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Prisons and probation: a Council of Europe White Paper on the management of offenders with mental health disabilities and disorders

By Professor Charlie Brooker
Royal Holloway, University of London
(United Kingdom)

and

Jorge Monteiro, Psychologist
(Portugal)

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1.Introduction

The Council for Penological Co-operation (PC-CP), in accordance with its terms of reference for 2020-2021 (Doc. CM (2019) 131-addrev2), started examining the management of offenders with mental health disabilities and disorders by the prison and probation services, the problems which might be faced by their staff in relation to this and what possible solutions and standards might need to be developed at European level.

The Confederation of European Probation (CEP) and the European Organisation of Prison and Correctional Services (EuroPris) are also contributing to the Council of Europe work in this area.

The PC-CP Working Group members and scientific experts agreed that the outcome of this work at this point should be a White Paper which takes stock of the situation in Europe, provides examples of existing challenges and good practices and a list of recommended steps to be taken by the Council of Europe member States to improve the management of such offenders. The White Paper is expected to be finalised and approved by the PC-CP by the end of 2022.

2. Background

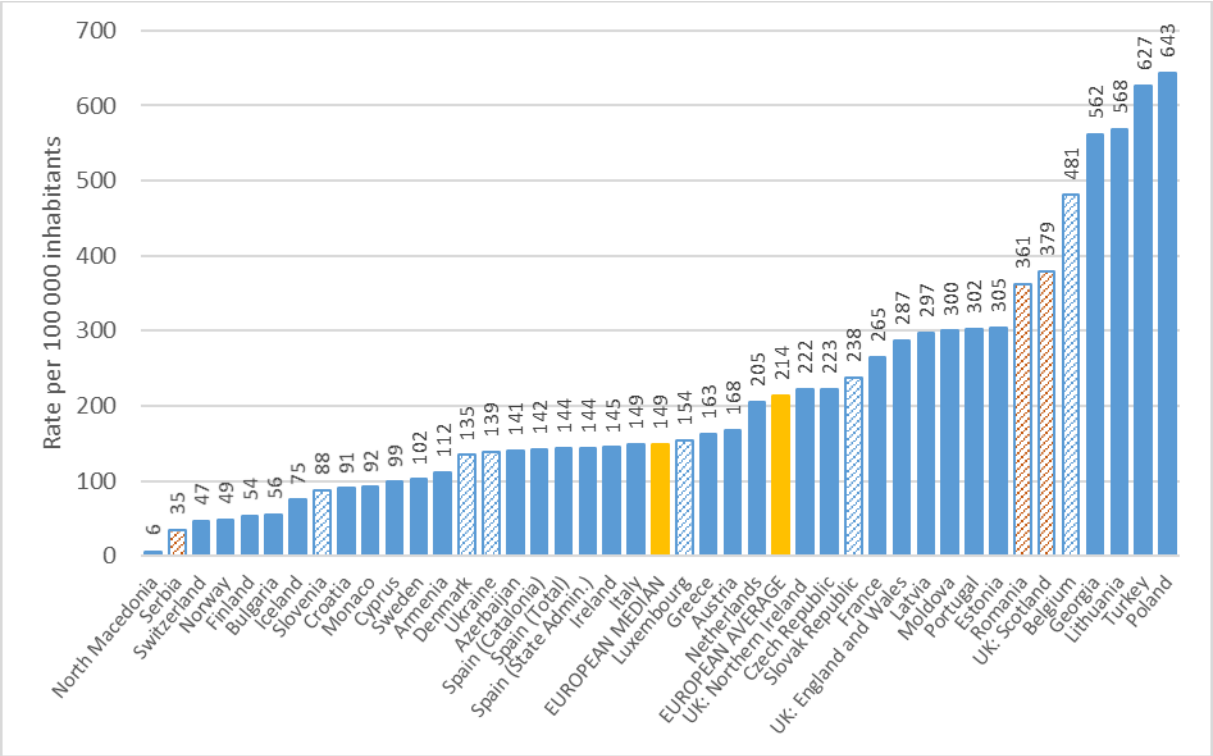
All the data presented in this section which describes the probation and prison population across Europe is based on the work of Aebi and his colleagues at the University of Lucerne (Aebi et al, 2021).

The population rate per 100,000 inhabitants of each country/jurisdiction is given in Figure 1 and 2 and it can be seen that there is wide variation.

The lowest rate of people per 100,000 who are serving a probation order is North Macedonia (where a new service is being established) the highest rate is 643/100,000 and this is found in Poland. The European median value is 149.

In terms of the rates in the prison population, we can find the highest rates in the Russian Federation, Turkey, Georgia, Lithuania and Azerbaijan, with more than 250 inmates per 100,000 inhabitants, and the lowest rates can be found in Germany, The Netherlands, Iceland and in the Scandinavian countries and some countries in the Balkan region.

