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Prisons and probation: a Council of Europe White Paper regarding the management of persons with mental health disorders

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1.Background

The Council for Penological Co-operation (PC-CP), in accordance with its terms of reference for 2020-2021 (Doc. CM (2019) 131-addrev2), examined, in the course of 8 meetings in 2021 and 2022, the management of persons with mental health disorders[1] by the prison and probation services, the challenges which might be faced by prison and probation staff in relation to this and what possible solutions and standards might need to be developed at European level. The result is the White Paper outlined below.

The elected members of the PC CP Working Group who took part in this work were Martina BARIĆ (Croatia) (in 2021); Annie DEVOS (Belgium); Anna FERRARI (Italy) (in 2021); Robert FRIŠKOVEC (Slovenia) (in 2021); Vivian GEIRAN (Ireland); Manfred KOST (Germany); Dominik LEHNER (Switzerland) (in 2022); Maria LINDSTRÖM (Sweden); Laura NEGREDO LÓPEZ (Spain); Nadya RADKOVSKA (Bulgaria); Paulina TALLROTH (Finland) (in 2022) and Jorge MONTEIRO (Portugal) (in 2022 as PC-CP member and in 2021 as scientific expert). The PC CP was assisted by two Scientific Experts: Prof Charlie Brooker, Royal Holloway, University of London (United Kingdom) and Jorge Monteiro, Head of Service, Directorate General of Reintegration and Prison Services (Portugal) (in 2021 and in 2022 as PC-CP elected member).

In the meetings representatives of the Confederation of European Probation (CEP), of the European Organisation of Prison and Correctional Services (EuroPris) and of the International Corrections and Prisons Association (ICPA) (in 2022) also took part, alongside Kresimir Kamber from the Registry of the European Court of Human Rights and Hugh Chetwynd from the Committee for the Prevention of Torture Secretariat (CPT).

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 working with such persons.

A questionnaire was sent to the prison and probation services of the Council of Europe member States to take stock of the situation and to inform the setting of key principles and recommendations (to be found at the end of the document, which are addressed, in the first place, to the prison and probation services but also to other stakeholders in the criminal justice system such as the police, magistrates and juvenile justice agencies).

This White Paper is aimed at encouraging the authorities of the Council of Europe member States to pay greater attention to the significant number of persons with mental health disorders who are managed by the prison and probation services. It also hopes to initiate a debate within their jurisdictions regarding how to address this issue inside and outside their

[1] In the survey questionnaire mental health disorders were defined, using the WHO definition, as including 'depression, bipolar disorder, schizophrenia and other psychoses, dementia, and developmental disorders including autism."

penal system and to undertake reforms as necessary. Such reforms should be based on the priorities defined over shorter or longer timespans. In doing so the national authorities should also keep under review the extent to which the criminal justice system and in particular the deprivation of liberty are the appropriate manner of tackling crime committed by persons with mental health disorders.

The White Paper should prepare the ground for a Committee of Ministers Recommendation containing Guidelines which should assist the national authorities of the Council of Europe member States in implementing a number of key principles and standards by the prison and probation services when working with persons with mental health disorders.

2. Introduction

All persons, whether sentenced or not, who might be managed by prison and/or probation services are covered by this White Paper.

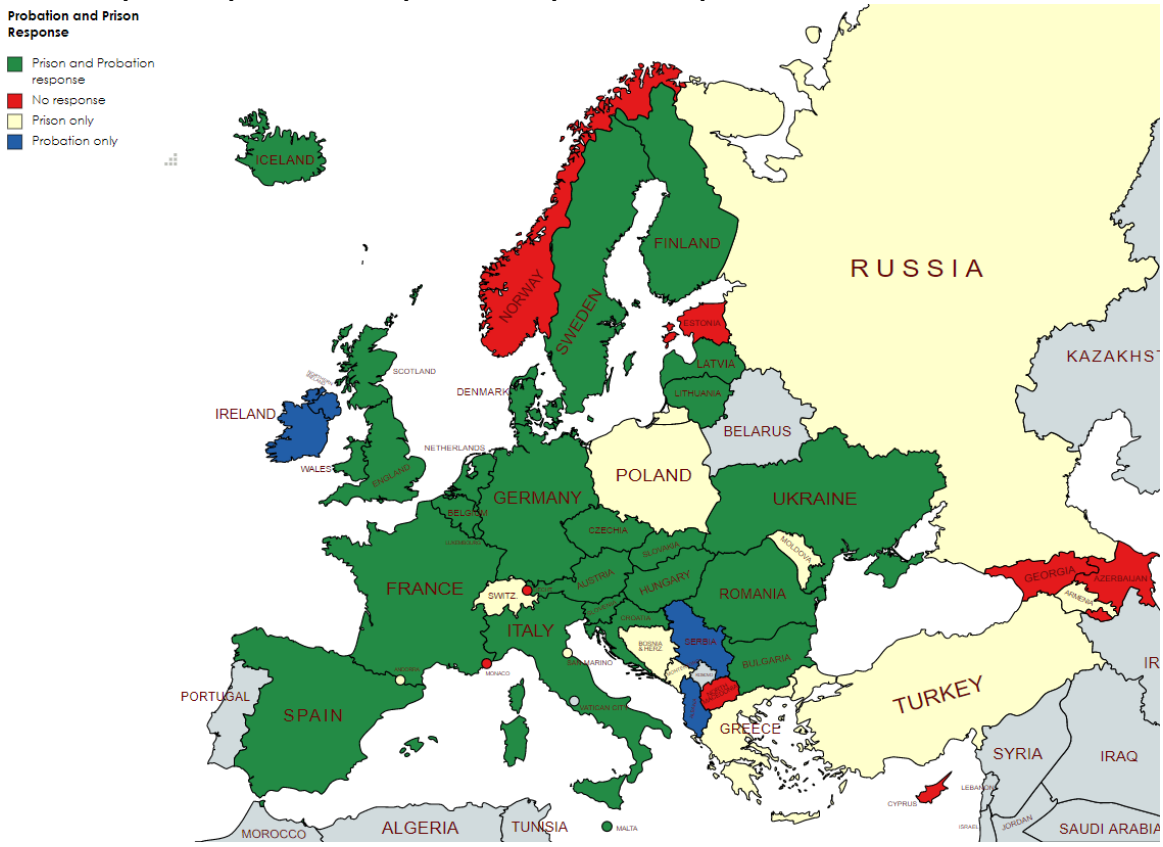
The current baseline for prison and probation services was established in the survey undertaken in 2021. Below is the map of responses. [2]

The complete 2021 survey will not be presented here. For those that would like to consult the entire survey please access it here: Prisons and probation: Council of Europe/CEP Mental Health Project (coe.int) or in Annex 2 of this report. The aim of this summary is to highlight the issues that should be taken forward by the Council of Europe.

In Appendix 3 good practice in prisons and probation are described in detail. These examples were again identified in the survey.

[2] The data was collected in 2021 when the Russian Federation was still Council of member States. It was expelled from the Council of Europe on 16 March 2022.

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



3. Mental healthcare in prisons and probation

a) The current picture

From the survey it appears that there is national policy for probation and mental health in just over half of the countries/jurisdictions (53%). This contrasted sharply with prisons where policy exists in nearly all countries/jurisdictions (93%). Clearly for probation, this is 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 some sort of training compared to only 37% of probation staff, that is in 25 countries/jurisdictions probation staff are not provided with any training on mental health issues.

Estimates of the prevalence of mental health disorders varied significantly in prisons ranging from 0-80% (median=18%) whilst in probation they ranged from 2%-90% (median 15%). It is worth reiterating that all respondents were given the same WHO definition to use in their answers:

'According to the World Health Organization, mental disorders are: depression, bipolar affective disorder, schizophrenia and other psychosis, dementia and developmental disorders, including autism'[3]

[3] 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 jurisdictions collected prevalence data routinely in probation and these were: Northern Ireland (UK), Catalonia (Spain) and the States of Berlin and Brandenburg (Germany).

In prison most inmates were screened at intake/admission and when leaving prison. Screening in probation took place mostly at the court stage and before leaving prison (for probation services which deal with released prisoners). The tools that are used are various. Two probation services that have in-house forensic mental health teams, Malta and Northern 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 medical 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 to implement mental health treatment orders decided by the courts. The jurisdictions where this occurs are: Catalonia (Spain); England (UK), France; Berlin, Mecklenburg-Vorpommern and Schleswig-Holstein (Germany); Northern Ireland (UK); Scotland (UK) and Türkiye. 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, Slovak Republic, Slovenia, Spain (including Catalonia) and Sweden.

There is a large discrepancy in the existence of suicide prevention measure depending on whether a person is in prison or is serving a community order. Some sort of suicide prevention measure exists in most prisons (90%) whereas only very few probation services (13%) have specific measures in place.[4]

In the survey were also highlighted the gender issues in the survey as it is known that women constitute by far the smallest element of prison and probation populations approximately 10%.[5] Nearly half (47%) of all prison related responses 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 (UK: 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.

[4] In one study, Bertolote and Fleischmann (2002) estimated that 90% of all suicides had a diagnosable mental health disorder, most commonly depression, psychosis and substance misuse (depression combined with alcohol misuse is the most common diagnoses of all).

[5] Whether prisons can be a therapeutic environment, in particular: See OSF Preprints | Trauma-Informed Care In Women's Prisons: A co-produced rapid literature review

b) Why are mental health disorders disproportionately represented in probation and in prisons?

There are a wide range of intersecting factors that explain the over-representation of people with a mental health disorder in the criminal justice system. A good description of these factors is set out in a recent publication from the Centre for Addiction and Mental Health (2020) in Canada:

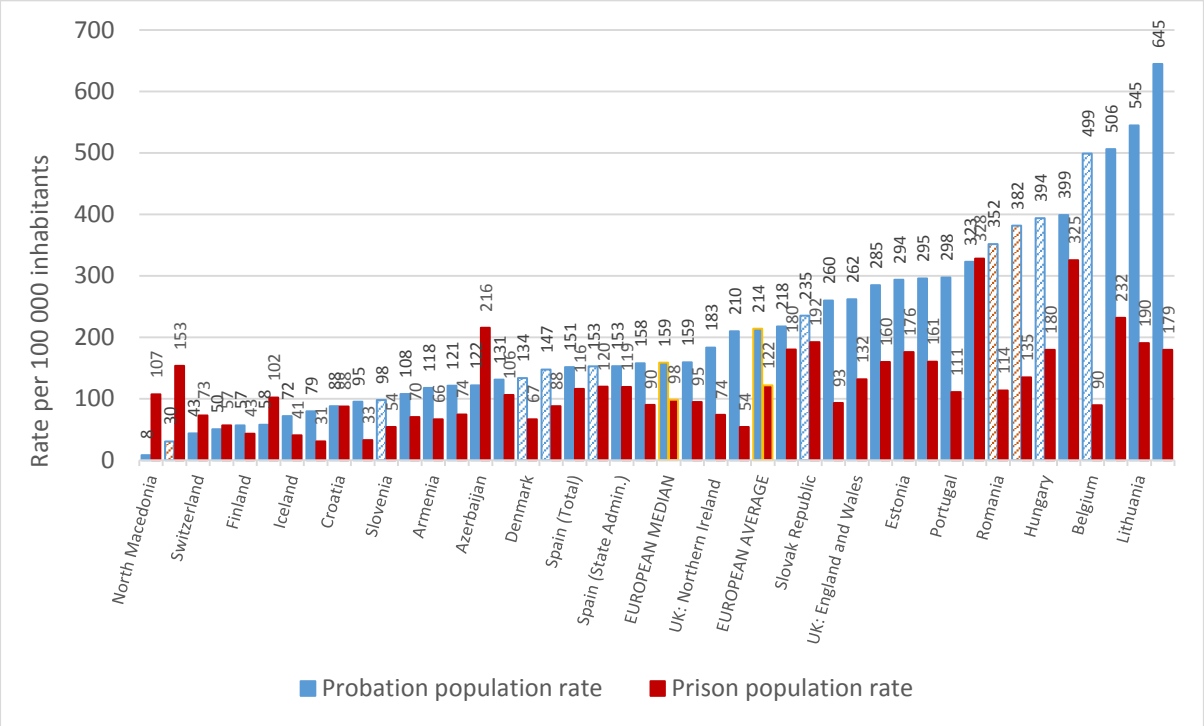
The reasons why people with mental illness end up in the criminal justice system are numerous and interconnected. Societal factors such as stigma, structural poverty, racism (particularly anti-Black and anti-Indigenous racism), inadequate housing and trauma can increase risk, as can co-occurring mental health and substance use problems. Policing and criminal justice policy can also increase criminal justice involvement. As well, there are instances when mental illnesses result in behaviours that lead to a criminal justice response. The overrepresentation of people with mental illness in the criminal justice system is often referred to as the "criminalization" of mental illness. (page 5)

It is also argued that mental health services are failing the criminal justice system. For example, in England (UK) there have been significant decreases in the availability of acute mental health beds and a reduction in community mental health spend (Criminal Justice Joint Inspection, 2021). The WHO and IRC describe the use of prisons as 'dumping grounds' for people with a serious mental health disorder who cannot obtain an acute bed (WHO/IRC Information Sheet, Mental Health and Prisons, 2005). The WHO describes the deleterious impact of prisons on mental health status itself.

