Mental health, aging and palliative care in European prisons

European roadmap with policy recommendations

Developed by
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MENTAL HEALTH, AGING AND PALLIATIVE CARE IN EUROPEAN PRISONS

EUROPEAN ROADMAP WITH POLICY RECOMMENDATIONS

INTERNATIONAL CONTEXT

Worldwide more than 10.74 million people[1] are currently being held in penal institutions and the global prison population rate is increasing (World Prison Brief, 12th Edition)[2]**.** Mental illness is especially prevalent in prison populations, by far exceeding the rate of mental disorders in the general population (Fazel *et al.*, 2008). Prisoners are also a high-risk group for suicide and self-harm: suicide rates in prisons are up to ten times higher than those in the general population. A recent UNODC report suggests that suicide among prisoners seems more frequent in Europe compared to other regions, with suicide rates among prisoners accounting for over 13% of all deaths in prison. While prison psycho-social treatment and healthcare have improved in the last decades, mental health care is minimal except for those with the severest problems. In fact, only a small proportion of all mental disorders prevalent in prison populations is diagnosed at all.[3]

These mental health issues are exacerbated with age: over 20% of adults aged 60 and over suffer from a mental or neurological disorder (WHO, 2015). As the world's population ages rapidly, the number of the elderly in jails and prisons is increasing as well, at an exponential rate of 3 times that of the general prison population.

[1] Missing are prisoners held under authorities not recognized internationally and those pre-trial prisoners who are held in police facilities and not included in published national prison population totals. The full total is therefore higher than 10.74 million and is likely to be well over 11 million.

[2] ICPR (2018). World Prison Population List, twelfth edition. Institute for Criminal Policy Research. Birbeck University of London. http://www.prisonstudies.org/sites/default/files/resources/downloads/wppl_12.pdf

[3] In the MENACE project we have focused not only the inmates that are considered mentally impaired and non-responsible for their actions - and therefore sentenced by the court to serve sentence in a specialized psychiatric forensic unit - but mainly on inmates that suffer from mental illness but have been considered responsible for their actions and serve their sentence in normal prisons with the general prison population without specific treatment.

The greying prison population poses new and costly challenges that the correctional system is not adequately prepared to address. First, the stressful conditions of prison confinement are associated with an accelerated aging process, with prisoners' health status generally considered to be equivalent to that of people 10 years older in the general population (Maschi *et al*., 2013). Further, these inmates present special health and mental health needs: compared to their counterparts in the community, they have a greater incidence of chronic disease, disability, and mental health issues (Fazel *et al.*, 2002).

Palliative care and dying with dignity are considered human rights to those who need essential pain treatment, and denying access to inmates in these medical conditions can be considered equivalent to torture. This topic is even more important considering that the prison population is getting old and that there are negative attitudes about compassionate release (medical parole) and therefore it is rarely used (cf. Burles, Peternelj-Taylor, & Holtslander, 2016; Linder & Meyers, 2009). However, despite the negative attitudes towards compassionate release, it is acknowledged that "there are numerous barriers to the achievement of a good death for incarcerated individuals" (Burles *et al*., 2016, p. 105).

INTRODUCTION

Experience in several countries of Europe has drawn attention to the problems that often arise in prisons. These include difficulty in recruiting professional staff and inadequate or lack of continuing education and training. It is now strongly recommended that prison health services work closely with national health services and health ministries, so that the prisons can provide the same standard of care as local hospitals and communities.

The need to change and improve practices can best be accepted, and change achieved, if the people concerned have the knowledge, appropriate attitudes and the understanding as to why their practice should be different.

The ***European Roadmap with Policy Recommendation*** was developed by MenACE Partnership in order to help countries that seek reform in meeting these needs.

