3: Association between the variable ""members considering that the inmates have improved their impairment and disability" and the variables "coordination between PAIEM team and other technical teams within the prison", "preparation for release in advance" and "Teams that manage the derivation through NGOs or Third Sector Organizations"

	Result of the assessment		
Activity	Improved results with regard to impairment and disability	Poorer results with regard to impairment and disability	Chi-square (p)
Very good/Good coordination with technical teams	85 (64.44) [6.4]	35 (55.34) [7.8]	28.75 (p<0.001)
Poor/ No coordination with technical teams	40 (60.3)[6.86]	72 (51.66) [8.01]	
Preparation for release with over six months	40 (29.52) [3.72]	27 (37.48) [2.93]	12.52 (p<0.001)
Preparation for release with less than six months	23 (33.48) [3.28]	53 (42.52) [2.58]	
NGOs participate in derivation	46 (34.55) [3.79]	83 (94.45) [1.39]	12.21 (p<0.001)
Derivation is done otherwise	14 (25.45) [5.15]	81 (69.55) [1.88]	

outline psychologists (35.5% of prisons), educators (30.6%), physicians (22.6%), nurses (17.7%) and social workers (8%). In 24.4% of the prisons considered such group activities are not carried out.

The specific intervention with families of PAIEM inmates is mostly carried out on the phone. Individual scheduled meetings are far less common. There are 17.7% of prisons where no specific intervention with families is carried out (See Table II).

Concerning the social reintegration the questionnaire included questions on the moment (as to the time of release) when the Team initiates the appropriate intervention, reporting that in most cases (65%) it began one year or six months prior to the estimated date of release.

The statistically significant correlation between the variable "members considering that the inmates have improved their impairment and disability" and "preparation for derivation in advance" shows that the teams which prepare with at least six months the derivation, are those which achieve better results with the inmates (See Table III).

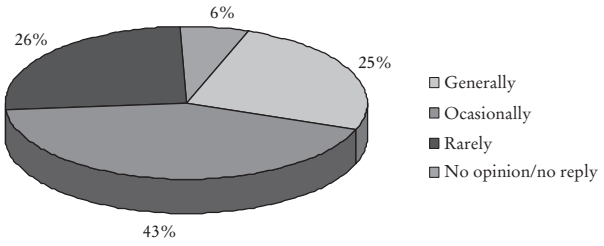
Concerning the use of different alternatives for social reintegration, most of the prisons use scheduled furlough (51.6%), yet excursions and cultural visits are far less common (19.3%) as well as leaves of absence for treatment (14.5%), family, training or employment issues (4.8% each).

Most of the professionals agree that there are difficulties regarding the implementation of measures aimed at social reintegration, both concerning social support and external follow-up (family, institutions, NGOs) (See Figure 1).

The members of the PAIEM Multidisciplinary Team responsible for the derivation of inmates to the community network of mental health care and support for drug users are mainly social workers (84%), physicians (55%), and NGOs (21%). Such derivation mainly includes a clinical and psychosocial report (60%).

Again, a significant correlation between the variables "members considering that the inmates have improved their impairment and disability" and "Teams that manage the derivation through NGOs or Third Sector Organizations" was found. A statistically significant correlation was found between teams with better results and derivation by means of NGOs (Chi2=12.2; p=0.0005) (See Table III).

Figure 1. Difficulties regarding social support and external monitoring (families, NGOs) for the implementation of measures aimed at social reintegration



Absolute values

Generally	Occasionally	Rarely	No opinion/no reply
82	143	86	20

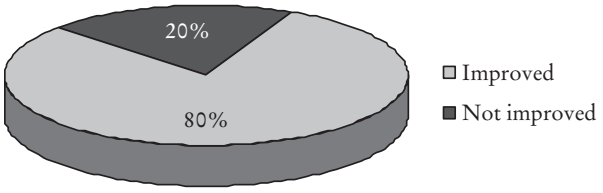
This fact is also depicted in Figure 2 where the reintegration by means of NGOs is compared to that where no third sector organizations were involved.

Regarding the item specific effects observed after the implementation of the program between 50 and 100% of the professionals reported that patients included in the PAIEM improve their impairment and disability.

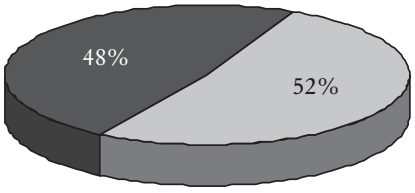
Among the advantages that professionals find after the implementation and development of the program we can outline the following: comprehensive and individual treatment of inmates (78%), improved adaptation and lower levels of conflict (75%), an improved cooperation between professionals (69%), the opinion by inmates that both healthcare and quality of life have been improved (69%) and a better compliance of treatment (63%). Among the disadvantages they mainly report a heavier workload (66%).