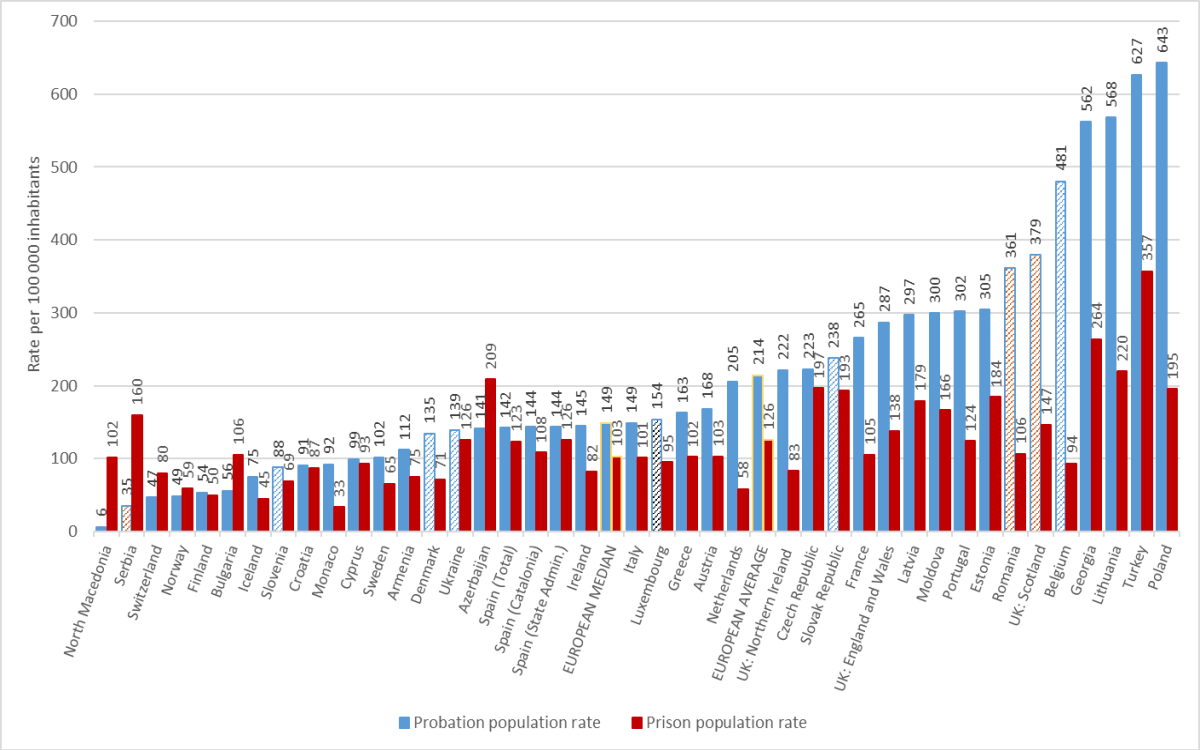
c) Mapping Prison and probation services: The SPACE data

In Figure 2 below the probation rates are presented alongside those same figures for prisons. One result of this comparison is that, in 34 out of the 40 prison services and probation agencies included in Figure 2, the probation per head of 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.

Figure 2: Probation and Prison population rates (per 100,000 inhabitants) on 31st January 2021 (N=41) (Aebi et al, 2021)



Note to Figure 2: 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.

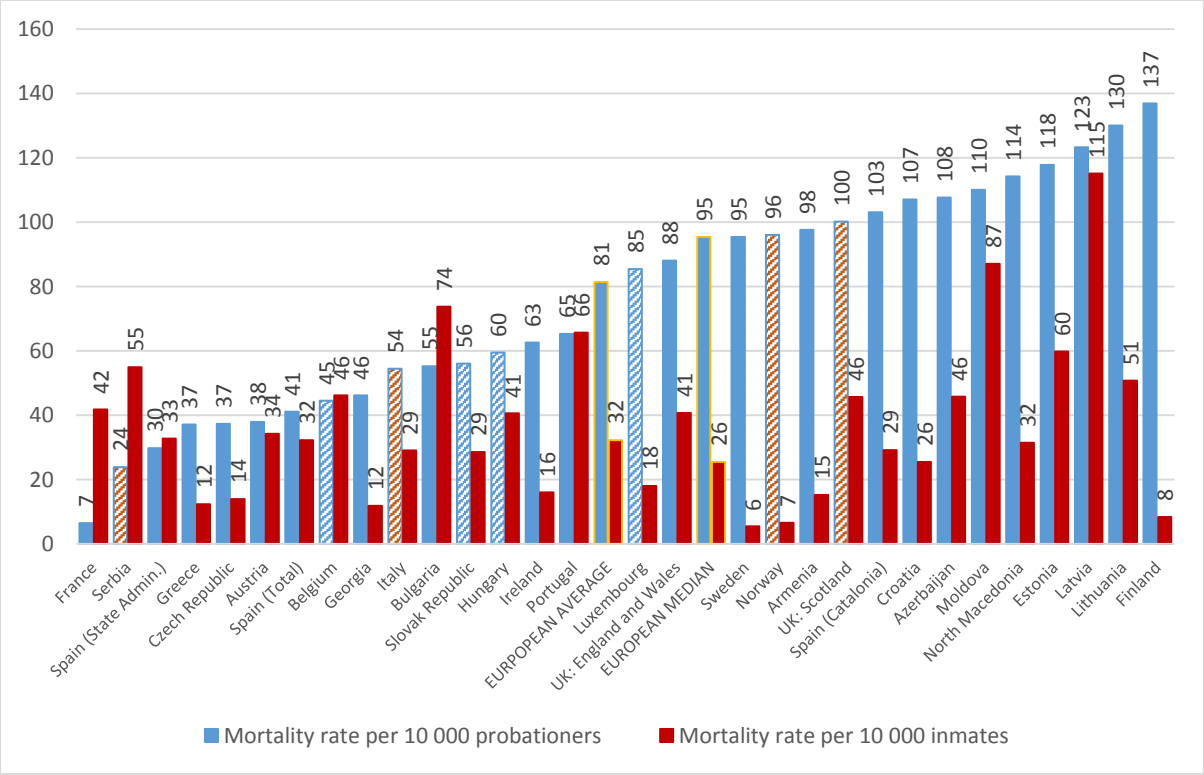


The data presented so far make it possible to categorise countries/jurisdictions on the basis of their prison and probation populations (with caveats about the way countries/jurisdictions

occasionally count differently). This typology is given in Table 1 and has been extracted from the paper by Aebi et al (2021).

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 3. Suicide thus only forms an element of these data.

Figure 3: Deaths of inmates per 10,000 inmates and deaths of probationers per 10,000 probationers during 2020 (N = 29)



Note to Figure 3: 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.

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

4. World Health Organisation (WHO)[6]

WHO underlines that mental health disorders occur at disproportionately high rate in prisons due to several factors: the widespread misconception that all people with mental disorders are a danger to the public; the general intolerance of many societies to difficult or disturbing behaviour; the failure to promote treatment, care and rehabilitation, and, above all, the lack of, or poor access to, mental health services in many countries. WHO further underlines that many of these disorders may be present before admission to prison, may be further exacerbated by the stress of imprisonment but may also develop during imprisonment itself.

The conclusions:

a. **Prisons are bad for mental health:** contributing factors to this are overcrowding, various forms of violence, enforced solitude or conversely, lack of privacy, lack of meaningful activity, isolation from social networks, insecurity about future prospects (work, relationships, etc), and inadequate health services, especially mental health services.
b. **Prisons are often used as dumping grounds for people with mental disorders**
c. **People with mental disorders are exposed to stigma and discrimination in prisons**
d. **Effective treatment is possible but too often the available resources are wasted.** The building of separate psychiatric prison hospitals in particular is not cost-effective, because they are very expensive to run, have a limited capacity and are associated with low release rates and also many of these hospitals operate outside of the health departments responsible for controlling the quality of health interventions which may lead to human rights violations.

Steps to be taken:

a. ***Detection, prevention and proper treatment of mental disorders***, together with the promotion of good mental health as part both of the public health goals within prison, and central to good prison management.
b. ***Diversion of persons with mental disorders to the mental health system at all stages of the criminal proceedings (arrest, prosecution, trial, imprisonment)***. The imprisonment of people with mental disorders due to lack of public mental health service alternatives should be strictly prohibited by law.
c. ***Provision of access to appropriate mental health assessment, treatment and care for all prisoners.***
d. ***Provision of access to acute mental health care in psychiatric wards of general hospitals for prisoners who require it.***
e. ***Ensuring the availability of psychosocial support and rationally prescribed psychotropic medication.***
f. ***Provision of staff training on mental health issues,*** including prison managers, prison guards and health workers, including recognition and prevention of suicides, raising

[6] WHO/ICRC Information Sheet "Mental Health and Prisons", 2005

awareness on human rights and encouraging mental health promotion for both staff and prisoners.

g. ***Provision of information/education to prisoners and their families on mental health issues.***
h. ***Promotion of high standards in prison management which promotes and protects human rights.***
i. ***Ensuring that the needs of prisoners are included in national mental health policies and plans.***
j. ***Promotion of the need to adopt mental health legislation that protects human rights.***
k. ***Encouraging the inter-sectoral collaboration.***

5. The Council of Europe position

The European Prison Rules (EPR)

The EPR contain the most comprehensive and most well-known and influential standards and principles related to the management of prisons and the treatment of persons in prison.

Rule 12 recommends that mentally ill persons whose state of mental health is incompatible with detention in a prison should be detained in an establishment specially designed for the purpose. If such persons are in prison, special regulations should address their specific needs.

Rule 15.1.f. and 16.a recommend that at the moment of admission to prison a written record of the health situation of each person is to be established and is to be promptly complemented by a medical examination. Rule 16.A recommends collecting on a regular basis information about behaviour and conduct, including risk to self and others and that the persons are to be granted access to their medical and other records.

Rule 40 recommends the medical services in prison should seek to "detect and treat mental illnesses or defects", including continuing a medical treatment started before admission to prison and that psychiatric services should be provided to the inmates.

Rule 42.3.h. that medical staff should also note "physical or mental defects that might impede resettlement after release".

There is a special section "Mental Health" in the EPR recommending "specialised prisons or sections under medical control for the observation and treatment of prisoners suffering from mental disorder or abnormality who do not necessarily fall under the provisions of Rule 12". It also draws attention to the need to pay special attention to suicide prevention.

Rules 53 and 53A which deal with special high security or safety measures and with separation provide that any such decisions should take into account the state of health of the person concerned to avoid the adverse effects this might have on them and in case such effects are observed on the physical or mental health such measures should be suspended or replaced with a less restrictive measure.

Committee of Ministers Recommendation n°R(98)7 concerning the ethical and organisational aspects of healthcare in prison

This Recommendation, adopted in 1998 contains very detailed standards related to healthcare in prisons. They provide for ensuring that all prisoners have access to a doctor; that the healthcare provided should be equivalent to the general healthcare in the country; that the patient's consent for treatment should be obtained and the same rigorous confidentiality of the medical files should be respected; the medical practitioners should be independent in their work and in taking clinical decisions and providing medical assessments.

There is a special section related to mental health (Rules 52-59) which insists on the need for prison and mental healthcare medical staff to work together in close contact in order to ensure maximum help, advice and adaptation of inmates. It recommends psychiatric and psychological examination of persons sentenced for sex offences and also holding inmates with serious mental disorder in hospital facilities, adequately equipped and staffed with a trained staff and that decisions to transfer an inmate to an outside hospital should be taken by a psychiatrist. It is further recommended to replace unavoidable solitary confinement promptly with one-to-one continuous nursing and to replace promptly physical restraint in urgent situations by appropriate medication. The need to deal with suicide risks (which is also to be constantly assessed jointly by medical and prison staff) is also underlined and the need to ensure the continuity of medical care after release is also stressed.