Table 1. Members of the MenACE Partnership

Institution	*City*	*Country*
HOSPICE Casa Sperantei (HCS)	Brasov	Romania
Direcao-Geral de Reinsercao e Servicos Prisonais (DGRSP)	Lisbon	Portugal
Administratia Nationala a Penitenciarelor (ANP)	Bucharest	Romania
De Federale Overheidsdienst Justitie – Le Service Pubic Federal Justice (FOD)	Brussels	Belgium
European Organisation of Prison and Correctional Services (EuroPris)	The Hague	Netherlands
Innovative Prison System (IPS)	Lisbon	Portugal
Universidade Da Beira Interior (BSAFE LAB Law Enforcement Justice and Public Safety Lab)	Covilha	Portugal
Helse Bergen Haukeland University Hospital	Bergen	Norway

This document starts by presenting transversal recommendations to mental health, aging and palliative care in prisons, and then details specific proposals structured in three chapters: Mental health and suicide prevention, Aging, and Palliative care, each of them having 3 sub-chapters: recommendations regarding staff training, legal framework and services / resources / infrastructure.

TRANSVERSAL RECOMMENDATIONS TO MENTAL HEALTH, AGING AND PALLIATIVE CARE

- Acknowledge this new reality and make it visible in penitentiary and public health policies (what is not acknowledge doesn't exist and cannot be properly addressed);
- Increase the quality of primary healthcare in prisons by:
    - Joint development of work between the penitentiary prison hospitals and local hospitals or other external mental ill treatment institutions;
    - The development and implementation of integrated and tailored approaches for early referral, assessment, diagnosis and treatment of inmates with special needs (assessment instruments and treatment programmes);
    - The improvement of the capacity to recognise and manage especial needs in prison settings with the introduction of scientifically tested and validated screening and assessment instruments;

- The development of a "unique" mental health recording system integrating different instruments (screening, assessments), diagnostic results and treatment logs, etc.
- The improvement of non-medical prison staff capabilities to identify symptoms and to act according to the defined procedures (referral);
- Implementation of telemedicine programmes involving prison hospitals, local hospitals or other external institutions; allowing the Exchange of knowledge between medical experts (from inside and outside the prison systems) and ensuring reduction of travelling of inmates (reducing high costs and high security risks);
- Referral of ill inmates to external to local or regional mental health care organisations that can provide treatment after incarceration or during community probation measures.

I. MENTAL HEALTH AND SUICIDE PREVENTION

1. Staff training

1.1. Training and support on mental health awareness is needed for all prison staff, particularly wing-based officers, to help them identify prisoners at risk of developing/experiencing mental health problems and respond appropriately to the needs of these prisoners;

1.2. A curriculum with specific modules should be developed for each category of employees involved in training sessions and staff training should be organised differently for prison frontline staff (e.g., prison guards) and technical staff (e.g., clinical);

1.3. Effective communication leads to better supervision in any situation, especially in a correctional facility. There are plenty of moments when communicating with inmates on their level, changing the speech patterns, the tone and body language in order to mirror inmate behaviours will lead to a better understanding of the message. That is why specific module on communication issues, on behavioural psychology should be included;

1.4. More practical guidelines on how to deal with mentally ill inmates, how to address them, how to manage safety risks for themselves and the others (inmates or staff) are needed;

1.5. Staff working with prisoners with antisocial personality disorders should receive appropriate training, support and supervision, preferably from outside the unit. It helps employees to cope with emotional distress and to prevent burn-out;

1.6. Correctional officers working with inmates should receive special training on how to recognise, on one hand, suicide attempts and, on the other hand, “fake attempts” and manipulation;
1.7. Peer interventions with prisoners offer a means to improve health and reduce risk factors for this population, although inmates need special training on peer support (and its potential risks).

2. Legal framework

2.1. First of all, it is necessary a review of the legislative framework of each country in order to check its compliance with international standards and norms. Those should be reflected in national legislation regulating prisons and govern every aspect of the policies and regulations adopted by a prison system;
2.2. Inmates have the right to be informed of these policies and regulations. Policies and norms must be developed in a way that does not constitute unacceptable discrimination between inmates. They must be applied fairly;
2.3. The policies and strategies to be developed should also include issues such as ensuring continuity of care after release;
2.4. There is a need for a legal framework to enable family and volunteer involvement in the rehabilitation process of prisoners suffering from mental disorders (more specifically, increase the family visits, resuming family ties with the support of social workers);
2.5. Introducing a suicide prevention programme is a must for every penal institution;
2.6. It is recommended to introduce a standard control procedure / algorithm to assess the risk of suicide and self-harm in prison. Drug and / or alcohol dependence should be taken into account in the control procedure as a factor that may increase the risk of suicide;
2.7. Alternatives measures of detention for offenders with mental disorders should be developed.