Figure 1: Probation population rates (probationers per 100,000 inhabitants) on 31st January 2020 (N=40)[1]

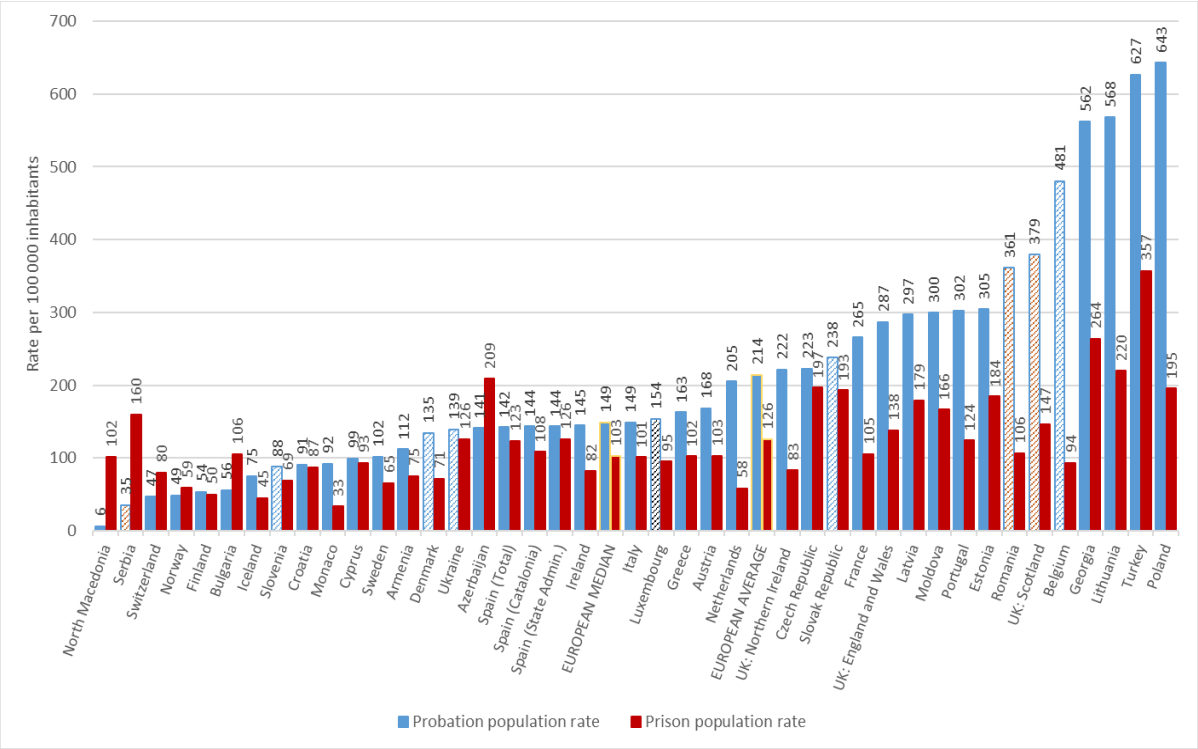


Note to Figure 1: Probation agencies not using the *person* as the counting unit of their statistics are presented in blue stripes, while those using it only *partially* are presented in orange stripes (Aebi et al, 2021)

In Figure 2 below the probation rates are presented alongside those same figures for prisons. One striking result of this comparison is that, in 34 out of the 40 prison services and probation agencies included in Figure 2, the probation population rate is higher than the prison population rate. The exceptions are (in order of magnitude) North Macedonia, Serbia, Switzerland, Norway, Bulgaria, and Azerbaijan, where the rates of inmates are higher than the rates of probationers per 100,000 inhabitants.

[1] The highest probation population rates are found in Lithuania, Turkey, and Poland, while the lowest are in North Macedonia, Serbia, and Switzerland. However, as noted earlier, comparisons across jurisdictions must be conducted carefully because the way in which data are collected varies. Data provided by the probation agencies that do not use the *person* as the counting unit for the total number of probationers are presented in a striped pattern. More specifically, Belgium, Denmark, the Slovak Republic, Slovenia and Ukraine reported that their counting unit is the *case* or the *file*. Luxembourg does not count *persons*, but did not specify its counting unit. Romania, Serbia and Scotland indicated that they partially count the *person*; however, they specified that they count the *case*, the *verdict*, or the *order* for the probation stock. These different counting units could explain the high probation population rates observed in Belgium and Scotland.

Figure 2: Probation and Prison population rates (per 100,000 inhabitants) on 31st January 2020 (Aebi et al, 2021)



The data presented so far make it possible to categorise countries/jurisdictions on the basis of their prison and probation populations (with caveats about the way the countries occasionally count their countries/jurisdictions differently). This typology is given in Table 1and has been extracted from the paper by Aebi et al (2021).

Table 1. Relationship between probation and prison population rates on 31st January 2020 (N=41, 8 categories)