European Court of Human Rights

Treatment of mentally ill prisoners[7]

The Court underlines that the State has to ensure that the manner of detention do not subject a prisoner to hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that his health and well-being are adequately secured by providing him with the requisite medical assistance. [8]

A person's continued detention without appropriate medical supervision and treatment constitutes inhuman and degrading treatment in violation of Article 3 of the Convention. In particular, prisoners with serious mental disorders and suicidal tendencies require special measures geared to their condition, regardless of the seriousness of the offence of which they have been convicted.[9]

The Court has recognised that detainees with mental disorders are more vulnerable than ordinary detainees. Certain aspects of prison life pose a greater risk to their health, exacerbating the risk that they suffer from a feeling of inferiority, and are necessarily a source of stress and anxiety.[10] Thus, in its assessment of whether the particular conditions of

[7] The Convention is a living instrument and the terminology used like "mental health disorder", "mental illness", "mental disorder" and "unsound mind" change over time to reflect societal changes and policy decisions.
[8] Kudla v. Poland, 26.10.2000 (Grand Chamber)
[9] Rivière v. France, 11.07.2006
[10] Rooman v. Belgium [GC], Application No 18052/11,31.01.2019.

detention are compatible with the Convention standards, the Court takes into consideration their vulnerability and their (in)ability to complain coherently or at all about their treatment.[11]

Under the Convention, the authorities are required to effectively take the necessary measures to secure appropriate conditions of detention for persons with mental disorders, and in particular to provide them with adequate medical treatment taking into account their state of health.[12]

For instance, in case of a prisoner suffering from epilepsy since his early childhood and then also diagnosed with schizophrenia and other serious mental disorders, the Court found that he was in need of specialised treatment and adapted conditions of detention. However, he was not held in a suitable psychiatric hospital or a detention facility with a specialised psychiatric ward which had a detrimental effect on his health and well-being. The Court also held that the authorities are to secure at the earliest possible date the applicant's transfer to a specialised institution capable of providing him with the necessary psychiatric treatment and constant medical supervision.[13]

In this connection, the State's duty under Article 3 may go as far as to impose an obligation to transfer prisoners to special facilities in order to receive adequate treatment and suitable medical supervision.[14]

Furthermore, the conditions in which persons with mental disorders receive treatment are also relevant for the "lawfulness" of their deprivation of liberty under Article 5 of the Convention. According to the Court's case-law, there is an intrinsic link to be drawn between the lawfulness of a deprivation of liberty and its conditions of execution.[15]

Thus, persons with mental disorders should be treated in "appropriate" facilities. The assessment of whether a particular facility is "appropriate" includes an examination of the specific conditions of detention prevailing in it, and particularly of the treatment provided to persons with mental disorders.[16] In the Court's assessment, it is not so much about the primary aim of the facility: what is relevant is the possibility for the individuals concerned to receive treatment. Thus, while psychiatric hospitals are by definition appropriate institutions, the Court has stressed the need to accompany the placement in such institutions by efficient and consistent therapy measures, which may in some instances also be provided in prison.[17]

When assessing whether the treatment received is "appropriate", the Court takes into account the opinions of health professionals, the decisions reached by domestic authorities, and general findings about the provision of health care in prisons made at national and international levels. Moreover, in each case, the Court examines whether an individualised

[11] Murray v. the Netherlands [GC], Application No 10511/10, 26.04.2016.
[12] Dybeku v. Albania, 18.12.2007
[13] Slawomir Musiał v. Poland, 20.01.2009
[14] Murray v. the Netherlands [GC], Application No 10511/10, 26.04.2016.
[15] Ilnseher v. Germany [GC], Application Nos 10211/12 27505/14, 04.12.2018.
[16] Rooman v. Belgium [GC], Application No 18052/11, 31.01.2019.
[17] Ibid.

and specialised approach has been adopted for the treatment of the disorder in question and whether it was aimed at reintegration of the person into society.[18]

The Court has further found that an issue may arise under the Convention if a prisoner's conduct resulting from a metal disorder – concerning, for instance, a risk of self-harm and suicide, is addressed through disciplinary sanctions, such as placement in a disciplinary cell without the necessary supervision and treatment.[19]

Some examples in the Court's examination of cases concerning specific mental disorders may be noted.

In the case of confinement of a mentally ill sexual offenders, found not to be criminally responsible in the psychiatric wing of an ordinary prison, without appropriate medical care, for more than fifteen years, the Court found violation of Article 3 of the Convention. The reasons for this were that the applicant's continued detention in the psychiatric wing without the appropriate medical care and over a significant period of time, without any realistic prospect of change, had constituted particularly acute hardship causing distress which went beyond the suffering inevitably associated with detention. [20]

In a number of similar cases concerning sex offenders, the Court has also found violations of the Convention because of their detention in an ill-suited to their condition prison environment for long years, without appropriate treatment for their mental condition and with no prospect of reintegrating into society. This has broken the link required between the purpose and the practical conditions of detention and that holding of such persons in a prison psychiatric wing was a structural problem due to the lack of alternatives. The Court found that there was a structural deficiency specific to the Belgian psychiatric detention system and that Belgium was required to organise its system for the psychiatric detention of offenders in such a way that the detainees' dignity was respected[21].

In the case of a prisoners, suffering from Ganser syndrome (or "prison psychosis"), the Court held that there had been a violation of Article 3, finding that the level of seriousness required for treatment to be regarded as degrading, within the meaning of Article 3, had been exceeded in that case. The prisoner's need for a psychological supervision had been emphasised by all the medical reports but his endless transfers had prevented such supervision. [22]

In the case of a person suffering from a personality disorder and bipolar disorder who had remained in detention in an ordinary prison despite domestic court decisions that he must be transferred to a prison psychiatric service, the Court held that there was violation of the Convention because his mental health state was incompatible with detention in prison and had not benefited from any overall medical provision for his illness aimed at remedying his

[18] Ibid; Murray v. the Netherlands [GC], Application No 10511/10, 26.04.2016.
[19] Renolde v. France, 16.10.2008
[20] Claes v. Belgium, 10.01.2013, Lankester v. Belgium, 09.01.2014.
[21] (W.D. v. Belgium (application no. 73548/13), 06.09.2016; Rooman v. Belgium, 31.01.2019 (Grand Chamber); Venken and Others v. Belgium, 06.04.2021)
[22] Bamouhammad v. Belgium, 17.11.2015

health problems or preventing their aggravation, all in a general context of poor conditions of detention. The Court further stated that the authorities are obliged in the absence of places in specialised institutions, to find an appropriate alternative solution.[23]

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

The CPT recognised the importance of psychiatric care in prisons soon after it started carrying out its first visits in 1990. When setting out its standards for health care in prison in 1993, it set out a few basic standards for psychiatric care in prison (see paragraphs 41-44 of the CPT's 3rd General Report at. https://rm.coe.int/16806ce943

The CPT has expressed its opinion on numerous occasions in its country visit reports regarding the treatment of persons with mental disorders who are deprived of their liberty, and has set out in each report recommendations to improve such treatment.

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."[24]

Indeed, untreated psychiatric illness in a prison setting leads to prison staff applying *ad hoc* measures, including separation, which may result in inhuman and degrading treatment. The CPT has recommended that the following measures in relation to prisoners with mental health disorders be implemented throughout the prison system [25]:

- motivate and train medical staff and psychologists working in prisons to diagnose persons with a mental disorder and to participate actively in their management;
- provide specialist care within prisons for persons with a mental disorder by assigning a psychiatrist to undertake regular consultations;
- ensure the availability of adequate supplies of appropriate psychotropic medication;
- ensure that, when necessary, longer term hospital care with an active psychosocial component is possible.

In many reports related to prisons, the CPT has stressed the need for training of staff to ensure that they are able to detect and provide assistance to persons with mental health disorders and who are at risk of committing acts of self-harm or attempted suicide.

The CPT also stated that the care and custody of persons subject to placement in a prison mental health-care facility as a security measure should be based on treatment and rehabilitation, while taking account of the necessary security considerations. This approach should be reflected in the living conditions and other facilities offered to this particular patient

[23] Sy v. Italy, 24.01.2022
[24] See CPT's 3rd General Report: CPT/Inf (93)12-part,[paragraph. 43
[25] CPT Visit to Türkiye 2004, CPT/Inf (2005) 18, paragraph 83

population, as well as in their treatment and activities on offer. Further, such establishments should be staffed by suitably trained health-care personnel who are able to develop positive relations with the patients by entering into direct contact with them.[26] Indeed, the high incidence of psychiatric symptoms among prisoners requires that a doctor qualified in psychiatry should be attached to the health-care service of each prison, and some of the nurses employed there should have had training in the area of mental health.[27]

Moreover, the CPT considers it important to be able to offer all prison officers a programme of training and refresher courses, such as those on mental health, psychology, suicide prevention, anti-bullying, cultural awareness, etc.[28] All prison officers, as part of their basic education, must be trained in how to interact with and offer support to prisoners with disabilities or mental disorders.[29]

Another important observation and recommendation made by the CPT is not to use prisoners (unless in an unavoidable extreme situations) to assist staff in dealing with persons with mental health disorders as this may lead to inhuman or ill-treatment. In the exceptional cases when prisoners are being used to assist staff, they should be supervised on an on-going basis by qualified health-care staff. The CPT recommended on multiple occasions that nurses with mental health care qualifications be recruited to work in prisons.[30]

The CPT has also recommended that the relevant national authorities develop appropriate psycho-social rehabilitative programmes for prisoners affected with mental disorders.[31]

The CPT further underlines that it is essential to ensure the protection of persons with a mental health disorder from other prisoners to avoid harm and injuries by ensuring adequate staff presence at all times in the wings where they are accommodated, including at night and at weekends. More generally, the CPT is of the opinion that a prisoner showing severe signs of suicidal or (auto)-aggressive behaviour or in a state of florid psychosis should be immediately transferred to an acute mental health unit. Pending such a transfer, the CPT has recommended that a care plan be drawn up for the person which should include being monitored directly by a psychiatric nurse (1:1), being offered access to a shower and to outdoor exercise and increased access to other services such as psychology.[32]

The CPT has highlighted that long periods of solitary confinement can seriously affect mental health and greatly reduce the possibility of resocialisation. Where persons in prison have been subjected to long periods of segregation, the CPT has been critical of the lack of psycho-social support provided to these prisoners, as well as the lack of step-down facilities to help prisoners reintegrate back into the mainstream population, linked with the adverse effects that prolonged solitary confinement can have on a person's mental and physical well-being. The CPT has invited the relevant national authorities to consider investing in smaller

[26] See report on the CPT visit to Spain in 2003, CPT/Inf (2007) 28, paragraph 111
[27] See report on the CPT's visit to UK (Scotland) in 2018: CPT/Inf (2019) 29, paragraph 119
[28] CPT Visit to the United Kingdom 2008, paragraph 75
[29] See report on the CPT's visit to Romania in 2021, CPT/Inf (2022) 06, paragraph 67
[30] See the CPT's report on the visit to Spain in 2020: CPT/Inf (2021) 27, paragraph 90
[31] CPT Visit to Serbia 2021, CPT (2022) 03, paragraph 89
[32] See the report on the CPT's visit to Ireland in 2019: CPT/Inf (2020) 37, paragraphs 63 and 64.

therapeutic units that could provide a more robust psycho-support system for these prisoners and help with the reintegration process.[33]

The CPT recommends that any resort to instruments of physical restraint should always be expressly ordered by a medical doctor and should never be used as a punishment. The CPT has raised concerns over the use of the measure of mechanical fixation to a bed, notably in relation to its necessity, the accurate documentation and supervision of each measure, its application on prisoners with a mental illness or in response to an act of self-harm. Indeed, it has called for such a measure to no longer be used in a prison setting due to potential to be abused[34]

Steering Committee for Human Rights in the fields of Biomedicine and Health (CDBIO)

Relevant principles of the Convention on Human Rights and Biomedicine

The Convention on Human Rights and Biomedicine (Oviedo Convention, ETS n°164) aims at protecting the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the applications of biology and medicine. Its provisions apply to medical practice and healthcare, including mental healthcare in prison, as well as to specific areas of medicine which may also be relevant to prisoners and persons on probation, such as research involving intervention on persons. Those provisions are further developed and complemented in additional protocols to the Oviedo Convention, including the Additional Protocol concerning Biomedical Research laying down specific provisions relevant to persons deprived of liberty.

The **principle of free and informed consent,** Article 5 is a key principle laid down in the Oviedo Convention which concerns any intervention in the health field. It requires that any intervention in the health field be carried out only after the person concerned has given free and informed consent to it. This means that the person beforehand shall be given appropriate information as to the purpose and nature of the intervention as well as regarding its consequences and risks. Furthermore, the consent is considered to be free if given in the absence of any pressure from anyone.

The Convention provides for an exception to this principle in specific circumstances specified in its Article 7 and Article 8. Article 7 provides for the possibility to subject a person who has a mental disorder of a serious nature and whose ability to decide is severely impaired by the very mental disorder, to an intervention aimed at treating his or her mental disorder only where, without such treatment, serious harm is likely to result to his or her health.

Article 8 of the Oviedo Convention addresses situations when because of an emergency the appropriate consent cannot be obtained at the time of the intervention. In such case, any

[33] See inter alia the reports on the CPT's visit to the UK (Scotland) in 2018 and 2019: CPT/Inf (2019) 29, paragraph 74 and CPT/Inf (2020) 28, paragraphs 9 and 26.
[34] See *inter alia* the reports on the CPT's visits to Spain in 2018 and 2020: CPT/Inf (2020) 05, paragraph 54 and CPT/Inf (2021) 27, paragraph 85 and the report on the CPT's visit to Romania in 2021: CPT/Inf (2022) 06, paragraph 112.

necessary medical intervention may be carried out immediately for the benefit of the health of the individual concerned.