3. Infrastructure/services/resources

3.1. Special units /sections for detainees with mental disorders should be created, so that they could be separated from general prison population;
3.2. Mental health facilities should be completely redesigned and properly staffed:
3.2.1. Increase the number of specialised units designed for mentally ill inmates’ detention;

3.2.2. Increase the number of health specialists, especially having one psychiatrist per unit;

3.2.3. Introduce the "naked" cell - self-harm protection cell (specialised cell for protecting inmates from self-harm) in each prison;

3.2.4. Ensure more recreational and sport areas for mentally ill inmates and increase the number of prison staff to guide these activities. Mental health patients would benefit from being included in specific therapeutic centres/ communities rather than by being isolated/ secluded in special confinement rooms or units;

3.3. Mental health of new inmates should be thoroughly screened using the available best practices and adequate screening tools;

3.4. Every health care service centre should have a lead nurse or manager who has responsibility for older prisoners, and for staff working with older prisoners to receive training in how to recognize signs of mental health problems;

3.5. Prisons with a significant number of prisoners with mental disabilities should look into the possibility of schemes where trained prisoners provide support under supervision as an addition to social care provision.

II. AGING

1. Staff training

1.1. Regarding older inmates, considering the special needs of this population that cover the four dimensions - physical, psychological, social and spiritual - staff training (including here medical professionals, security and counselling staff, and field parole officers) should cover all these aspects of care, focusing more on the changes associated with the aging process and less on statistics (for example, geriatric training, psycho geriatrics training, etc.);

1.2. In order to build a stronger community among inmates, raise awareness, and foster more effective management of the prison population, training about aging and associated responses should also be provided to the inmates.

2. Legal framework

2.1. First of all, it is necessary to define clearly, in legal terms, what is an "old inmate";

2.2. Developing special strategies for older prisoners is needed;

2.3. Considering the diverse issues to be addressed in relation to the supervision and care of older prisoners, management policies and strategies should involve the input of a multidisciplinary team of prison specialists;

2.4. A steadier legislation allowing prison service staff to work with organisations of civil society, as well as health and welfare services, in order to cover all the needs of older prisoners, while laying the basis for their continuum of care in the community following release is required;

2.5. Re-entry can be an extremely difficult process for all inmates and for elderly inmates in particular because not all of them want to be released. There are many reasons to consider here: maybe they have no family, have lost contact with family, don't want to be a burden on their family, or they simply feel at home in prison and have a social support group there. All of these issues are important to consider when discussing re-entry of elderly inmates and there is a need of developing comprehensive continuum of care protocols and mechanisms with community mental health systems to break the cycle of release, re-offending and imprisonment;

2.6. The policies and strategies to be developed should also include issues regarding:

2.6.1. Alternative measures to imprisonment (for example, use of electronic monitoring, special placement in unit);

2.6.2. Special programmes involving younger inmates to help older inmates;

2.6.3. A reward system for younger inmates who choose to nurse for older inmates;

2.6.4. Finding additional funds to allow prison staff's involvement in occupational therapies/other activities with older inmates;

2.6.5. Special laws for the protection of the elderly;

2.6.6. A legal framework to establish separated units for older inmates;

2.7. It is recommended to review and revise sentencing policies for older inmates (e.g. development of alternatives to incarceration).

3. Infrastructure/services/resources

3.1. Special accommodation is required for elderly prisoners that need to deal with the problems arising from a loss of mobility or the onset of mental deterioration. Attention needs to be given to the different problems, both social and medical, of this group of prisoners including:

3.1.1. infrastructure adapted to reduced mobility (improve accessibility while maintaining security) - increasing the number of wheelchairs and the space in cells for wheelchairs;
3.1.2. No double beds;
3.1.3. Toilets adapted to reduced mobility;
3.1.4. Elevator;
3.1.5. Diet adapted to their needs;
3.1.6. Recreational rooms;
3.1.7. Panic button for emergencies.