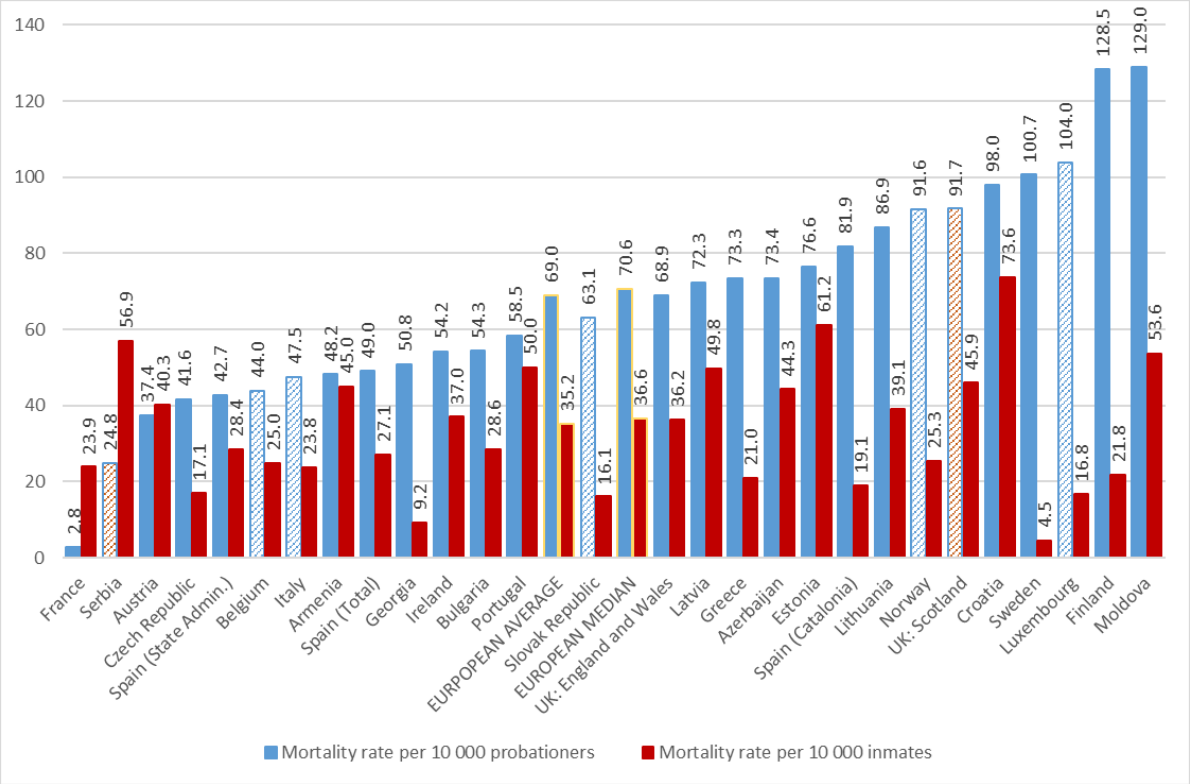
Jurisdiction	Probation population rate	Prison population rate
1. Jurisdictions with a low probation population rate (≤ 100 per 100,000 inhabitants) and a low prison population rate (≤ 100 per 100,000 inhabitants)		
Switzerland	46.8	80.2
Norway	48.8	58.8
Finland	53.5	49.9
Iceland	75.0	45.0
Slovenia	*87.8*	*69.1*
Croatia	90.6	87.1
Monaco	92.3	33.3
Cyprus	98.9	93.4

2. Jurisdictions with a low probation population rate (≤ 100 per 100,000 inhabitants) and a relatively high prison population rate (>100 to <200 per 100,000 inhabitants)		
North Macedonia	6.1	101.8
Serbia	*34.9*	*159.9*
Bulgaria	55.6	105.6
3. Jurisdictions with a relatively high probation population rate (>100 to <200 per 100,000 inhabitants) and a low prison population rate (≤ 100 per 100,000 inhabitants)		
Sweden	102.0	65.0
Armenia	112.2	75.0
Denmark	*134.6*	*71.1*
Ireland	144.9	81.6
Luxembourg	*153.6*	*94.9*
4. Jurisdictions with a relatively high probation population rate (>100 to <200 per 100,000 inhabitants) and a relatively high prison population rate (>100 to <200 per 100,000 inhabitants)		
Ukraine	*139.1*	*126.1*
Spain (Total)	142.3	123.3
Spain (Catalonia)	143.6	108.4
Spain (State Admin.)	143.8	126.2
Italy	149.0	101.2
Greece	163.0	102.4
Austria	168.1	103.2
5. Jurisdictions with a relatively high probation population rate (>100 to <200 per 100,000 inhabitants) and a high prison population rate (> 200 per 100,000 inhabitants)		
Azerbaijan	140.8	208.7
6. Jurisdictions with a high probation population rate (≥ 200 per 100,000 inhabitants) and a low prison population rate (≤100 per 100,000 inhabitants)		
Netherlands	204.9	58.5
UK: Northern Ireland	221.8	82.8
Belgium	*480.6*	*93.6*
7. Jurisdictions with a high probation population rate (≥ 200 per 100,000 inhabitants) and a relatively high prison population rate (>100 to <200 per 100,000 inhabitants)		
Czech Republic	222.6	196.8
Slovak Republic	*238.2*	*193.4*
France	265.5	105.3
UK: England and Wales	286.7	138.0

Latvia	297.4	179.0
Moldova	299.8	166.5
Portugal	302.3	124.3
Estonia	304.5	184.4
Romania	*361.4*	*106.5*
UK: Scotland	*379.1*	*146.6*
Poland	643.3	195.3
8. Jurisdictions with a high probation population rate (≥ 200 per 100,000 inhabitants) and a high prison population rate (≥ 200 per 100,000 inhabitants)		
Georgia	561.8	263.8
Lithuania	568.1	219.7
Turkey	626.7	357.2

Finally, given that suicide rates across probation and prisons are so high in comparison to the general population the data on 'all-cause' deaths in both settings is given below in Figure 4. Suicide thus only forms an element of these data.

Figure 4: Deaths of inmates per 10,000 inmates and deaths of probationers per 10,000 probationers during 2019 (N = 27)



Note to Figure 4: Probation agencies not using the *person* - or using it only *partially* - as the counting unit of their statistics are presented in stripes.