According to the PAIEM members, most of the prison professionals are involved with the program (>60%) or accept it (>55%), while only rare cases remain skeptical (>7%). It is worth noting that surveillance officers highly accept the program (43%), yet are rarely involved (9.4%) and show high rates of skepticism (40.2%).

Figure 2: Improved derivation of patients to community resources



Teams where NGO or mediator agencies are involved in derivation processes.



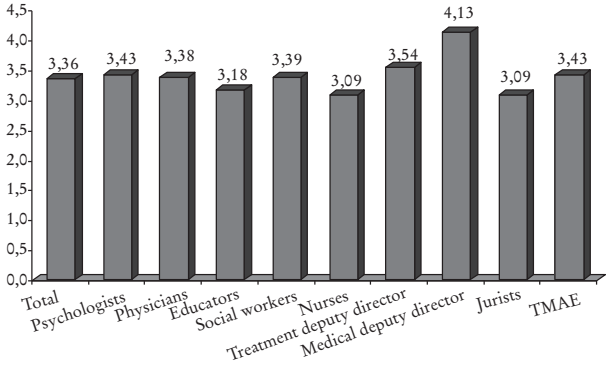
Rest of centers

Absolute values

	NGO involved	No NGO involved
Improved	55	127
Not improved	14	135
Total	69	262

Most of the members of PAIEM Teams are highly or moderately satisfied with their involvement, deputy chief medical officers being the most satisfied (See Figure 3).

Figure 3. Average satisfaction value (1 unsatisfied vs. 5 very satisfied) regarding the participation of professionals in PAIEM.



DISCUSSION

We can say that the evaluation of PAIEM was carried out from a very reliable information source, since virtually the entire population being evaluated (91% of professionals involved in the teams) has participated in the analysis. PAIEM multidisciplinary teams are formed by professionals belonging to Penitentiary Institutions most of whom have a collaboration experience in the program of over two years. Most centers also integrate professionals from social entities whose role has shown determining in the beneficial results of the program, especially at the stage of derivation of the patient upon release.

The participation of psychiatrists in PAIEM is lower than that of other professionals because they mainly perform clinical tasks and generally do not develop psychosocial rehabilitation and reintegration activities.

The figure tutor of inmates is one of the most outstanding aspects of PAIEM. In view of the results, it seems evident that this role is being developed in the vast majority of the centers and that all professionals do so evenly. Tutors are reference professionals against the various stressful situations that the patient may face such as changing department or destination, modifying rehabilitation activities, collecting of demands and needs, solving doubts, family mediation, search and referral to resources.

Mental illness itself may have a great influence on the patient's prison system lifestyle and this regime in

turn in the care and rehabilitation process and in the expression of his symptomatology. Thus, in the evaluation, a revision of the relationship between PAIEM and the Technical Team in charge of all regimental and treatment monitoring of all inmates including those in PAIEM, according to prison regulations, was carried out.

Although the degree of coordination between these teams seems high, in a significant percentage of prisons the PAIEM team did not draw up any proposals to other collective bodies, a fact that can affect the quality of the intervention with mental health patients. PAIEM professionals count upon updated information on patients that could be very useful for making decisions regarding the correctional situation of these patients.

Traditionally in prisons, healthcare services were considered to be responsible for the assistance of mental patients on their own. Partially for this, the infirmary has been usually where inmates with some type of mental disorder were permanently hosted. This was especially evident if the disorder entailed some type of coexistence issue. This fact has strongly contributed to approaching the management of these patients exclusively from a clinical and pharmacological point of view. The PAIEM emphasizes the importance of the patient's rehabilitation during imprisonment and a way of approaching this is allowing that patients take part in all the spaces with rehabilitative content available at the facility, as long as the inmate's psychological abilities at each moment throughout his/her evolution process allows to do so.