Finally, Article 26.1 of the Oviedo Convention, specifies that no restriction shall be placed on the exercise of the rights and protective provisions contained in the Oviedo Convention, including Article 5 unless such that are prescribed by law and are necessary in a democratic society for the protection of collective interests i.e., public safety, the prevention of crime and the protection of public health, or the rights and freedoms of others. It thus echoes partially the provisions of Article 8 par. 2.

The notion of freedom when it comes to consent, is particularly relevant in the context of research in which the results do not have the potential to produce direct benefit for the health of the participants. Consent to research participation shall not only be free and informed but also given expressly, specifically and be documented: Article 16 of the Oviedo Convention. This cannot be subject to any restriction in accordance with Article 26.2.

Dependent persons are those whose decision on participation in a research project may be influenced by their reliance on those who may be offering them the possibility of participation in the research. This may be the case of persons deprived of liberty. Article 20 of the Additional Protocol to the Oviedo Convention concerning Biomedical Research sets out the additional conditions pertaining to research on persons deprived of liberty, including prisoners, where such research is allowed by the law.

When a prisoner and/or a person on probation is considered, according to law, does not have the capacity to consent due to a mental disability, the Oviedo Convention provides in its Article 6 that the intervention may only be carried out for the direct benefit of the person concerned, and with the authorisation of his or her representative (i.e. an authority or a person or body provided for by law). Deviation from the rules laid down in Article 6 are only possible in two cases, covered by Articles 17 and 20 of the Convention, i.e. medical research (under certain strict conditions) and the removal of regenerative tissues.

The principle of **equitable access to health care of appropriate quality:** Article 3 of the Oviedo Convention and the **respect for private life** in relation to any information about the health of the participant (Article 10 of the Oviedo Convention) are also important principles that apply to prisoners and persons on probation.

Finally, reference should be made to Recommendation (2004)10 of the Committee of Ministers concerning the protection of the human rights and dignity of persons with mental disorder, which lays down, in its Article 35, specific provisions applying to persons with mental disorder in penal institutions. It recommends that such persons should not be subject to discrimination in penal institutions. In particular, the principle of equivalence of care should be respected with regard to their health care. They should be transferred from the penal institution to a hospital if their health needs so require. Appropriate therapeutic options should be available for persons with mental disorders detained in penal institutions. Treatment for mental disorders should not take place in penal institutions except in hospital units or medical units suitable for the treatment of mental disorders. An independent system should monitor the treatment and care of persons with mental disorder in penal institutions.

5. Literature and good practices review

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

5.1.1. Probation

In the last two years three systematic reviews have been produced 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. The study reviews what the research evidence tells us about the rates of suicide amongst persons under probation supervision in comparison to the general population. Drawing on evidence from a recent systematic review, is considered 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 persons under probation supervision. In particular, it is demonstrated the dearth of probation-specific evidence-based studies in this area and is offered some insight into how the current gaps in the literature could be addressed in the future.

Substance misuse - This narrative systematic review of the literature on substance misuse and community supervision 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.

5.1.2. Prisons

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 UK.) on "Psychological Therapies for Prisoners with Mental Health Problems", conducted by Fazel (2017), suggests that the Cognitive-Behavioural Therapies (CBT) and mindfulness-based therapies are modestly effective in treating depression and anxiety symptoms in persons in prison.

Furthermore, that there is no clear difference between group and individual-based treatments.

Furthermore, this review suggests there are higher effect sizes (greater improvement) with mindfulness-based therapies which can improve the symptoms of depression, anxiety and trauma symptomology. This is in line with a meta-analysis undertaken by Malik et al (2021).

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

In summary overall there are very few interventions that have been examined that are likely to provide an improvement in mental health outcomes for prisoners. 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 the outcome of interventions.

5.2. Summary of Good Practice

There are significant areas of good practice that exist or are being developed within most European countries/jurisdictions in both prisons and probation (see Appendix 3). 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 certain German Länder there are also some useful initiatives, for example, in Baden-Wurttemberg, probation staff members are trained to be mental health specialists and provide input to remaining staff of the nine probation offices. Also, Lower Saxony have developed standards for mental health in probation.

The responses to the survey cited many more examples of good practices in prisons when comparing them to probation.

Legal regulations, provisional procedures, internal guidelines and other written orientations related to dealing with inmates with mental health disorders are becoming a standard practice in the prison systems of the majority of the European jurisdictions, as is the case in Austria, Belgium, Germany, Finland, Italy, Montenegro, Portugal, Romania, Spain and Switzerland, among others.

The examples highlighted here are solely indicative and many countries could have been highlighted. There were good examples of multidisciplinary mental health team working (Austria and Iceland). In England and Wales there was an initiative focused solely on personality disorder - the “Offender Health Personality Disorder Pathway” as well as the RECONNECT pathway out of prison. Suicide rates, unlike probation, were monitored on an annual basis in Belgium, Denmark Finland, Germany, Italy, Slovenia and Spain but there were

many other examples in other jurisdictions. Most countries trained staff in suicide awareness and mental health. The mental health training in Armenia has been funded by the Council of Europe and videos of the process involved can be found here. Continuity of care was mostly recognised as a key issue and was being systemically addressed in Denmark and the State of Bavaria, Germany. The North-Rhine Westphalia State, Germany has been trialling telemedicine in a number of prisons.

Other good practices seem to be the partnerships established of the prison authorities with academic experts in terms of assessment, evaluation and research on mental health conditions. Several countries had published research on the prevalence of mental health disorders in prison including: The Netherlands (The prevalence of mental disorders and patterns of comorbidity within a large sample of mentally ill prisoners: A network analysis | European Psychiatry | Cambridge Core); Spain (Spanish survey on health and drug use among prisoners ESDIP 2016 (sanidad.gob.es); and England, a recent study of prevalence (https://link.springer.com/article/10.1007/s00127-019-01690-1). Finally, there was important research being undertaken in France, for example. A longitudinal study, conducted by PRISME examines prisoner's mental health through time in prison and begun in 2021. France was also conducting a study which is evaluating the prison suicide prevention policy. Meanwhile in Belgium, are being examined factors related to prison suicide (Distinguishing prisoners who think about suicide from those who attempt suicide - PubMed (nih.gov)

6. Guiding principles and Recommendations

6.1. Guiding principles

a) Agreement at political/decision taking level

At a political/decision taking level, all relevant stakeholders should come to an agreement to declare as a priority ensuring a high level of service in the mental health area, including in the case of persons managed by the prison and probation services. A policy for working with mental health disorders should be developed as part of a larger general mental health strategy. This policy should contain interventions which are evidence-based, carried out by multidisciplinary teams, have a gender perspective and involve the engagement of service users.

b) Setting up of joint multidisciplinary teams

Setting up of joint working groups, including multidisciplinary teams composed of prison and probation staff (prison officers, psychologists, case managers, social workers), health professionals (physicians, nurses, psychiatrists) and volunteers working in all sectors (prison, probation, mental health), should be created and should work together on a regular basis.

c) Unified mental health recording system

A unified mental health recording system integrating different tools (screening, assessments), diagnostic results and treatment files, should be designed and developed at an appropriate level in collaboration with scientific experts, and the collated and anonymised results should inform the decision makers about the trends and actions needed to be taken.

d) Early detection of mental health disorders

The key criminal justice agencies (courts, prosecution, police, prison, probation services and juvenile justice services) have a shared responsibility in putting this principle in practice. The early detection of mental health disorders at the moment of first contact of a person with the criminal justice system and thereafter must be a key aim as this might lead to timely diversion from prison to probation or to a referral to an appropriate mental health service. In prison, early detection of a mental health disorder will reduce the likelihood of suicide, can lead to transfer to a mental health service outside the prison, or treatment inside the prison by the mental health professionals. Information regarding the mental health condition of the person should be shared while respecting the existing data protection rules in order to endeavour to ensure appropriate treatment and care.

e) *Regular data collection*

Both prisons and probation services should collect data routinely which focus on the risks and needs of mentally disordered persons in contact with either agency. This would allow to identify the relevant needs and to plan the services.

f) *Information about suicidal risks*

Suicidal risks should be monitored routinely alongside other demographic and clinical factors in order to prevent suicide. It is often very difficult for staff and relatives to identify prior indicative factors allowing to predict suicide risks. Therefore, communication protocols and procedures, aligned to data protection rules, should be agreed and adopted by both agencies, in order to allow them to share relevant information regarding the risk of suicide or previous attempts. In this case apart from working together, also the continuous sharing of risk factors related information is very important. Thus, the person at risk can be flagged up from the outset and referred to the relevant mental health service either within the prison or in the community.

Staff should be trained to detect such signs of risk. In the majority of cases, before a suicide attempt, there are signs or symptoms that are present before the incident, and if that information is shared in due course, suicide attempts might be prevented.

g) Focus on continuous professional development and staff support

There is significant variation in the skills that both custodial and probation staff have acquired in relation to mental health. Staff in prisons seems much more likely than probation officers to have such training. In most jurisdictions a social work or a psychology degree is required to become a probation officer and probably more skills in mental health are expected in these instances. Probably this is the reason why very few probation services formally define the role of staff in relation to detecting and dealing with persons with mental health disorders. Unless this is agreed at national level, it seems that specialized training is not usually designed and provided for probation staff. It is highly recommended to organise such a training. .

h) *Clearly defined partnerships that include the voice of the service users*

Prison and probation services and their interaction with healthcare services can be a very complicated exercise. There are complex partnerships that include: social care, mental health services, healthcare within prisons, community healthcare services in general, such as access to a general medical practitioner. These partnerships can cease 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 and their family members should also have a place at any discussion table.

Increasingly, in some countries there are calls to involve those with relevant lived experience in all areas of healthcare provision: staff assessment, planning services, research and evaluation.

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

There are many models for accrediting the standards of mental healthcare received by prisoners. No jurisdiction in Europe has a standards-based model for mental health in probation. 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). 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.

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

There is little hard evidence of useful interventions for those with mental health disorders in prison or under a probation supervision. Thus, it is crucial that interventions continue to be evaluated and researched to a high standard (see for example, Sirdifield and Denney, 2022). Even allocation of any research funding for mental health studies in the criminal justice system is regarded as a low priority by many funding bodies. Researchers should develop relationships across Europe that allow comparative studies.

6.2. Recommendations

6.2.1. Prison and Probation

- Standards for managing persons with mental health disorders should be agreed in order to evaluate all such services in a given jurisdiction.
- The staff's role in the recognition and assessment of mental health disorders and in providing interventions and/or facilitating access to mental health care should be defined thereby allowing the design of appropriate training.
- Methods should be developed for collecting data on mental health disorders in line with the relevant data protection rules in Europe. The use of structured assessment tools would facilitate this process.

- Monitoring anonymised data on suicide should be collected routinely by the relevant services over a period of time (3-5 years) so that trends might be examined, and possible preventive actions examined.
- Continuity of care for mental health disorders should be maintained after release from prison and transfer to probation and after the probation period has ended.
- Sufficient research funding should be made available to evaluate the implementation of mental health policies and practices and their impact on health and re-offending outcomes.
- There should be a network of mental health researchers and experts working in probation settings.
- Every probation service should be aware and be updated on the pathways and access criteria to mental health and other related services (such as drug and alcohol treatment services).

6.2.2. Prisons

- Each jurisdiction should have a policy for working with mental health disorders in the prison context as part of a larger mental health strategy for the general population. This policy should aim for equivalence (with the general population) in relation to: quality of service and the number and level of expertise of the clinical staff that provides care inside prisons.
- Interventions should be evidence-based, carried out by multidisciplinary teams and have a gender perspective. Service users should be involved in the development of these interventions, e.g., trauma-informed care in women's prisons.
- In accordance with EPR, Rule 12 persons who are suffering from mental illness and whose state of mental health is incompatible with detention in a prison are sent to an establishment specially designed for the purpose. If such persons are nevertheless exceptionally held in prison, there shall be special regulations that take account of their status and needs.
- In accordance with the EPR, Rules 15.1.f, 16.a and 42 "All prison services should screen new prisoners at admission, subject to the requirements of medical confidentiality and should register any relevant information regarding their physical and mental well-being. This information should be supplemented promptly by a medical examination".
- In accordance with the EPR, Rules 39-48 "All prison services must ensure adequate access to treatment and care of all inmates in general in order to mitigate the effects of imprisonment on their health, including their mental health".
- Prison administrations should be vigilant and should follow specific written procedures to detect early signs of mental disorder or distress, as well as indicators of potential

risks of suicide attempts, as admission to and stay in prison can be a traumatic experience.