In seeking an explanation for the much higher mortality rates in probation, Aebi and his colleagues (2021) offer these explanations:

(a) the constraints of the prison environment reduce the risk of engaging in risky behaviour or suffering a fatal accident;

(b) inmates suffering terminal or serious illnesses are frequently released from prison and placed on probation; and

(c) suicide is more common while on probation than while in prison.

This certainly true of the UK (Philips et al, 2018) where the suicide rate in probation was 118 per 100,000, in prison was 83 per 100,000 and for the general population was 13.6 per 100,000. Thus, suicides in probation were nearly nine times more likely than the general population and in prisons there was a six-fold increase in risk.

3. Principles that should underpin mental health care in prisons and probation

There are a set of basic principles that should underpin mental health care both in probation and in prisons, there are list below:

Use of data on health needs and treatment outcomes to inform mental health service provision

a) Routine data collection

Both prisons and probation services should collect data routinely which focuses on the needs of mentally ill people being seen by either agency. We know from research that a particular problem can be the co-ordination of mental health care/treatment when people leave prison on a conditional discharge. We also know from research that many people in prison or serving a probation order have histories of serious childhood trauma. Trauma services are under-developed in most countries in the community but also in prisons. Promoting access to such services, on the back of routine data collection, would enable trauma services to be planned.

b) Information about suicidal thoughts/behaviour

Protocols and communication procedures should be adopted by all public and private organizations, including NGOs, police forces and courts, to share relevant information that already exists regarding the risk of suicide or previous attempts, so that the probationer or inmate can be flagged right from the beginning and be referred to the mental health care department or service, depending on the context. We all are aware that in the majority of cases, before a suicide attempt/behaviour, there were some sort of signs or symptoms that were present for a while before the incident, and if that information had been shared it is possible a suicide attempt might have been prevented.

Focus on continuous professional development and workforce planning.

In the recent survey (Brooker and Monteiro, 2021) there was significant variation in the skills that both custodial staff and probationers had acquired in relation to mental health. In some countries, such as the Republic of Ireland, a social work degree was required to become a probation officer. In such instances, one would expect there to be more skills in mental health. A knowledge is also required of the local mental health service provision and their pathways and referral criteria. Staff in prisons seemed are more likely than probation officers to have such training, however, whether or not, mental health awareness is enough to help, for example, a highly suicidal client to be managed, is maybe another matter. Very few services formally define the role of staff in relation to mental health, until this is agreed nationally, training cannot be designed.

Clearly defined partnerships that include the voice of service users

Prison and probation services and their interaction with healthcare can be a very complicated exercise. There are complex partnerships to form that include: social care, mental health services, healthcare within prisons, community services in general (such as access to a general practitioner). This can fall down easily at the prison gate when prisoners are released. Those that commission services clearly need to be involved in funding services and evaluating how effectively they work. Service users should also take a place at any discussion table.

At the ground level, local discussion on the ways in which national guidelines should be implemented, should be encouraged. Joint working groups, including multidisciplinary teams composed of prison and probation staff (prison officers, psychologist, case managers, social workers) health professionals (physicians, nurses, psychiatrists) and volunteers working in all sectors (prison, probation, mental health), should be created to share experiences and knowledge about their own context of work. The working groups should be encouraged to reflect and collect sufficient data and evidence in order to evaluate new approaches and innovative strategies. Regular debates and workshops should be organized in order to raise awareness and to inform the policy makers on how the situation is developing in their own countries and enable them to take actions to overcame the obstacles and to improve the practices. At a political/decision level, all relevant stakeholders should come to an agreement to declare as a priority the improvement of the level of service in the mental health area, Increasingly, in some countries there are calls to involve those with 'lived experience' in all areas of healthcare provision: recruiting staff, planning services, research and evaluation to name but a few. Although the survey did not ask any questions about the involvement of those with lived experience, we believe this is an important principle to pursue.

Continuous improvement through the use of accreditation and/or standards, quality indicators and health information systems.

There are many models for accrediting the standard of mental healthcare received by prisoners or probationers. National systems should be in place to allow all services to benchmark themselves against each other (see, for example, prisons-standards-4th-edition.pdf (rcpsych.ac.uk). As far as we aware no country/jurisdiction in Europe has a standards-based model for probation. This should be developed within each country.

The Council of Europe's own committee for the prevention of torture (CPT) has its own set of standards for psychiatric care in prisons (see sections 41-44 here: https://rm.coe.int/16806ce943. These standards could be used as the basis for a minimum set of minimum standards across Europe. Minimum standards could be routinely assessed/audited where explicit indicators are assessed on a regular basis. The level of service and the quality of care must be assured by all probation and prison services with standards equivalent to those provided for the public in general.

Investment in research and evaluation in order to align funding with care that is both evidence-based and accessible.

As will be shown in the next section there is little hard evidence of useful interventions for those with mental health problems in prison or serving a probation order. Thus, it is crucial that interventions continue to be evaluated and researched to a high standard. We are well aware of the problems attached to this simple statement (see for example, Sirdifield and Denney, 2022, in press). Even allocation of any research funding for mental health in the criminal justice system can be problematic. It would be extremely useful to consider a Europe-wide prison/probation research network and a long-term funding provision. One key weakness of the research in this field is the lack of large multi-centre randomised controlled trials. A new network for such activity would be a serious improvement and will ensure independence, continuity and quality of data collection. This will allow health and justice departments to develop evidence-based policies in this area.