Obviously, the infirmary is the most appropriate space whenever acute episodes require further control and care. Nevertheless, the objective on this program is for patients to progressively recover their resocialization abilities, experimenting with their progress and finally executing their fully recovered social skills, always with the appropriate training and prior to release. Therefore, when the program operates as it was initially designed, the effective time spent in the infirmary has to be as short as possible, the minimum for diagnosis and clinical stabilization. Permanent hosting should only be considered in cases with a severe deterioration of coexistence or an important lack of psychosocial relations. The results of the evaluation conclude that this premise is observed, with a minimum number of inmates hosted in infirmaries. Half the inmates included in the program are hosted in common modules and the other half in respect modules or in Therapeutic Educational Units (TEU), with scheduled activities in a therapeutic environment where patients can progress in a more controlled and protected way. These modules where inmates share activities belonging to other programs can be the ideal space for patients to have a less stressful coexistence while developing new interaction skills in a progressively demanding environment. It is important to conceive these as passing spaces and not as new ghettos in substitution of infirmaries.

The collection of data on inclusion in the program and the progress made by inmates is not systematized. Some facilities use clinical records, other treatment protocols, some use both and others use different records (specific records and spreadsheets). For most of the inmates included in PAIEM, when transferred to other prisons it is difficult to know whether they had been included in the program or not, and this can entail a relevant interruption of continuous rehabilitation and treatment.

In most prisons, representatives from social entities are the main responsible agents for group interventions. Prison professionals are largely involved in these activities yet their interventions are more on an individual basis. 25% of the facilities do not develop group interventions, therefore entailing an important impairment for the physical, psychological and social recovery of inmates suffering from mental disorders.

Interventions regarding the inmates' families are essential both from a therapeutic point of view and as to improve adaptation possibilities upon release. Upon release it is crucial that families count upon counseling in different fields (information on the features and the evolution of the disease, behavior patterns in critical states, the importance of treatment adherence, available social resources, etc.) as to allow a more efficient action to achieve the reintegration of these patients in society. Yet only a third of the prisons under study have personal and direct contact with families by means of scheduled meetings or on the phone. It has been shown that this contact enables the involvement of families in the recovery process and ultimately in social reintegration. However, most of these actions take place on the phone, which is less effective. We should be concerned that in some prisons there are no such interventions. This can be due to several facts, including the negative or absence of families to become involved.

Most of the prisons prepare the inmate's release between six months and one year before the expected date, a recommendable period of time. Data also shows that most of the prisons implement measures aimed at social integration. Yet only one third of inmates were correctly derived to the community resources that they needed. As to facilitate social reincorporation the most common tool are scheduled leave permits.

The fact that other measures with undoubted therapeutic value are being underused greatly jeopardizes the reincorporation of these patients to society upon release. Since no contacts are made with families, or with community mental health centers, or with hosting institutions and entities, continuous care in the community's social and healthcare network together with family and social support are severely reduced.

The evaluation has evidenced the importance of interventions carried out y third sector organizations included in PAIEM and the success of derivation. If improved derivations are compared between teams which include NGOs and teams which don't, the difference is absolutely determinant in favor of better results achieved when third sector entities are involved. Last one of the most interesting variables assessed in this evaluation is the percentage of patients included in the PAIEM which professionals thought that had greatly improved regarding the abilities and impairment entailed by their mental disorder. In the absence of a more objective indicator, perceptions of correctional professionals dedicated to the care of these patients may become acceptable evidence. For most of the professionals, over 50% of patients have improved after being included in the program. The clinical stabilization of the patient together with the therapeutic actions developed by PAIEM allows the rehabilitation of their skills and an improvement of the shortcomings of prisoners who suffer from some type of mental illness. This will never mean that prisons should become specialized centers in the treatment of these diseases but it does imply that there has been a formidable effort by penitentiary professionals to support healthcare institutions in the treatment and rehabilitation of mental patients. This way, such institutions will be able to develop their tasks in prisons as to grant the right to equal care that the law provides for patients deprived of liberty.

PAIEM professionals consider that the implementation and development of the program entails a generalized improvement of the patients' social rehabilitation and reintegration since comprehensive individual treatment is provided, adherence and adaptation are promoted and conflict is reduced.

The assessment of the progress made in referral to community resources and in collaboration with their professionals is also favorable. This is a key aspect that should be emphasized to improve the effectiveness of treatment and of the program as a whole. Yet the main difficulty to achieve this objective is structural since social reintegration and the collaboration with external resources are aimed at from an isolated enclosed environment. Most probably, a complementary program should be implemented, capable of carrying out this important task from a more open approach, as in Social Reintegration Centers.

According to the PAIEM members, most of the prison professionals are involved with the program or accept it, while only rare cases remain skeptical. Probably the high rates of skepticism among surveillance officers is due to a lack of information on the program, and so it seems important to disseminate the main features of the program among all officers as to promote the involvement of all professional groups developing their tasks in prison.

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