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DEALING WITH PRISONERS WITH MENTAL DISORDERS

Document prepared by:

Dr Jean-Pierre RESTELLINI
FMH specialist in internal medicine and forensic medicine, Jurist
Former President of the (Swiss) National Mechanism for the Prevention of Torture

and

Dr Régis MARION-VEYRON
FMH specialist in psychiatry/psychotherapy,
Head of the Psychiatric Liaison Unit of the University Medical Polyclinic (Lausanne)

I. PREAMBLE

Dealing with prisoners with mental disorders is a vast and complex issue, where much work still needs to be done. The quality of provision varies significantly among Council of Europe member states but remains very limited on the whole.

II. INTRODUCTION

Recapitulation of the various facilities currently holding prisoners with mental disorders in Council of Europe member states:

- **Prisons / pre-trial detention centres** in which:
  - prisoners are mixed in with other prisoners or,
  - grouped together in small separate units.
- **"Forensic medicine" wards/departments**
  - separate facilities,
  - forming part of a prison,
  - forming part of a civil mental hospital.
- **Civil mental hospitals**

Which of these various facilities is best?

The European Court of Human Rights has wisely ruled several times that what mattered most was for patients to receive appropriate care, regardless of the type of facility.

In its 1992 general report, the CPT stated that "a mentally ill prisoner should be kept and cared for in a hospital facility which is adequately equipped and possesses appropriately trained staff. That facility could be a civil mental hospital or a specially equipped psychiatric facility within the prison system."

III. CPT RECOMMENDATIONS ON PSYCHIATRIC CARE IN PRISONS AND ON DETAINEES IN NON-PRISON HOSPITAL SETTINGS

The CPT has sought to clarify its position through its many visit reports. Below are a few brief excerpts from these reports, followed, where applicable, by the comments of the authors of this text in blue.

A. PSYCHIATRIC CARE IN PRISONS

- A doctor qualified in psychiatry, tasked with holding regular consultations, should be attached to the healthcare service of each prison. He or she must also be able to draw on the support of psychologists. It is also important that some of the nurses employed there have had training in this field.

This is still far from being implemented in many Council of Europe member states. In this context, boosting posts whose attractiveness is not obvious at first sight is vital. Clinical practice in prison settings is very varied but does generate legitimate fears. Promoting regular and frequent training for the three professions is therefore not a luxury but the key to continuity that is beneficial to the relevant facilities and prisoners first and foremost.

- When necessary, transfers to a prison psychiatric facility should be treated as a matter of the highest priority. Waiting times should be minimised. Prisoners who are regarded as dangerous as a result of a serious mental illness should no longer automatically be placed in high security units.

When the institutional and regional or, indeed, national context does not allow such transfers, (less expensive) compensatory investment in care resources should be required as a minimum. A competent on-the-spot nursing team with appropriate supervision can be at least as effective as the irregular presence of a consulting psychiatrist.

- A mentally disturbed prisoner who commits violent acts should be treated through close supervision and nursing support, combined, if considered appropriate, with sedatives.

For many years, it has been shown that antipsychotic and antimanic medication (mood stabilisers) is vitally important for persons with schizophrenic and bipolar disorders. If violent acts occur during episodes of these types of disorder, particular emphasis must be placed on facilitating access to such medication. The possibility of long-term treatment must be considered in certain circumstances.

- Prison staff should also be trained in engaging with prisoners with mental disorders. Prison officers should not openly carry truncheons in prison psychiatric hospitals; preferably they should not carry them at all.

The experience of the authors of this report shows that very beneficial collaboration can be established between carers and security personnel in units of this kind, to the great benefit of the patients and without calling into question the differences between the duties of the two categories. This generates significant added value for prison staff, provided that participation is voluntary.

- Any resort to instruments of physical restraint should always be expressly ordered by a medical doctor and should never be used as a punishment. Instruments of physical restraint should be removed at the earliest possible opportunity.

The removal of physical restraint should be agreed between healthcare and prison staff. There may, for example, be clear improvements in psychotic symptomatology but persistent dangerousness which prison staff are entitled to question on account of their experience of daily prison life.

- In the event of resort being had to physical restraint, an entry should be made in both the patient's file and an appropriate register, with an indication of the times at which the measure began and ended, as well as of the circumstances of the case and the reasons for resorting to such means.

- The availability of adequate supplies of psychotropic drugs should be ensured.

- Placement of a patient in a judicial psychiatric hospital does not necessarily allow the healthcare staff to disregard the generally recognised rule of "free and informed consent" to treatment.

- The provision of therapeutic activities to persons undergoing forensic psychiatric assessment does not interfere with the assessment process

B. PSYCHIATRIC CARE IN NON-PRISON HOSPITAL SETTINGS

In general, it is strongly recommended that persons with psychiatric disorders who have committed offences during episodes of such disorders should receive care in an appropriate setting rather than in prison. Although this principle is indisputable as a general rule, it is nevertheless difficult for a good number of Council of Europe member states to implement, and not only for financial reasons.