4. A mini-review of the effectiveness literature - where interventions have been shown to lead to mental health gain in probation and prisons

Probation

In the last two years there has been the production of three systematic reviews in areas of mental health concern in probation: namely, mental health (Brooker et al, 2020); suicide (Sirdifield et al, 2020) and substance use (Sirdifield et al, 2021).

Mental Health - In this systematic review the methodology is briefly outlined and the results considered in more detail. The major conclusion is that effective mental health interventions in probation have rarely been described. Just four studies that met inclusion criteria were elicited that examined: the offender personality disorder pathway in England; the mental health of residents in approved premises and their use of mental health services; the impact of mental health courts on participants' use of mental health services. Other useful research was identified that did not meet the criteria for effectiveness but nonetheless was useful, for example, studies that tried to understand why the take-up of mental health treatment orders in England was so low. The results of the review are discussed and it is concluded that effectiveness research is hard to undertake in probation but efforts must continue.

Suicide - Prevention of suicide is a priority area within the policies of most countries/jurisdictions. Here we review what the research evidence tells us about the rates of suicide amongst people under probation supervision in comparison to the general population. Drawing on evidence from a recent systematic review, we then consider what is

known about risk factors associated with suicide, including probation-related factors; how probation can offer an important opportunity for intervention, and what is known about approaches to reducing suicide amongst people under probation supervision. In particular, this chapter demonstrates the dearth of probation-specific evidence-based studies in this area, and offers some insight into how the current gaps in the literature could be addressed in the future.

Substance Use - This narrative systematic review of the literature on substance misuse and community supervision. It includes an overview of what is known about the prevalence of substance misuse needs of people under probation supervision, and the effectiveness of different approaches to substance misuse treatment in terms of engagement with treatment, retention in treatment, and impact on health outcomes.

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A systematic review of the outcomes of 37 studies published between 1979 and 2015 from 7 different countries (China, India, Iran, Norway, Spain, US, and U.K.) on "Psychological Therapies for Prisoners with Mental Health Problems", conducted by Senna Fazel (2017), suggests that the Cognitive-Behavioral Therapies (CBT) and mindfulness-based therapies are modestly effective in prisoners in treating depression and anxiety symptoms. Furthermore that there is no clear difference between group and individual-based treatments.

In fact, this review suggests that CBT and mindfulness-based therapies have shown moderate evidence that there are improvements in dimensions as depression and anxiety symptoms in prisoners where no preexisting treatments were taken, with mindfulness-based therapies possibly demonstrating higher effect sizes, as well as trauma-based therapies demonstrated limited evidence of effect on trauma symptomology.

In conclusion, the authors found that psychological therapies for mental health have moderated effective outcomes in prisoners and suggest the investment and development of this type of intervention inside prisons.

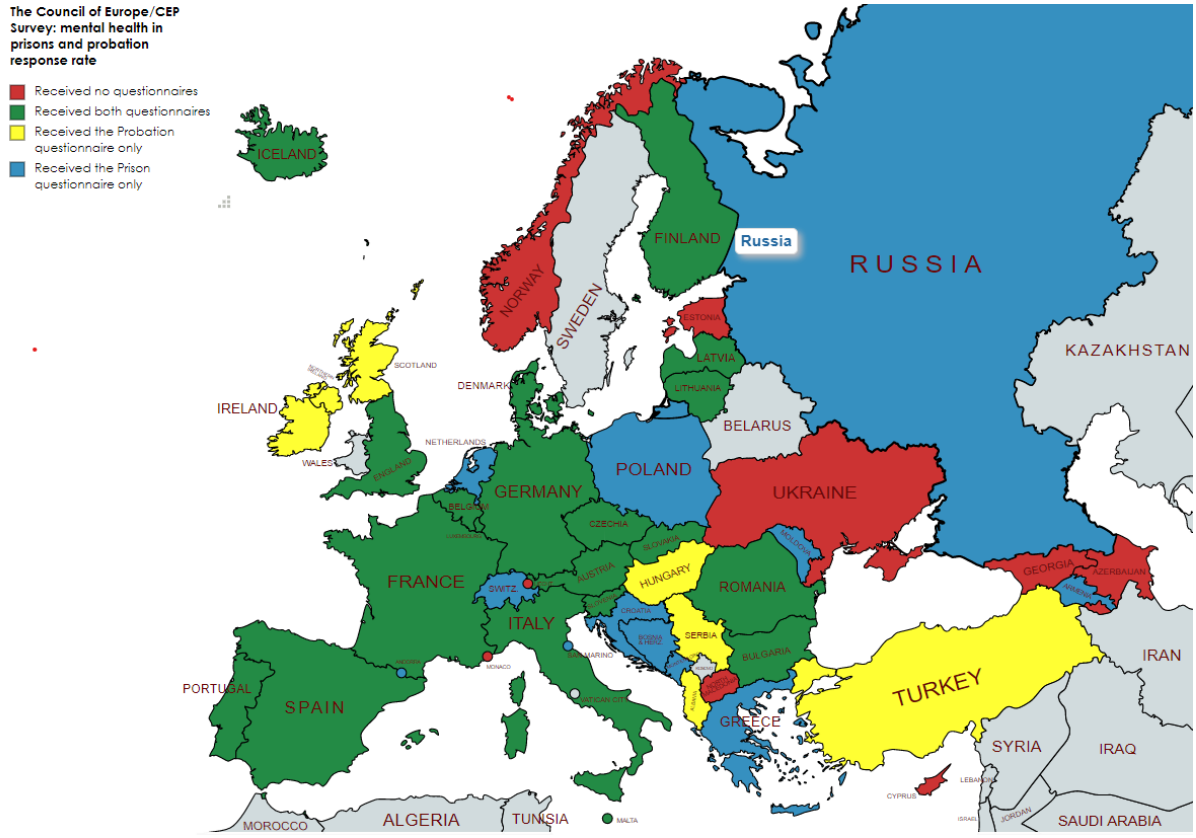
In summary there are very few interventions that have been examined that are likely to provide an improvement in health outcomes. There are many reasons for the lack of evidence but they include: the challenges that exist in relation to obtaining mental health research funding in probation and prisons and the methodological issues that arise when conducting randomised controlled trials in criminal justice settings. In contrast there is much research on the prevalence of mental health disorders in prison but little meaningful research on prevalence in probation.