- A multidisciplinary assessment should be standardised, integrated and regularly used across the prison system and these initial and ongoing assessments should be carried out by professionals to identify the individual needs of persons with mental health disorders in prison.
- The development and implementation of integrated and tailor-made programmes for early referral, diagnosis, and treatment of persons with mental health disorders should be carried out in all prisons, preferably with written guidelines and procedures that should be followed at admission onwards.
- Prison staff should be trained with different aspects of knowledge and techniques of intervention, possibly including restorative approaches. "At a minimum, initial suicide prevention training should include but not be limited to, the following: why correctional environments are conducive to suicidal behaviour, 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[35]"
- 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 health disorders and/or risk of suicide so that appropriate interventions can be used in such situations.
- Persons in prison with mental health disorders should not be excluded from participating in meaningful activities, as well as in cognitive therapies and specific therapeutical activities, as these reduce the negative impact of imprisonment on their mental health.
- Prisoners should have access to relevant information on what, by whom and how they can get help if needed, especially during the initial period of detention. All information regarding important aspects of life inside prison (daily routine, access to healthcare service, visitation procedures, access to telephone) should be made readily available and understandable by prisoners with mental health disorders.
- Prisoners with mental health disorders should receive a disciplinary sanction or measure following their inappropriate or dangerous behaviour, only in case this behaviour is not the result of their mental health disorder. In accordance with EPR, Rule 53A.i. when separation used as a special high security or safety measure affects adversely the physical or mental health of a prisoner, it should be suspended or replaced by a less restrictive measure.

[35] WHO, Preventing Suicide in Jails and Prisons, 2007

- Prisons should facilitate contact between prisoners and their positive social network as they potentially play an important role which impacts on the prisoner's mental health condition.
- The design of the prison infrastructure should respond to the increasing care needs of persons with mental health disorders and should include the development and regular use of specific programmes for treatment and rehabilitation, especially regarding self-harm behaviours and suicide attempts.
- Referral of persons with mental health disorders to external mental healthcare services that can provide treatment after release should follow written protocols and partnership agreements in order to have a shared responsibility. Cooperation between prison healthcare services (in particular forensic psychiatric hospitals) and local mental healthcare services is essential in order to promote the necessary collaboration in ensuring the continuation of treatment after the release of prisoners with mental health disorders.

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Appendix I

Government policies

Albania: There is no policy regarding people under probation who experience mental disorders, mainly because they are sent for hospital treatment.

Austria: The rehabilitation assistance for offenders in Austria involves probation assistance as a judicial sanction instead of or after imprisonment, but also as an assistance for the release without any judicial order (optional choice of inmates during the release management). On behalf of the Ministry of Justice, the organization NEUSTART offers these kinds of care and support throughout Austria. In addition to helping perpetrators and victims, the services of NEUSTART also include preventive measures.

Probation service: Probation can be a judicial order instead of a prison sentence or in case of an early release. The responsibility of probation is to support a future lifestyle without committing new crimes. Probation officers helps the people concerned in coping different individual problems and/or everyday difficulties. At the center of the work is the effort to cover the main needs, such as finding a home or a place to live and finding a job. The probation service provides a solid foundation from which to begin a new life.

Further care offers: In addition to the offers of probation assistance, the follow-up care of those released from prison is an important pillar of the rehabilitation assistance. All inmates are informed by the prison social service that they can use the support of NEUSTART for preparing their release. In addition to the support of social needs, such as looking for a home and job, questions of employment and pursuant to insurance law and debt settlement, the development of finding individual solution strategies for the risk of relapse is another main part of the advisory service.

Inmates who have not received probation assistance as a judicial order can take advantage of the care and support offered by the assistance for the release or they can ask for probation assistance on a voluntary basis.

The organization NEUSTART is available in all federal states in Austria. Beside the mentioned release support, they also offer communication and work training, the mediation of charitable activities, the drug advice, the family care, the school social work, the youth welfare and the crime victim assistance.

Inmates with mental disorders or disabilities: If a person with mental disorders or disabilities has probation service supervision as a judicial sanction instead of or after imprisonment as well as using the optional choice of this support during the release management, generally all involved professionals (e.g. prison staff, relevant institutions, probation service, …) cooperate with each other in form of collecting the personal data as well as the individual needs and risks. In course of that - if necessary - the connection to stationary and/or ambulant institutions are made such as psychiatry, out-patient treatments, other institutions for care and treatment, psychologists, psychiatrists … The main aim is to give the person the support

of a stable and self-determined life and give general and individual information of institutions and addresses for contacting when needed.

Involuntary detention ("Maßnahmenvollzug gem. § 21 StGB"): Basically, a distinction can be made between the executions of measures against insane, mentally abnormal lawbreakers (§ 21/1 StGB) and the execution of measures against sane, mentally abnormal lawbreakers (§ 21/2 StGB).

The placement in an institution for mentally abnormal lawbreakers is intended to prevent the detainees from committing criminal offenses under the influence of their mental or emotional "abnormity". The placement is intended to improve the condition of the detainees to such an extent that they can no longer be expected to commit acts threatened by a penalty, and to help the detainees to adopt a righteous attitude towards life that is adapted to the requirements of community life.

In Austria, generally all mentally abnormal lawbreakers have in case of their release the judicial order of probation. For the (optional) release management of mentally abnormal lawbreakers before the release, a very strict and interface management regulation was worked out by the Ministry of Justice and NEUSTART. The main goal is the ensurance of a timely and individual risk management and the widespread care and support in the finale phase of prison in preparation of the release between the prison and the probation service (the further probation officer). For a demand-oriented return in a social environment, a very close and coordinated teamwork between all involved persons (Case Manager, other prison staff, probation service/further probation officer, judge and other institutions) is necessary. In form of case-conferences and different forms of risk assessments, the individual needs and required supports are identified, so that when being release the gap between time inside the prison and the release is as small as possible.

Belgium:

French speaking: We do not have any reports on the issue. There are no statistical links between persons on probation and mental disorders/disabilities because the matters are dealt with by two separate entities and there is no specific documentation in either of them. Probation is managed by the justice system (as regards court rulings) and the Communities (as regards monitoring and supervision), while the public health system is responsible for care for mental disorders and disabilities. The Ministry of Justice has more detailed information on persons confined to mental hospitals, but they are not within the scope of this questionnaire.

Flemish speaking: The Flemish concertation platform for Mental Health (Vlaams Overlegplatform Geestelijke Gezondheid - VLOGG) has made a report addressing the description, the evaluation and the shared vision regarding the guidance and treatment of non-detained probation clientele who have a psychological vulnerability.

Shared vision = cooperating partners are Mental health services, general social work services and the houses of justice (probation services).

Non-detained probation clientele = in Belgium that means every form of criminal execution outside of prison for adults (over 18): community service, conditional sentences, early release from prison, electronic monitoring, …

The report serves as a starting point to take actions to facilitate the accessibility to and to improve the continuity of the aid and care that is provided. Special attention goes to the collaboration between the social worker / mental health provider and the probation officer (cooperation protocols and consultation structures are needed).

The Flemish Agency Care and Health (Vlaams Agentschap Zorg en Gezondheid) developed a framework for forensic mental health care. Through this instrument the government wants to improve the quality of mental health care for non-detained probation clientele. The framework provides specific and additional quality standards for this specific group of clients. The framework must be evaluated (refined and adjusted if necessary) in cooperation with the partners concerned.

Czech Republic: MANUAL FOR WORKING WITH DEPENDENT PERSONS (topics)

Theoretical part (Dependency phase, change cycle stage, available services for dependents)

Practical part (Safety of worker working with drug addicts, security at the Centre PMS, tester manipulation, field work safety, working with addictive or alcohol-dependent offenders, mapping the offenders' situation, communication with dependent offenders

Finland: Supervisors are obligated to guide a person to social services if he/she assess the need for support and services. Supervisors are also obligated to inform social services if a person is incapable to take care of himself or if interests of the child are involved. (Social Welfare Act 35)

➔ Referring to social services
https://stm.fi/en/social-services

OR

➔ Referring to general practitioner / psychiatric nurse at public health care
https://stm.fi/en/mental-health-services

France: Persons in semi-liberty (on day release) are covered by ordinary law and therefore have access to ordinary healthcare. The same applies to all those under the supervision of prison rehabilitation and probation services in community settings. In addition, strand 5 of the 2019-2022 health roadmap for persons under judicial supervision ("Ensuring continuity of care in the case of prison release and ending of judicial measures") is intended to ensure continued care and treatment for detained persons, in particular between secure and community settings.

Germany:

BW: The Bewährungs- und Gerichtshilfe Baden-Württemberg /BGBW) has established a specialist concept. In each of our 9 facilities, we have a specialist for different topics, such as

the topic “persons under probation with mental disorders”. Theses specialists have up-to-date expertise as well as methodical and didactical skills. Core tasks of the specialists include training and counselling of the probation officers, if needed case analysis, crisis intervention and tandem support for difficult cases. They also organize specialist days, training courses and lectures as well as networking meetings. The specialists offer case discussions and consultation hours for their colleagues. In order to enable continuous knowledge building, the specialists have 5 training days per year at their disposal. For quality assurance purposes, the central social work department of the BGBW, holds an annual meeting with all specialists.

BY: In Bavaria, there are no special (political) programs, recommendations or similar. The binding quality standards of the Bavarian probation service apply to the work of the probation service in Bavaria. These are available on the homepage of the Bavarian State Ministry of Justice under the following link:

www.justiz.bayern.de/gerichte-und-behoerden/oberlandesgerichte/muenchen/bewaehrungshilfe.php

NI: There are quality standards in the ambulant judicial social services in Lower Saxony. The corresponding manual in English is attached as an appendix ambulant.

SH: In Schleswig-Holstein, there are no known special programs or procedures for the treatment of probationers with mental illness in the sense of health care. In order to counteract stigmatization and promote participation in the health care spectrum, the support of mentally ill or conspicuous probationers is aimed at enabling access to general medical and therapeutic services.

In general, health care for mental illness/psychiatric disorders is organized as decentralized and community-based as possible. In Schleswig-Holstein, outpatient services as well as inpatient or day-care services are available for persons with mental illnesses, which are also open to offenders. Probation officers have knowledge of the regional support services and cooperate with/provide access to:

- Low-threshold regional counselling services provided by governmental and non-governmental organizations
- Psychotherapists in private practice, who are required by the Psychotherapy Guidelines to offer timely consultation hours and acute treatment.
- Specialists in private practice (neurology/psychiatry, addiction medicine)
- The emergency rooms of psychiatric clinics/departments (in the event of acute psychiatric or psychotic crises), as well as day clinics and outpatient follow-up care
- Specialist and rehabilitation clinics
- Social psychiatric services of the health authorities
- Offers of addiction support for probationers with ICD10 F10-F19 disorders;

- Offense-specific services for sex offenders and violent offenders, which are also open to probationers with mental disorders.

The following programs are available for probationers with crime-relevant disturbance patterns:

- "Don't become an offender" - low-threshold counselling and treatment offer for persons with sexual preference disorder directed at minors
- Forensic specialist outpatient clinics - for treatment for persons with sexual preference disorder, usually in accordance with a directive under the Criminal Code
- Suspension of execution of sentence according to § 35, 36 des Betäubungsmittelgesetzes (Narcotics Act) in favour of a mostly inpatient addiction therapy measure.

BE, BB, HE, MV, NW; SL, TH: Specific political programs, recommendations, reports or similar documents as mentioned above do not exist.

Iceland: A mental health interdisciplinary mental health team has been established for the prison system, starting in 2020. The team includes psychologists, a psychiatrist, psychiatric nurses and hopefully will have the resources to access other professions as needed. The team operates on the basis of internationally recognized standards, evidence-based methodology and clinical treatment guidelines. The team works both onsite (within the prisons) as well as using teleconferencing equipment when needed or when appropriate. The team works closely with employees of the prison service, mental health teams in the community, health care institutions and other service providers to ensure continuity of services once the detainee has left prison

Italy: Act No. 180 of 1978 (the so-called Basaglia law, from the name of the psychiatrist behind this reform) granted dignity and rights to those suffering from serious psychiatric disorders; it abolished mental asylums, a total institution in which inpatients felt their identity had been erased and identified the territory as the most appropriate place of intervention for the protection of mental health.

However, the Judicial Psychiatric Hospitals, so called since 1975 (i.e.: OPGs in Italian), which used to house offenders suffering from psychiatric problems, remained in operation. These facilities depended on the Penitentiary Administration Department and therefore suffered from the prevalence of custodial needs over treatment needs.

The Italian Parliament decided to close the OPGs by Act No. 81/2014 that entered into force on 31 March 2015. This epoch-making reform replaced the OPGs with the Residential facilities for the Execution of Security Measures (REMS in Italian), managed by the Regions, to ensure assistance and care inspired by the principles of deinstitutionalisation and social inclusion.

Therefore, the criminal offenders who are acquitted on grounds of insanity are, since then, subject to either non-custodial (probation) security measures or custodial (REMS) security measures, in accordance with Act No. 81/2014.