In particular, regardless of the goodwill shown by the authorities and the resources they allocate for the purpose, it is still difficult to change certain representations of dangerousness among the general public and healthcare staff, as well as among the other residents in psychiatric hospitals. Moreover, in the case of serious offences and, in particular, acts of a sexual nature, it is perhaps wiser to set up suitable psychiatric wards in prisons rather than to seek at all costs to provide care in general psychiatric hospitals, while hoping at the same time that prevention and destigmatisation campaigns

will allay the fears of all those concerned. Expectations of this kind are based more on an ideal than on empirical arguments.

CPT Recommendations CPT (continued)

- Measures must be taken to offer all patients, including those accommodated in acute psychiatric wards, at least one hour a day of outdoor exercise, in a reasonably spacious and secure setting.

- In a forensic psychiatric hospital, the treatment should involve a wide range of therapeutic, rehabilitative and recreational activities - including appropriate medication and medical care - and should be aimed at both controlling the symptoms of the illness and reducing the risk of reoffending.

- Consent to participate in a research programme, even if indicated by signing a consent form, cannot be considered as informed and therefore valid, unless the patients concerned are informed about both potential benefits and risks of participating. In addition, clear doubts remain about the competency of patients to consent when they are being treated for acute symptoms of a chronic psychotic disorder.

IV. COUNCIL OF EUROPE REGULATIONS AND CASE LAW

European Prison Rules:

43.1 The medical practitioner shall have the care of the physical and mental health of the prisoners and shall see, under the conditions and with a frequency consistent with health care standards in the community, all sick prisoners, all who report illness or injury and any prisoner to whom attention is specially directed.

Nothing else!

V. EUROPEAN COURT OF HUMAN RIGHTS

FACTSHEET: Detention and mental health (January 2020), based on some 50 judgments of the Court, from 1998 to 2020.

In short:

- The judgments are relatively disparate.
- In most cases, the Court ruled against States Parties on the ground of the overall inadequacy of the psychiatric care provided.

VI. SOME OTHER INTERNATIONAL INSIGHTS

FRANCE[1]:

- Eight out of ten prisoners have at least one psychiatric disorder (all types of mental disorders combined, including personality disorders and addiction disorders).

- Individual psychotherapeutic support remains the exception, including in the most serious cases. Prisoners only receive treatment on an emergency, outpatient basis, primarily by means of medication.

- Imprisonment leads to a deterioration in prisoners' mental health, often to the extent of developing new psychiatric disorders.

[1] According to the Inspector-General of Places of Deprivation of Liberty (CGLPL).

- There is a need for secure sections of hospitals or "light" detention centres to enable psychiatric day care to be provided outside prison.

NETHERLANDS:

- The judicial system in the Netherlands reduces the prison population by providing specialised rehabilitation for persons with mental illnesses.

- The persons concerned present psychotic vulnerability, autism and severe learning difficulties, often combined with severe personality disorders, addictions, financial problems, poor housing or severely disturbed relationships with their families.

- They must have committed a serious offence with a minimum prison sentence of four years and have a high risk of reoffending: the programme is aimed specifically at their reintegration into society. If that is not deemed possible or if they refuse to co-operate, they can ultimately be transferred to an ordinary high-security hospital and detained indefinitely.

SWITZERLAND:

Articles 59 to 61 of the Swiss Criminal Code introduce the possibility of ordering in-patient treatment:

- When the offender suffers from a serious mental disorder, the court may order in-patient treatment if the offender's mental disorder was a factor in a felony or misdemeanour and it is expected that the measure will reduce the risk of further offences being committed in which his or her mental disorder is a factor.

- The main aim is to reduce or prevent the risk of reoffending under an approach based on treatment rather than punishment.

- In practice, the ending of the measure is decided on the basis of improvements in the prisoners' clinical condition.

ALBANIA:

- In four prisons, the prison authorities have recently established units known as SKVs.

- SKVs are facilities holding prisoners with various mental disorders. Prisoners are free to refuse to be assigned to them.

- Their specific features are as follows:

    - presence of a nurse round the clock and of a psychologist during the day;

    - outdoor exercise and some workshops separate;

    - as a rule, no compulsory chronic psychiatric treatment but, in emergencies, the psychiatrist can order compulsory treatment for a maximum of 72 hours.

VII. CONCLUSION

The CPT's recommendations are aimed at encouraging the effective implementation of European and international resolutions on dealing with prisoners with mental disorders. Since as long ago as 1992 (see under point II above), the CPT has wisely not given absolute priority to the need to treat all prisoners with psychiatric disorders in healthcare facilities. On the basis of 30 years of hindsight on the subject, it should now be asked whether a still more pragmatic approach should be taken. Providing the most appropriate care possible in line with current knowledge does not necessarily have to be opposed overly dogmatically to taking account of the relevant contexts. This is a very

common issue in general psychiatry and it should therefore be taken into consideration, including in view of the principle of equal treatment. Accordingly, care in a prison setting, with sufficiently sound resources and approaches, may be preferable in some member states at present to insisting at all costs on the building of new facilities or specialised wards in general psychiatric hospitals.