5. Summary of the Council of Europe survey

The whole survey undertaken earlier in 2021 will not be presented here for those that would like to see the entire survey please access it here: Prisons and probation: Council of Europe/CEP Mental Health Project (coe.int). The aim of this summary to highlight the issues that should be taken forward by the Council of Europe as a result of this white paper.

First it should be stated that responses to both the prison and probation surveys were good. It might be of interest to see the map of response overleaf.

Figure 1: Map of Response to the prison and probation questionnaires.



First, there was national policy for probation and mental health in just over half of the countries/jurisdictions (53%). This contrasted sharply with prisons where policy existed in nearly all countries/jurisdictions (93%). Clearly for probation, this is a action that needs to take place at a national level. A similar disparity was seen in relation to mental health awareness training with 74% of prison staff receiving training and half this, 37% of probation staff, that is 25 countries/jurisdictions do not ensure that probation staff are trained in mental health.

Estimates of the prevalence of mental health disorders and probation varied significantly in prisons the estimates ranged from 0-80% (median=18%) whilst in probation the estimates ranged form 2-90% (median 15%). It is worth reiterating that all respondents were given the same definition to use in their answer ss follows from the World Health Organisation:

'According to the World Health Organization, mental disorders are : depression, bipolar affective disorder, schizophrenia and other psychosis, dementia and developmental disorders, including autism'[2]

[2] Please note that we have adhered to this definition throughout the paper so we have not discussed the complexity of mental health disorder (such as a dual diagnosis). Neither have we addressed the issue of personality disorder.

Only four countries/states collected prevalence data routinely in probation and these were Northern Ireland, Catalonia, Berlin and Brandenburg.

In prison most clients were screened at intake/assessment. Screening in probation took place mostly at the Court stage and when leaving prison. In prison this was likely to occur at admission/intake and when leaving prison. The tools that are used are various. Two probation services that have in-house forensic mental health teams, Malta and N Ireland use: the BDI (Beck depression Inventory); the STAX (used to assess personality disorder); the GAD (Generalised anxiety and depression scale) and the PDE (the personality disorder examination. Other assessment tools used by other services include: the Hare Psychopathy Checklist (Bulgaria); the CAGE (Spain) in Iceland the mini-mental state is employed. Prisons tend to use data bases to record diagnoses that are made. So, for example, in Austria, the Integrated Execution Management System is used (IEXS). The person screening is usually the GP in both prisons and probation although the psychologists in the Forensic mental health services (Malta and N. Ireland) undertake the screening.

One-third of probation services have mental health treatment orders in probation countries where this occurs are: Catalonia, England, France, Berlin (G), Mecklenburg-Vorpommern (G), Northern Ireland, Schleswig-Holstein (G), Scotland and Turkey. Whereas, 70% of prisons have special orders or requirements for the treatment of mental health disorders within prisons and these include:

Armenia, Austria, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Greece, Italy, Lithuania, Latvia, Luxemburg, Malta, The Netherlands, Poland, Portugal, Romania, Russian Federation, Slovak Republic, Slovenia, Spain, Catalonia, Sweden. There is a large discrepancy in the monitoring of suicide depending on whether you are in a prison or serving a community order. Monitoring occurs in most prisons (90%) but very few probation services (13%).

We looked at gender issues in the survey as it is known that women constitute by far the smallest element of prison and probation populations. Nearly half (47%) of all prison returns stated that they had gender-sensitive approaches in place. The figure for probation was much smaller at approximately one-quarter (24%) of all probation services. Three probation services described their approach as trauma-informed (England, Scotland and Northern Ireland). In France research is being undertaken by SPCS, a team in Lille, one aspect of which focuses on women leaving detention. Other aspects of good practice will be elaborated upon in the next section.

6. Good practice in Europe

Probation

Some examples of good practice were given in the survey by the respondents who were mostly the Chief executives of national probation and prison services. The examples for probation are given in Table 2 below:

Table 2: Examples of good mental health practice in probation by country

Country	Example of Good Practice
Austria	The use of a not-for-profit company called Neustart. This uses a case management model including counselling across Austria
Belgium	VLOGG is a multidisciplinary platform for mental health has guidelines for probation and mental health. There is also a framework for forensic mental health care which describes standards.
Czech Republic	Has developed a manual for working with dependent people.
Baden-Wurttemberg (G)	Use probation trained mental health specialists in their nine centres for probation
Lower Saxony	Developed standards for mental health in probation
Iceland	Employs a mental health multidisciplinary team in prisons which will develop to include probationers.
Italy	There is the equivalent of a mental health treatment order monitored by probation and the Regional Mental Health Depts.
Malta	Employs psychologists from probation resources to provide advice support and intervention
Northern Ireland	Also employs psychologists from probation resources to provide advice support and intervention.
Portugal	Monitor the involvement of community mental health services with probation (Report available). New referral procedures are being developed as there have been some problems. These criteria would be useful.
Romania	Guidelines in the probation counsellor manual. Mental health treatment orders can be imposed by the court.
Spain	The Extended Bridge Programme which aims to connect clients with a mental health disorder to community mental health services.
Turkey	Scope for individual plans and programmes for those in probation identified with mental health disorders