However, until 2019, no such protection existed for those who had not been identified at the trial stage (i.e., acquitted on grounds of insanity) or for those who had witnessed the onset of the illness during the execution of the sentence and, therefore, were not subject of a security measure.

The Constitutional Court's judgment no. 99 of 2019 has intervened, in accordance with Article 3 of the Constitution, to ensure the care of detainees with psychiatric problems by cancelling such an unequal treatment between those who suffer from a serious physical infirmity and those who have a psychiatric pathology, thus allowing the enforcement of alternative measures even in cases of serious mental illness that emerged eventually.

At present, therefore, judges can enforce a set of rules which ensure equal treatment to all persons with mental problems who enter the penal circuit, whether they were identified beforehand and were therefore regularly recipients of security measures or they were already detained, and their pathologies emerged subsequently. If a serious psychiatric illness manifests itself during imprisonment, the judge may order that the offender be treated outside the prison. The alternative measure of home detention may be granted, as is already the case for serious physical illness, even when the remaining sentence is more than four years. In addition, the measure of Probation may be granted under the supervision of the local Social Service in order for the offender to continue or undertake a therapeutic and psychiatric assistance programme. This measure shall be monitored by the Probation Services of the Ministry of Justice in close cooperation with the Region's Mental Health Department.

Latvia: No data has been gathered on the mental health of people on probation as of now but there are plans to do this in the future.

Lithuania: Law on Mental Health Care; Lithuanian Health Strategy for 2014–2025; The Mental Health Strategy.

Malta: We don’t have any specific guidelines related to probation, however, recently a 10-year national mental health strategy was launched (encompassing 2020 to 2030). Link: https://deputyprimeminister.gov.mt/en/Documents/National-Health-Strategies/Mental_Health_Strategy_EN.pdf

Montenegro: There is no any recent national document (in the form of a policy, procedure, guide or report) relating to the treatment of persons with mental disorders or disabilities who are under probation service supervision.

Portugal:

Report “Case Management: Need analysis and guideline proposals” (Directorate-General for Probation and Prison Services, November 2016): 42% of community measures include the court order of mental health treatment, including treatment for addictions; such order is the most frequent among probation measures (between 52 and 58%); for parole, mental health treatment is present in 12% of the measures, most frequently related to the treatment of addictions; mental health treatment is most frequently imposed in domestic violence crimes (50%), theft (58%), road offences (41%), drug related crimes (37%) and sex crimes (33%). It is also a very common order in arson crimes (48,2%).

Report “Probation intervention in security measures for non-criminally responsible offenders” (Directorate-General for Probation and Prison Services, October 2018): all offenders are subject to mental health treatment (required by law); most common disorders are intellectual disability (37,8%), psychosis/schizophrenia (32,4%), personality/impulse control disorder (13,5%) and bipolar disease (10,8%).

Report “Probation and community mental health services” (Directorate-General for Probation and Prison Services, November 2019): The majority of the community mental health services that collaborate with probation teams are NGO (32%), followed by hospitals (29,5%), institutions for the treatment of addictions (23,0%) and primary healthcare units (13,0%).

Recommendations for referral and collaboration between probation and community mental health services (under development): joint recommendations are being prepared between the Directorate-General for Probation and Prison Services (Ministry of Justice) and the National Mental Health Program (Ministry of Health) to define procedures for the referral of probationers and parolees with mental health treatment orders and/or mental health problems. Such procedures stem from the need to overcome difficulties that have been identified when requesting mental health interventions, as well as communication problems between institutions.

Romania:

The approach of mental health issues is still being a challenge for the Romanian probation system due to the difficulties faced in working with mental disorders and to the lack of specialization regarding training the probation counsellors in addressing such issues. First, it is important to mention that the probation supervision in Romania is focused both on control and assistance/support for the supervised person in order to address the social and criminogenic needs and to diminish the reoffending risk. The two central elements of the probation work are the main directions of the supervision process, and also, are applicable in working with mental health probationers. The balance between control and support is very sensitive in working with mental health disorders, having in mind that most of these aspects are not medically diagnosed (certified by documents) and the probation counsellor has only a few clues about it, observing the changes regarding behaviour of the persons (violent and aggressive actions, impulsivity, abuse of drugs/alcohol, refuse of cooperation, excitement and others). In working with mental health disorders, it is important for the probation counsellor to identify the signs and symptoms which could lead to medical diagnosis regarding a mental health disorder. In this respect, some guidelines are offered by the Probation Counsellor Manual, which contains a distinct chapter dedicated to approaches of the mental health disorders in probation and specific aspects in working with mental illness.

The main activities of the Romanian probation services are related to the following stages of the criminal trial:

- before the trial, during the prosecution - the pre-trial reports for juveniles in order to assess the reoffending risk and the risk factors;
- during the trial, before the sentencing - the pre-sentential reports for minors and adults, at the request of the court (similar like before, the assessment of the risk);
- post-trial - stage- the execution of the community sentences and post release phase (the supervision of educative noncustodial measures imposed for minors, the supervision in case of the postponement of the sentence, the suspended sentence under probation supervision, the conditionally release from prison).

1) The principles of the Romanian probation system

It is relevant to emphasize the most important principles of probation work in Romania in order to show a clear overview of the probation system. Thus, according to the legal provisions and to the probation working standards, the most relevant principle is the case management, meaning the coordination of the following stages: the assessment of the supervised person, planning the intervention, guiding and monitoring the control measures and the assistance process and effectively implementing the sentence or only coordinating the community institutions involved within this stage. This principle is relevant in addressing mental health probationers in order to conduct the assessment, to plan and monitor the intervention within the community by the probation case manager and to cooperate with medical care units in order to offer an adequate framework for a specialized intervention.

As well, we can highlight the proportionality of the intervention during supervision, according to the level of risk and to the criminogenic needs in order to guide the intensity of the control measures and the intervention. The signs of mental illness are explored during the supervision meetings with the case manager and are addressed accordingly, within the probation service or within the community institutions, in special in medical care units, through specialists.

Last, but not least, in case of mental health disorders identified within the probation population, the proper approach envisages a multidisciplinary intervention, based on the case referral within the community in the first stage for a focused and adequate/appropriate support, which involves social care, psychotherapy, psychological counselling and sometimes, medical treatment, recommended by a psychiatrist.

2) Assessing the defendants with mental health problems

The reports for defendants are an important tool used by the courts in order to impose the penal sanction having in view the individual and the offence. Actually, the conclusions of the pre-trial reports as a result of the assessment process are used by the court to guide and justify the sentence, in most cases. Thus, the assessment process conducted in order to prepare the pre-trial/pre-sentential report for juveniles or adults includes the following aspects and items: a complete analysis of the criminal behaviour, criminal record, information concerning the social and familial environment, with an accent on the support, resources, values and principles, the educational and school instruction level, the working status and working experience, skills, motivation to change the problematic behaviour, the physic and psychological health and addictions, and as well, other information regarding the general

behaviour of the defendant within the community. Based on the above-mentioned dates, the probation counsellor is able to evaluate the reoffending risk, the factors that could increase and decrease the level of the risk, and to propose to the court an adequate measure or sanction, including some specific obligations according to the social and criminogenic needs of the assessed person. As we mentioned above, the pre-trial assessment is focused on the evaluation of the general health of the person and medical/psychological issues, and in this respect, the probation counsellor can cooperate with specialists (psychologists and psychiatrists) in order to address properly mental health issues and to obtain useful information for the report. In such cases, the conclusions of the assessment report are related to the identified mental health problems and could include the recommendation to follow medical and psychological treatment within the noncustodial or custodial sanction imposed by the court. As well, it is important to early detect the sings of the mental illness for an adequate plan that could help take measures and guide the intervention.

3)Working with persons under probation supervision

If we have in view how we specifically address the mental health issues, it is relevant to highlight a few aspects regarding the supervision process as it is developed and implemented within the Romanian probation system. Starting with the first probation meeting between the probation counsellor case manager and the supervised person, focused on building the professional relationship, gaining trust, showing respect and offering all the necessary information related to the sanction and the supervision process, the next stages envisages the risk and needs evaluation, planning the sentence and the whole process and developing the proper intervention (or only monitoring the intervention when it is conducted by another specialist) and at the end, assessing the finalization of the supervision. As it is mentioned before, the social assessment of the criminogenic needs in order to estimate the level of the reoffending risk could guide the following steps: the supervision plan and the intervention. The signs of mental health illness are explored and approached within the first probation meetings and at the end of the initially assessment, the case manager would be able to decide the referral of the case to another community institution for medical care, psychological therapy or counselling or medical treatment. If the probation counsellor has some doubts about the signs of mental illness, he can collaborate with specialists in order to clarify and obtain an accurate overview of the case. Usually, in such cases it is difficult to obtain the consent of the probationer (because sometimes he denies or he doesn't recognize the problem) in order to follow a treatment program, if the court hasn't imposed a specific obligation for the convicted person.

According to the Romanian criminal code provisions, such obligation could be to comply with the requirement of treatment and healthcare measures - for drug and alcohol addiction and for other medical conditions. This specific obligation it could be established by the court when decides a community sanction for the defendant, and as well it could be disposed during the supervision at the request of the probation counsellor case manage. In this respect, an important and useful tool of the probation case manager is the possibility of changing the content of obligations imposed by court according to the criminogenic needs and the level of reoffending risk. Thus, during the supervision period, the case manager could ask the court to impose the obligation to comply with medical care measures, if the case. The revocation of

the sentence is possible in case of breaches related to the obligation; in such cases the person could serve the sentence in prison.

Another obligation that could be imposed to the supervised person is to follow a social reintegration program, meaning, according to the probation working standards, the following:

- intervention programs, focused on cognitive-behavioural therapy;
- intervention programs, such as those focused on the Goldstein method, the Moreno method;
- psychotherapy;
- psychiatric treatment;
- occupational therapy;
- educational, prevention and short-term intervention program;
- informative programs, including legal issues;
- psychological counselling;
- vocational counselling;
- support- counselling;
- relationships counselling;
- motivational counselling;
- any other type of assistance and counselling activities, which aims to adequately cover the identified criminogenic needs

The access to mental health care providers is problematic. Making sure that individuals have access to mental healthcare could improve their lives and could raise the safety within the communities and also could facilitate the reintegration process during the probation supervision. For many, it could dramatically reduce or eliminate the risk of suicide, clarify legal issues, solve family conflicts, employment issues, address substance abuse and further mental and physical health problems. Even the probation system deals with many issues in order to support the reintegration of these persons in the community, it is important to understand the access the mental healthcare services, in order to ensure this access during the supervision term; as well inter-institutional collaboration is very important, and the case management is playing a central role in this respect.

Trainings for probation staff in order to identify the mental health issues during the risk and needs assessment process and to manage mental health probationers is also a key for improving the social intervention during the supervision period.

The increased number of supervised persons with mental illnesses represents a big challenge for the probation counsellors and also for the entire society. The support relationship between probation counsellor and probationers with mental illnesses has a significant importance in this area, despites the fact that we don't have interventions designed specifically for this type of problems and also, we don't have training initiatives designed to prepare probation staff about mental health issues. The lack of specific programs and interventions to address mental health of probationers should be addressed by the Romanian

probation system and in this respect measures and actions should be developed and implemented.

In the Romanian probation system, the mental health education by developing special social programs is a reality and the need of specific approaches in order to decrease stigmatization and to increase the knowledge of mental illnesses among probation staff it is known and accepted as a direction to follow.

Slovakia: There is no special policy or guidance regarding the persons under probation service supervision who experience mental disorders or disabilities in SK.

Spain: First, we want to clarify that we will include under the term “probation”, offenders serving an alternative sentence and offenders on conditional release // Regarding people who are serving a sentence or an alternative measure, there are two options: In some cases, the court decision includes the obligation of the offender to participate in a mental health treatment programme. In that case, the probation officer refers the offender to a public resource and makes a follow up of the case, informing the court periodically. // When an offender with a mental disorder is sentenced to a regular alternative measure (community work or suspended sentence) because his/her mental condition has not been identified in court, the probation office may refer him/her to the Extended Bridge Programme (EBP). The main objective of the program is to detect these cases and establish a connection between the offenders and the community resources, both social and health, thus improving their health and at the same time avoiding new prosecutions and imprisonments. For example, if the probation officer detects that an offender who has to serve a community service sentence has a severe mental disorder, he/she will propose to the judge the possibility that the offender serves the sentence through his participation in the EBP. This will prevent compliance breaches and will contribute to a better rehabilitation of the offender. // Similarly, for offenders with intellectual disabilities, the Integrate Programme (IP) is available. The main objective of this program is the early detection of intellectual disability, improving their health and establishing connections with community social and health resources. This programme is in a pilot phase. // It is intended that these types of interventions continue when the offender finishes his/her sentence. // For people on conditional release there is the Bridge Programme. The objective of this programme is to facilitate and develop a process of reintegration into the community for people with mental disorders who are in open regime in any of its modalities, also covering the period of conditional release. Different types of intervention are carried out: psychosocial care, support for psychiatric and psychosocial rehabilitation, acting as health mediators, providing legal advice, foster care and family support, and job development programs.