3.2. Increase the number of staff working with older inmates and geriatric specialists in the prison hospitals;
3.3. Increase schedules of doctors inside prison;
3.4. Routinely monitor older prisoners to ensure they are not being victimised;
3.5. Some older prisoners will require social care in the community. They should be routinely referred to their receiving local authority for a social service needs assessment.

III. PALLIATIVE CARE

1. Staff training

1.1. All staff working in each prison's clinical unit should have training about the general concept of palliative care including:
1.1.1. The hospice concept (the key features of the benefit, including the emphasis on palliative care over curative care);
1.1.2. The medical perspective (interdisciplinary team approach and specific pain management methods);
1.1.3. Psychological, social and spiritual assistance for ill patients;
1.1.4. Patient care techniques;
1.1.5. Caring for the family;
1.1.6. Grief and bereavement;
1.1.7. Ethical issues;

1.2. A group discussion in the training programme about death and dying can help bring about a greater understanding of personal biases. The group discussion allows prison staff to get in touch with their own views on death and dying and allows them to relate

it to the hospice's mission. More importantly, they learn that their views should not be imposed on those they are trying to help;

1.3. Because prisons have a unique culture, inmates themselves are the most qualified to provide hospice and palliative care to fellow inmates. In many cases, inmates themselves represent the only family dying inmates have. That is the reason for encouraging all inmates to participate in a training that will provide the skills to ensure dying prisoners' physical, emotional, and spiritual needs are met (peer care support).

2. Legal framework

2.1. Considering the fact that most of the prisoners that suffer from a chronical progressive disease can be better cared in the community, within the framework of suitable non-custodial sanctions and measures, the age of offenders, their mental and physical health, prospects of receiving adequate care in prison should be taken into account by sentencing authorities, to ensure that the sentence does not comprise an unproportionate harsh punishment;

2.2. The compassionate early release legislation should be reviewed so that people diagnosed with a chronicle progressive disease and need palliative care, especially those in terminal stage, should be released in order to benefit of specialised palliative care or specific family care support;

2.3. A working procedure on therapeutic conduct at the time of diagnosis for all penitentiary units would be a great help because end of life and palliative care plans should be initiated at an appropriate and ideally early stage for prisoners who are diagnosed with a terminal illness. These plans should include all aspects of a patient's care, including effective pain relief and psychological and emotional support and, where appropriate, should involve the prisoner's family;

2.4. Regarding staff's well-being, because we are dealing with a "high-risk profession", some adjustments to the legal age of retirement/ right to have more holidays are needed.

3. Infrastructure/services/resources

3.1. The Palliative Care team should include a physician, a nurse, a social worker, a psychologist, a therapist and a spiritual counsellor;

3.2. Prisons should ensure that terminally-ill prisoners who require intensive palliative care are treated in a suitable environment, in consultation with the prisoner. The benefit gained by keeping the prisoner in a familiar place should be as important as ensuring to

the prisoner the quality of healthcare, and staff's ability to adequately care for the prisoner;

3.3. If it is not possible to provide palliative care for prisoners with chronic progressive disease or terminally ill prisoners, the penal institution should try to focus on developing connections with local hospices to enable prisoners to receive treatment outside prison;

3.4. There is also the need of creating a space inside the prison's clinical wing for promoting other therapeutic and social/ occupational activities (a "cosy corner", quiet environment so that inmates can escape the illness space);

3.5. Prisons should ensure that end of life and palliative care plans are initiated at an appropriate and ideally early stage for prisoners who are diagnosed with a terminal illness. These plans should include all aspects of a patient's care, including effective pain relief and psychological and emotional support and, where appropriate, should involve the prisoner's family;

3.6. Prisons should work with the family and keep them involved by appointing a family liaison officer. It is recommended that a prison family liaison officer should, where possible, be appointed at the time of diagnosis (rather than after the prisoner's death) and be the key contact for the family during the prisoner's final months and days.