England	The CSTR project working to improve uptake of mental health treatment orders made by courts. Liaison and Diversion services working in the courts means some might be diverted away from the CJ system altogether. RECONNECT and Enhanced RECONNECT are care-after-custody services. Seek to promote engagement with community mental health services. OPD Pathway is a connected pathway of services for people who are likely to be diagnosed with a personality disorder.
Scotland	Mandated court orders for mental health treatment

The examples of good practice for prisons are given in Table 3 below.

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Table 3: Examples of good mental health practice in prisons by country

Country	**Example of Good Practice**
Austria	There are different regulations and procedure specifically developed for inmates with mental disorders, intended to "improve the conditions of the detainees" and to assure a specific treatment and approach, including special unis and infrastructures.
Belgium	Besides several specific Laws and Orders, there is a "Collective Letters" approach that defines which prison establishments have "psychiatric departments". A Ministerial circular regulates the constitution of "multidisciplinary teams" that provides care in those psychiatric detention centres.
Bulgaria	Preparation of an "Action-Plan 2020-2030) to develop a "Mental Health" strategy.
Croatia	Implementation of the "Ombudsman's" recommendations in all prisons since 2018 with the purpose of protecting prisons with Mental Health problems or disabilities.

Denmark	Developed e-learning modules on how to deal with detainees with signs of Metal Disorders prisoners
Finland	Development since 2016 of polices and rules of good clinical practices, also available in the intranet of the prison system.
France	In 2019 the Ministry of Health and the Ministry of Justice signed an agreement for the development of studies and research of the mental health status of all prisoners during 2019-2022
Iceland	Establishment in 2020 of an interdisciplinary team for the prison system to provide, among other tasks, general and specialized mental health services in prisons, working independently but alongside and in close collaboration with other agencies.
Italy	In 2019 the "National Committee on Bioethics issued a paper on "Mental Health and Psychiatric Assistance in Prison", containing general guidelines on Mental health in prisons.
Luxemburg	Prisoners with mental disorders are under the supervision of the Prison Psychiatric Department, which consists exclusively of staff from Luxemburg´s neuropsychiatric hospital.
Montenegro	Developed and published in January 2020 a "Mandatory Mental Health Care Act" that regulates the rights of those who have to serve compulsory care in mental institutions.
Portugal	Recently (2019) a decree-law that foresees the improvement of quality of services provided for inmates who were considered non-responsible for their action due to a mental disorder, and that regulates and defines procedures and methods of assessment and treatment to all inmates in these conditions, independently if they are under a security measure inside a prison facility or in a psychiatric hospital.
Romania	Recently implemented their responsibilities foreseen in the "National Strategy for the Child and Teenager´s mental Health 2016-2020, including a "Crisis response Guide" for staff working with this target group which was developed in collaboration with the academy.

Russian Federation	Specific laws that approve the organization of provisional care for prisoners with psychiatric diseases.
Slovack Republic	Established an advisory board ("Mental Health Council") that coordinates and cooperates in creating the tasks of the National Plan for Mental Health.
Spain / Catalonia	Ministries of health and Justices are carrying out a number of actions aimed to improve the quality of the treatment that is provided to patients that are inside prison or in psychiatric hospitals
Switzerland	The "Swiss Centre of Expertise in Prison and Probation is currently developing a handbook on psychiatric care in detention, containing recommendations for professionals who deal with inmates with mental health disorders.

There are significant areas of good practice that exist or are being developed within most European countries/jurisdictions. In probation there are two interesting models described within the probation service itself where forensic psychologists are employed to address the needs of clients with a mental health disorder. Other countries are attempting to address the issues with mental health in the transition from prison to probation (England and Spain). Others are in the midst of strategy development such as Bulgaria. In German states there are also some useful initiatives, for example, in Baden-Wurttemberg, probation officers are trained to be mental health specialists and provide input to the nine probation offices. Also, Lower Saxony have developed standards for mental health in probation. Currently, these are only in German, but as a result of this project, they are currently being translated in English. It will be very interesting to see these standards when translated as obviously they might have wider applicability.

In prisons the same scenario is observed with an optimistic feeling for the future implementation of good practices in prison context, when dealing with mentally disorder inmates. It´s not only a matter of building new prisons with better physical conditions, which of course is a good sign of the investment and importance that each country is paying to the living conditions of those who are deprived of liberty deserve, but above all is the level of attention and priorities that has been growing in the European context, and that the questionnaire brought to our attention and highlighted.

Law orders, provisional procedures, internal guidelines and other written orientations are becoming standards in the majority of the European jurisdictions, as is the case in Austria, Belgium, Germany, Finland, Italy, Montenegro, Portugal, Romania, Russia Federation, Spain and Switzerland, among others.