Sweden: In Sweden persons serving probation sentences are included in the general health care system, it is called “a principle of normalization”. The Swedish Prison and Probation Service do not provide any national policies apart from general policies from the national health care services. In prisons there can be special policies due to security reasons.

Türkiye: Individual plans and programs are developed for probationers who experience mental disorders or disabilities.

Intensive Individual Interview

As a result of the determination of risk and needs, the suicidal attempt of the responsible person is determined by factors such as his / her history of violence, self-harm behaviour, and the demand for more frequent guidance. In these interviews, the relevant factors are discussed first.

Individual Intervention Interviews (Long Term Individual Interview)

Group work with probationers with mental health disorders is not planned for different reasons such as physiological and psychological health problems or criminal history. Individual work is considered more relevant as it aims at creating a change in the behaviour of the probationers.

United Kingdom

A. **England**: The Government take mental health very seriously and recognises that providing the right interventions at the right time is vital to improving outcomes for people with mental health needs. Offenders often have complex health and care needs and generally experience poorer physical and mental health than the general population. In order to improve health outcomes and tackle the root causes of offending it is essential we take a whole system approach to healthcare provision for people in the criminal justice system.

The Community Mental Health Framework for Adults, now in early stages of implementation by NHSE/I, is a new approach in which place-based and integrated mental health support, care and treatment are situated and provided in the community.

- This framework will support local community mental health services to move away from siloed, hard-to-reach services towards joined-up care and whole-population and whole-person approaches.
- This should include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, support with medicines management and for self-harm and coexisting substance use.
- One of the aims of the framework is to maximise continuity of care and ensure no “cliff-edge” of lost care and support by moving towards a flexible system that proactively responds to ongoing care needs.

Integrated Care Systems

In the recent White Paper, ‘Working together to improve health and social care for all’, the Government set out its ambition for every part of England to be covered by an integrated care system (ICS). Building on work set out in the NHS Long Term Plan, the move towards ICSs will enable different parts of the health and care system to work together more effectively, in a way that will improve outcomes and address inequalities, including for people on probation.

The Community Sentence Treatment Requirement Programme

Through the Community Sentence Treatment Requirement (CSTR) programme, health and justice partners are working to increase the use of Mental Health Treatment Requirements. This aims to screen/assess those with mental health and/or substance misuse needs and associated vulnerabilities with the ambition to increase the use of community treatment orders rather than custodial sentences.

Liaison and Diversion Services

The Liaison and Diversion Programme was created in 2010 following on from the publication of the Bradley Report in 2009. Liaison and Diversion services now cover 100% of England. Liaison and Diversion services place clinical staff at police stations and courts to provide assessments and referrals to treatment and support, including those with mental health needs. Information can then be shared with police and courts (with consent) to inform sentencing and disposal decisions. Offenders may be diverted away from the criminal justice system altogether, or away from custody. This may include diversion into a community sentence with a treatment requirement.

RECONNECT and Enhanced RECONNECT: In England, NHSE are rolling out RECONNECT, a Care After Custody service. This service will support those coming out of prison custody to navigate the complexity of health and social care provision and thus maintain and safeguard health improvements made in custody and thereby improve health outcomes and reduce reoffending.

The Enhanced RECONNECT service (with funding from Health), is currently being co-developed and piloted with MoJ to support the reduction of reoffending of prisoners with complex health needs (that are related to offending) who are released from prison with a high risk of harm to self or others. This service will work with the most complex and high-risk individuals for up to 1 year post release to ensure that they not only engage initially but continue to engage with community based health and support services.

The OPD Pathway

The Offender Personality Disorder (OPD) pathway programme is a cross-government change programme that jointly commissions, designs, co-finances and delivers a connected pathway of services for people in contact with the Criminal Justice System who are high risk, and likely to satisfy the diagnosis of 'personality disorder'. This is a joint responsibility between NHS England and Her Majesty's Prison and Probation Service. The pathway includes delivery of a range of processes and interventions, including case screening, psychological consultancy for Offender Managers, as well as treatment and progression services for people in prison, those in secure mental health services and to those on probation. The pathway incorporates some CSAAP accredited interventions within its range of treatment options, such as Democratic Therapeutic Communities and Mentalisation Based Therapy (MBT). Through delivery of the pathway, the Offender Personality Disorder (OPD) Pathway Programme aims to more effectively manage risk of harmful offending, reduce repeat serious harmful offending, improve psychological health and wellbeing, and improve the competence, confidence and

attitudes of staff working with complex offenders, whilst aiming to increase overall efficiency and cost effectiveness.

B. **Northern Ireland:** PBNI employ a number of Forensic and Clinical Psychologists who provide a dedicated Psychology service across the province. This includes the delivery of regular mental health awareness training to all staff. The content of this training focuses on an awareness of the different types of mental disorders, presentation of associated behaviours, recognising signs and symptoms of mental illness and associated disorders. The training also includes information and awareness on the wide range of medication prescribed to service users as well as potential side effects, an overview of services available both within PBNI and externally across the region e.g., mental health services, community/voluntary sector services. The training contains a practical element of working through case studies and providing guidance to probation staff on a range of approaches to utilise when working with service users who may be experiencing mental health problems, suicidal ideation or engaging in self-injurious behaviour.

C. **Scotland:** The Community Payback Order Practice Guidance (https://www.gov.scot/publications/community-payback-order-practice-guidance/pages/11/) outlines the operation of, and best practice for, Mental Health Treatment Requirements as part of a CPO, for justice social work services.

The Memorandum of Procedure on Restricted Patients – a reference document for those who are involved with the management and care of patients subject to a compulsion order with restriction order, a hospital direction or a transfer for treatment direction; that is, patients who are subject to special restrictions. This is aimed at those working in forensic mental health services. Apart from the growing body of trauma-informed practice training for justice social work services, there is no other specific policies/guidance etc.

Appendix II

The complete survey results for prisons and probation

Method

Design

Two questionnaires were designed by the PC-CP and sent out to the Council of Europe's member states and their jurisdictions. The survey instruments are appended at Appendix A and B. The questionnaires aimed to elicit government policies and practical approaches to mental health disorders in probation services and in prisons. The survey was out in the field for approximately 10 weeks and a number of reminders were sent to non-responders. In the light of the Covid pandemic and the extra work that has been caused a response rate of 63% for prisons and 66% for probation was good (see Table 1 and Figure 1).

Table 1 – Responses

	Prisons	**Probation Services**
Number of Total Returns	Note: Germany sent 10 different responses (out of a possible 16), Spain sent 2 Thus, there was a possibility of 67 'Response Units' Data is reported from 42 out of a possible 67 'response units'	Note: Germany sent 11 different responses (out of a possible 16), Belgium sent 3 and Spain sent 2. The UK sent 3/4. Thus, there was a possibility of 67 'Response Units' Data is reported from 46% out of a possible 67 'response units'
% Overall Response	63%	66%

Data were set up on Excel spread sheets and a full copy of all responses can also be found on the Council of Europe's website at: Mental Illness in Offenders on Probation: Draft Preliminary Survey (coe.int)

Analysis

Simple quantitative analysis was undertaken and mostly yielded percentages although some median values are reported. The qualitative data was analysed in terms in relation to emergent themes. We also sought to ascertain examples of Good Practice. Some follow-up requests were made for further information.

Results

Where possible data for prison and probation services are reported together which allows for simple comparison between the two sectors.

First, the existence (or otherwise) of Government policy was examined (see Table 2 below). In probation there was a fairly even split between countries/jurisdictions supported by Government policy or not. In prisons, the answers indicate that almost all countries/jurisdictions have in place policies at Government Level that regulates the treatment of prisoners with mental health disorders.

All data relating to this question is given at Appendix C.

Table 2 The existence of Government policy for the treatment of prisoners or probationers with mental health disorders.

	Prisons**	**Probation***
'Yes, policy exists	39/42 (92,8%)	17/32 (53%)
No, there is no policy (N/A)	3/42 (8,2%)	15/32 (47%)

*Countries/jurisdictions where Government policy exists in probation include: Austria, Flemish speakers (Belgium), Czech, Finland, Albania, Baden-Wurttemberg (G), Lower Saxony, Malta, Iceland, Italy, Lithuania, Northern Ireland, Portugal, Romania, Spain, Türkiye, England, Scotland

** Countries/jurisdictions where government policy exists in prisons include: Andorra, Austria, Belgium, Bosnia and Herzgovina, Bulgaria, Croatia, Germany (all answers), Greece, Iceland, Italy, Lithuania, Latvia, Luxemburg, Malta, Montenegro, The Netherlands, Portugal, Romania, San Marino, Slovak republic, Spain, Catalonia, Sweden, Switzerland

All relevant Government policies are given in Annex 1.

Probation and mental health awareness training

Table 4 below indicates that only half the proportion of probation staff are given mental health awareness training compared to prisons (37% vs 74%). A number of countries indicated that mental health awareness training was not required, as training for core discipline required to be a probation officer, included mental health. One example of this was in Berlin (Germany) which stated that:

'….only state-certified social workers, special educators and psychologists are employed in the probation service, who already have the necessary knowledge and appropriate awareness of the topic of mental health due to their training. Routine training for employees is therefore not required'

Another theme arising from the qualitative data in this section was the 'non-mandatory' nature of training that was on offer after qualifying as a probation officer (this included: Denmark, Brandenburg (G), Hesse (G), Nordrhein-Westfalen (G), Schelswig-Holstein (G), Scotland and France. In other countries training is either mandatory or part of the initial probation officer training (Austria, England, Malta, Northern Ireland, Romania, and Spain). Some countries described the content of training but only England and France cited 'the prevention of suicide' as an important area to cover. In the Czech Republic the main focus was on drug addiction. Most countries used external training providers apart from Baden-Wurttemberg (G) who used their specialist mental health trained probation staff:

'Probation staff can receive intern or extern trainings. Intern we provide further training on the topic "Clients with mental disorders". Probation officers have also the possibility to take individual supervision. Every of our 9 facilities has a probation officer with special skills in this subject. This specialized probation officer can advise colleagues or organizes trainings'

Finally, several countries mentioned the importance of teaching about commonly prescribed psychotropic drugs and their side effects (Belgium and Northern Ireland).

Table 4 – Receiving mental health awareness training

	Prisons	**Probation Services**
Number receiving training	31	14
No. of Valid responses	42	39
% 'Yes' training received	74%	36%
Range	N/A	N/A

Probation and budgets for mental health services

Very few countries were able to provide details about the budget for mental health service input to probation (see Table 5). By far the greatest majority of countries stated that mental health care was provided by external agencies (health and the voluntary sector) and therefore costs were unknown. The response from Northern Ireland is worth highlighting as forensic psychologists are employed across the service from the probation budget itself.

'There is no dedicated budget for the provision of mental health care for people on probation in N. Ireland. PBNI have employed their own Forensic/ Clinical Psychologists over the years to work directly with and in partnership with probation staff in the management of this complex cohort of individuals. The Psychologists work very closely with the local Health Trusts and Community Forensic Mental Health Teams/ Regional Psychiatric Secure Unit to ensure that service users are able to access appropriate mental health care in the community'

Table 5 – Total budget for mental health expressed for prison/probation population

	Prisons	**Probation Services**
No of valid responses	4	30 (2 valid responses) 27 = unknown

List budgets for all replying countries	450,000 (Iceland); 1,5 Million Euros (Malta); 15,5 Million Euros (The Netherlands); 20 Million Euros (Finland)	1. Hesse (Germany): 668 000 euros 2. Iceland: 450,000 euros

Probation and the prevalence of mental health disorders

The survey response to the question about prevalence of mental health disorders in prisons and probation elicited a highly variable response (see Table 6). The range of prevalence reported in prisons was 0%-80% and in probation 2%-90%. This, despite the fact, that an attempt had been in the questionnaire to define 'mental health disorders' as follows:

'According to the World Health Organisation "Mental disorders include: depression, bipolar disorder, schizophrenia and other psychoses, dementia, and developmental disorders including autism.'

In probation, robust research, based on random samples, indicates that the 40% of probation clients experience a mental health disorder. The median value reported in this survey was 15% clearly an underestimate. In prisons the same variation occurred and then the median value was 18%. We asked countries jurisdictions on what basis the prevalence estimate had been calculated. In probation some estimates were based on research (Ireland, Finland, and Sweden). In other countries the response indicated that probation staff undertook assessments that that aggregated into national administrative data (Belgium, England, the majority of the states in Germany, Hungary, Malta, Northern Ireland, Portugal, Scotland, Slovenia and Türkiye). Only 4 probation services collected prevalence routinely (Catalonia, Northern Ireland and two German states: Berlin and Brandenburg).

Prisons and the prevalence of mental health disorders

From the 26 responses that were analysed, the range has a large variation, and the median value was 18%.

Table 6 – Estimation of Prevalence of mental health disorders in Prisons and Probation

	Prisons	**Probation Services**	**Is data collected routinely?**
No of valid responses	26 (61.9%)	22(52.0%)	3 = yes
List estimates by Country/ Jurisdiction	Andorra- 20%; Armenia- 12%; Bulgaria- 0,36%; Croatia- 10/80%; Czech Republic- 60%; Finland- 65%; France- 6/24%; Greece- 9%; Iceland- 15%; 10%- Lithuania- 10%; Latvia- 38%; Luxemburg- 15%; Malta-	Austria: 2.5% received a forensic order Belgium (French speaking): 30% Belgium (German speaking): 8% Catalonia: 7%	Yes Yes

	20%; Montenegro- 65%; Portugal- 2%; Romania- 16%; San Marino- 0%; Slovenia- 5-13%; Spain- 4%; Spain-Catalonia- 19%; Sweden- 46%; DE- NI- 30%; DE-SH- 20%; England - 78%	Czech: 11.6% Denmark: 50% England: 11% Brandenburg (Germany): 50-60% Hessen (Germany): 15% Niedersachsen (Germany): 20% Nordrhein-Westfalen (Germany): 13% Hungary: 13.55% Iceland: 15% Ireland: 40% Northern Ireland: 65% Portugal: 50-60% Schleswig-Holstein (Germany): 15-25% Thüringen (Germany): 10% Scotland: 70-90% Slovakia: 2% certified Slovenia: 15%	Yes
Range	0%-80% (Median 18%)	2-90% (Median 15%)	

Who provides care and treatment of mental health disorders in probation and prison?

Apart from health services and the voluntary sector very few organisations were involved in the provision of mental healthcare to probationers (see Table 7a and 7b). Probation mostly refers to external service providers apart from in Northern Ireland and Malta. In prisons, most countries rely on the MoJ to provide care inside prison, although in some countries the MoH is performing treatment as well.

Table 7a – Organisations providing mental health care in prisons and probation services

	Prisons	**Probation Services (n=37 valid responses)**
Ministry of Justice	a) 42,8%); b) 73,8%	7 (19%)
Healthcare	a) 14,3%); b) 21 (50%)	32 (86%)
Voluntary sector	b) 4 (9,5%)	10 (28%)
Other	a) 8 (19%); b) 2,3%	8 (22%)

a) Only institution providing mental health care
b) Combined with other institution

For more information about the 'other' category see A5

Table 7b – What is the role of prison/probation services in providing mental health care

	Prison	**Probation**
Valid responses		37
Proving interventions/treatment themselves	35 (83,3%)	5 (14%)
Inviting external services to work on the premises	27 (64,2%)	4 (11%)
Referring people to external services working elsewhere	26 (61,2%)	31 (84%)
Mixture of the above	23 (54,7%)	7 (19%)

Screening tools and probation

Table 8 shows that screening in probation takes place mostly at the court stage and also when people are about to leave prison. The screening tools used vary greatly and are generally used by the experts often pre-court appearance. However, there are two services, which both have in-house psychology teams that use structured screening tools. The probation service in Malta uses such the GAD (for generalised anxiety disorders) and the STAX (suitable for assessment of personality disorder). Whilst the service in Northern Ireland uses the BDI (Beck Depression Inventory) and the PDE (Personality Disorder Examination). Bulgaria makes use of the Hare Psychopathy Checklist, an adapted suicide assessment schedule (PSRAC – Prison Suicide Risk Assessment Schedule) and structured tools to assess the severity of drug and alcohol consumption. In Iceland the Mini-Mental State is employed in order to assess symptoms of mental health. Spain has access to use of the CAGE (Alcohol consumption), the GHQ-28 (anxiety and depression). Otherwise, probation services do not assess mental health disorders themselves although a description of current mental health status and previous contact with mental health services is integrated mostly into routine data collection that seeks to examine risk. Table 8 below shows that most often screening takes place in court or prior to leaving prison.

Table 8 – When does screening take place in probation

	Probation
Valid responses	36
Arrest	15 (42%)
Court	34 (94%)
Prison	31 (86%)
Probation	16 (44%)

Furthermore, that general practitioners are most likely to be undertaking the screening function (see Table 9)

Table 9 – Who usually screens for mental health disorders in prison and probation?

	Prison	**Probation Services**
Valid responses	42	36
Prison Staff	12 (28,5%)	
Probation staff		11 (32%)
Other criminal justice staff	5 (11,9%)	2 (6%)
Nurse	16 (38%)	3 (8%)
General Practitioner	32 (76,2%)	11 (31%)

Screening and Prisons

In prisons structured assessment tools are mainly applied at the initial phase of imprisonment (Intake and Admission) and are conducted at least once a year, either by medical order or by request from the prisoner.

Mostly psychiatrists and psychologists screen the inmates.

Table 10 – When does screening for mental health problems take place in prison

	Prisons
Intake	30 (71,4%)
Admission	34 (80,9%)
Preparation for release	12 (28,5%)
Probation	

Table 11 – How often are prisoners screened for MH problems

	Frequency of Prisoner screening for mental health problems
By request of the prisoner	28 (66,6%)
By medical order	28 (66,6%)
Once a year or less	24 (57,1%)
Every two years or more	28 (66,6%)

Psychiatrist	33 (78,5%)	22 (61%)
Psychologist	35 (83,3%)	22 (61%)
Social Worker	17 (40,4%)	9 (25%)
Other *	1 (2,3%)	7 (19%)

***Others listed include:** Sociologists, teachers, social pedagogues, experts commissioned by courts and judicial authorities, mental health teams working within prison/probation, persons who work in the healthcare services.

Table 12 – Does the prisons in your country/jurisdiction have special units to provide treatment to detainees with psychiatric mental health disorders?

	Prisons
No of valid responses	**42**
% stating 'yes'	29 (69%)

NB Respondents are asked to give examples

Probation and mental health treatment orders

Table 13 below shows that one-third of probation services can obtain orders for the mental health care of clients. Countries where this occurs include: Catalonia, England, France, Berlin (G), Mecklenburg-Vorpommern (G), Northern Ireland, Schleswig-Holstein (G), Scotland and Türkiye.

More than half of the countries mentioned that there are special units with specific resources (including physical conditions) adapted to the needs of prisoners with mental health disorders, for example, Armenia, Austria, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Chech Republic, Denmark, Finland, France, Greece, Italy, Lithuania, Latvia, Luxemburg, Malta, The Netherlands, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Catalonia, Sweden.

Table 13 – Does the service, prison or probation, have any special order/requirements for people with mental health disorders?

	Prison	**Probation services**
No of valid responses	42	38
% stating 'yes'*	26 (61,9%)	12 (32%)

Probation and Suicide Monitoring

In probation services Bulgaria, France, Ireland, and Northern Ireland all say they monitor suicides, but they give no examples of trends. England collects this information nationally and a website address was given (See Table 14 below) as follows: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/981212/Probation_Q4_2020.ods.

Prisons and Suicide Monitoring

In the prison context the rate of affirmative responses regarding the existence of a suicide prevention strategy is very high (90%), which includes not only the suicide prevention programs (Table 15) and a systematic collection of data related to the number of suicides that occur inside prison (Table 14).

Table 14 - Do you collate the number of deaths by suicide nationally?

	Prisons	Probation services
Valid responses	42	38
% stating 'yes'*	38 (90%)	5 (13%)

Table 15 – Is there a prison suicide reduction programme established in your country/jurisdiction

	Prisons
Valid responses	42
% stating there is such a programme	37 (89%)

Prisons and co-operation with the community

Almost 90% (Table 16) of the countries have co-operation with community and some include families (45,2% - Table 17)), in order to prepare the reintegration of offenders.

Table 16 – Do your organisation work in co-operation with the community on resettlement plans?

	Prisons
Valid responses	42
% stating there is such a programme	37 (88%)

Probation and prison work with families

Five countries say that efforts are made to engage with families where this is relevant (see Table 17) including: France; Italy; Spain; Türkiye; Northern Ireland.

Table 17 - Is there specific work with families?

	Prisons	Probation services
Valid responses	42	38
% reporting yes and countries listed	19 (45,2%)	5 out of 38 (13%)

Probation and prison: gender specific approaches

Table 18 below shows that in 27% of services gender-approaches were employed. Three probation services stated that their approach to women with mental health disorders in the criminal justice system was trauma-informed namely Scotland, England and Northern Ireland. In England the CSTR programme is an example of a gender approach to the delivery of mental health treatment requirements in primary care see the link here: Community Sentence Treatment Requirements | London City Hall. In Scotland some local authority social work services are developing specific services for woman involved in the criminal justice system. In

Northern Ireland, 'gender approaches are always considered with a trauma informed lens in terms of appropriate assessment, intervention and treatment pathways.

In France research is being undertaken by SPCS by a team in Lille one aspect of which focuses on women le4aving detention. In the other 6 countries answering this question all made general statements about how important a gender approach was and that it was used in their services.

Table 18 - Is there a gender approach?

	Prisons	**Probation services**
Valid responses	42	38
% reporting yes and countries listed	20 (47%)	10 out of 38 (26%) Belgium (German speaking); Berlin (Germany); Brandenburg (Germany), Hessen (Germany); Iceland; Italy; Türkiye; Northern Ireland; England; Scotland

Gender approaches were specified by nearly half of the prison services (47%). Twenty prison services stated that their approach to women with mental health disorders in the criminal justice system was a practice that they are developing and making investments and that the specific needs of the inmates, independent of their gender, are taken into account when they are placed in a prison facility, and for that matter they have special concerns.

For example, In Finland this individualized assessment and approach is in place in several prison establishments and in Portugal, there is a "Manual of Good Practices" being developed in order to establish and determine the procedures of assessment, placement and individual care for inmates with specific needs in terms of gender identity or other issues related to gender.

Conclusions from the survey findings

Probation:

- There was good response to the survey boosted by the returns of 11/16 German states.
- Half the proportion of probation staff received mental health awareness training compared to prison staff (74% vs 37%)
- Estimates of the prevalence of mental health problems in probation varied from 2% (Slovakia) to 90% (Scotland) with a median of 15%.
- Robust research indicates that the figure is closer to 40% so largely probation services seriously under-estimated the prevalence
- Only 4 jurisdictions collected prevalence data routinely.
- By far the most common model for probation clients to access mental healthcare was through the use of external healthcare agencies (86%), 10% accessed services in the voluntary sector.

- Screening for mental health disorders was most likely to take place in the court (94%) or in prison (86%). Psychiatrists (61%) and psychologists (61%) were mostly involved although GPs were involved in nearly one-third of cases (30%)
- Most probation responses indicated that the role of probation services was to direct probationers to external services (as above). It should be noted that two countries, Malta and Northern Ireland, used an 'in-house' treatment service run by psychologists. England had a one-off initiative for offenders with a personality disorder.
- 12 (32%) countries/jurisdictions had specific treatment orders for mental health. In England, there had been concerted efforts to maximise the use of mental health treatment requirements in the CSTR project.
- 5 (14%) of countries jurisdictions monitor suicide rates in probation (Bulgaria, N Ireland, France and Ireland) but provide no data. England provides a website address showing that probation suicides have been examined for a number of years.
- A small number of probation services work with families (14%) and 27% provide a gender approach to probation which was often trauma-informed.

Prisons:

- Good reaction from members states to the questionnaire (63%).
- Extensive reports with detailed and relevant information about the state of the art in terms of the treatment of prisoners with metal disorders inside prisons.
- Clear increasing investment from member states on the mental health of inmates.
- Training and raising awareness on mental health disorders is provided for all prison staff in the majority of the countries (74%).
- Importance of research on the prevalence of mental health disorders among inmates in order to better acknowledge the specific needs of this population (62% of answers)
- Increasing shared responsibilities between MoJ and MoH in the treatment of inmates with mental disorders (66%).
- Existence of specials units with physical conditions and human resources specialize in the accommodation and care of inmates with mental health disorder and other disabilities (69%).
- Very impressive rate of positive responses to the collection of data related to suicide behaviours (90%).
- As well as the existence of suicidal prevention programs and strategies (89%).
- Good responsive rate referring to the work with the community in resettlement plans.

Appendix III

Collection of good practices

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 1: Examples of good mental health practice in probation by country/jurisdiction

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.
Germany (Baden-Wurttemberg)	Use probation trained mental health specialists in their nine centres for probation
Germany (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
UK (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.
Türkiye	Scope for individual plans and programmes for those in probation identified with mental health disorders
UK (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.
UK (Scotland)	Mandated court orders for mental health treatment

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

Prisons

Table 2: Examples of good mental health practice in prisons by country/jurisdiction

Country/Jurisdiction	**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 disorders.
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.
Slovak 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.