The existence of these approved written guidelines can be the beginning of the mentioned above desired "National Minimum Standards for the Treatment of inmates with Mental Disorders". Other good practices seem to be the association of the prison authorities with the

academic experts, stablishing partnerships in terms of assessment, evaluation and research about the mental health conditions of the inmates, as is the case in France, Italy and Switzerland, among others, which gives a more credible and scientific results of the evaluation, and provides the prison administration with stronger arguments to call for more investment and improvement of conditions, not only for these inmates, but for the generality of those who are incarcerated.

Finally, it´s also a trend that inspires us on a better future in terms of the level of care provided to the offenders with mental disorders is the fact that the notion of a shared responsibility between the justice and the health ministries on the shared responsibility of treat, rehabilitate and reintegrate these offenders, each of them contributing with their knowledge and experts in the respective field, in a complementary and collaborating platform of multidisciplinary work, contributing this way to a better and safer society for all citizens.

7. Recommendations

Probation

- There should be a national strategy for mental health and probation as part of a larger mental health strategy for the criminal justice system as a whole

- The strategy should commission work on agreeing standards for mental health within the probation service in order to benchmark all services in that country/jurisdiction

- The strategy should operationalise the probation officer's role in the recognition and assessment of mental health disorders and in providing interventions and/or facilitating access to mental health care

- It is likely that once the probation officer's role is understood and clearly articulated that training might be required.

- The strategy should address methods for collecting data on mental health disorders within the probation service and the extent to which people experiencing mental health problems are engaged with services. It might be that formal outcome measures should be employed as part of assessment.

- The plan should also examine how best to collect monitoring data on suicide by probationers. The data should be collected routinely over a period of time (years) so that trends might be examined.

- The strategy should be explicit about how continuity of care/treatment for mental health disorders can be achieved on transfer from prison to probation.

- The involvement of experts by 'lived experience' should be considered in all initiatives

- National research funding should be made available to evaluate the implementation of strategy and its impact on health and re-offending outcomes.

- There should be a network of mental health researchers working in probation settings

- Every probation service should understand the pathways and access criteria for all local mental health services.

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- Across Europe there should be agreement about minimum standards of prison mental health care even though most countries/jurisdictions have national strategies for prison mental health.

- All prison administration should ensure adequate treatment and care for the health of all inmates, and to mitigate the effects of imprisonment on mental health of inmates.

- As entry into prison can be a traumatic experience, prison administration should develop practical written procedures to detect early signs of mental illness or distress, as well as collecting suicide profiles that can be used to target high-risk groups and situations.

- A well-organized procedure should be in place in all prison establishments to help inmates to have access to relevant information on what, who and how they can get help if needed, especially in the first period of incarceration, reinforcing the information regarding all important topics of life inside prison (health department, schedule for visitation, telephone calls).

- Conducting initial and ongoing comprehensive assessments to identify the varied and changing needs of mentally disordered prisoners should be put in place in all jurisdictions, to prevent and early detect signs and symptoms of mental illness.

- The development and implementation of integrated and tailored approaches for early referral, assessment, diagnosis, and treatment of inmates with mental disorders, including (assessment instruments and treatment programmes should be in place in all jurisdictions, preferably with written guidelines and procedures that must be followed at the early-stage admission/intake.

- The standardisation of the use of assessment and referral instruments across the prison system must be a priority to all prison administration.

- The development of a "unique" mental health recording system integrating different instruments (screening, assessments), diagnostic results and treatment logs, should be designed and developed, in collaboration with scientific experts, and their results should inform the decision makers about the trends and actions needed to be taken, at a national level.

- Prison staff should be trained with different levels of knowledge and techniques of intervention, at a minimum, initial suicide prevention training should include, but not be limited to, the following: why correctional environments are conducive to suicidal

behavior, staff attitudes about suicide, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, recent suicides and/or serious suicide attempts within the facility/agency, and components of the facility/agency's suicide prevention policy.3

- All staff should receive initial suicide prevention training, followed by refresher training every year.

- Basic mental health awareness training should be regularly provided to all prison staff, specifically oriented to the detection of early signs and symptoms of mental disorders and/or suicidal ideation or risk of suicide and how to recognize and deal with mental disorders, as well as to be aware of emotional distress and crisis, and should also include examples of lived experiences from the past and teach the "dos and don´ts" of each example.

- Prisons should promote the contact between inmates and their family and friends, since they play an important role on inmate´s mental health conditions.

- Inmates should be provided with meaningful activities to make the best use of their time and reduce the negative impact of imprisonment on their mental health, especially cognitive therapies, and specific ergo therapeutical activities should be available by all prison wings/sectors with inmates with mental illness.

- Member states should consider allocating inmates with severe mental disorders, especially those who were considered by court not responsible for their action, in appropriated units, preferably outside the prison walls and integrated in the health care system or social security departments.

- Planning prison infrastructure to respond to the increasing needs of vulnerable groups should include, whenever possible, specific units adapted to host inmates with mental disorders, and they should have in place in a regular basis specific programme for treatment, rehabilitation and to reduce risk factors of recidivism, especially in self-harm behaviours and suicide attempts.

- Joint development of work between the penitentiary prison hospitals and local hospitals or other external mental ill treatment institutions in essential in order to promote the necessary collaboration and co-responsibility in the preparation of release of inmates with mental disorders.

- Referral of ill inmates to external local or regional mental health care organisations that can provide treatment after incarceration or during community probation measures should follow written protocols and partnership agreements should be signed between local institutions.

8. References (to be added)

[3] WHO, 2007