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INTRODUCTION

Whether or not mentally disordered persons 'belong' in prison is a societal question concerning historical, philosophical, political and legal aspects and different countries have developed different approaches to deal with the issue.

Most countries have developed procedures that allow for the diversion of severely mentally disordered individuals from criminal justice to health settings, either based on (lack of) criminal responsibility or need for treatment. For these individuals, secure detention in a forensic mental health institution can be ordered if necessary. Of course this principle does not prevent people from becoming mentally unwell when put in a prison environment, nor does the presence or a history of mental disorder automatically result in diversion to a health setting. On the contrary, the total number of mentally disordered individuals in prisons by far exceeds that in forensic or even general mental health settings (Torrey, Kennard, Eslinger, Lamb & Payle., 2010). This paper concerns prison *psychiatry*. For health issues concerning prisoners more generally please refer to the WPA Position Statement on Prison Public Health (Forrester et al., 2017).

The prevalence of mental disorders in prisoners is high – and much higher than that expected in the general population - as has been robustly demonstrated in a number of surveys. In a systematic review of 109 studies from 24 countries including nearly 34 000 prisoners 3.6% of the men (3.9% of the women) had psychotic illnesses and 10.2% (14.1%) major depression (Fazel & Seewald, 2012). For substance use disorders, based on 24 studies from 10 countries including over 18 000 prisoners, estimates for alcohol abuse or dependence were 26% (20%), and for drug abuse / dependence 30% (50%) (Fazel, Yoon & Hayes, 2017). According to Fazel & Danesh (2002), the prevalence of personality disorders in prison is 65% (42%) based on a review including 62 studies. While most studies on the subject have been conducted in high-income countries, a recent review summarized findings from 23 studies from 13 low-middle-income countries including over 14 000 prisoners. Rates for psychoses were almost twice as high (6.2%) compared to figures in Fazel & Seewald (2012). The prevalence for depression was also higher (16%) while alcohol (3.8%) and substance use disorders (5.1%) had lower prevalences (Baranyi, Scholl, Fazel, Patel, Priebe and Mundt, 2019).

The increased risk of suicide in prisoners is of particular concern and is the leading cause of death in penal institutions, especially during the early stage of confinement (e. g. pretrial detention). Suicide rates per 100 000 prisoners have been found to range from 23 to 180 in a review of 24 studies from high income, 3 to 9 times higher than rates for the same sex and similar age in the general population (Fazel, Ramesh & Hawton, 2017). The most commonly used method is hanging.

HUMAN RIGHTS AND ETHICS

There are numerous ethical challenges within prison psychiatry, e. g. relating to consent to treatment, compulsory treatment, means of restraint and confidentiality. In navigating these issues, practitioners need to be guided by the general principles of medical ethics: respect for autonomy, beneficence, non-maleficence and justice.

The United Nations International Resolutions (esp. Standard minimum rules for the treatmentof prisoners), the Council of Europe (esp. Recommendation No R (98) 7 on the Ethical and organizational aspects of health care in prison), the World Medical Association (esp. Declaration of Tokyo 1975), the World Psychiatric Association (esp. Declaration of Hawaii1977) as well as the Oath of Athens (International Council of Prison Medical Services) highlight respect for the dignity and value of all people, including prisoners, free from torture and other cruel, inhuman or degrading treatment but lack more detailed guidance on dealing with mentally disordered prisoners.

SERVICE PROVISION

The Nelson Mandela Rules clearly describe the principle of equivalence, meaning that "prisoners should enjoy the same standards of healthcare that are available in the community", as has also been mandated by the European Convention on Human Rights and other international charters. While this principle is generally accepted in most countries, the practical implementation might lag behind. In addition, some authors have pointed out that even equivalent mental health care is not sufficient to meet the complex needs of prisoners and therefore promote the application of a person's right to health that is available, accessible, acceptable and of good quality (AAAQ, Exworthy, Samele, Urquía & Forrester, 2012).

Imprisonment can exacerbate mental health problems due to the psychosocial stress associated with being imprisoned and conditions in prison (e. g. overcrowding). Mentally disordered individuals in particular are also at risk of being victimized further contributing to an increase or exacerbationof mental health problems. Furthermore, human rights violations occur in prison (e. g. prolonged solitary confinement, capital punishment, torture to gain confessions) further contributing to poor mental health. Prison mental health services offer the opportunity of identifying and treating acute and chronic mental disorders at all levels of severity.

GUIDANCE

The Section Forensic Psychiatry of the World Psychiatric Association has developed guidance for prison mental health care as follows[1]:

1. Planning of prison mental health services needs to consider contextual issues (e. g. legal, resources), cultural diversity and the existing model of mental health care. The Nelson Mandela rules have to be respected.

[1] While this paper is concerned with prison psychiatry, one needs to also be mindful of individuals in police custody to whom the basic principles of respect and access to health care should also apply.

2. Prison mental health services need to be resourced and staffed appropriately to meet the needs of prisoners. All staff need to have appropriate training, including in cultural awareness. In addition non-clinical staff, such as prison officers, etc. need to be trained in mental health issues. Countries with shortages in mental health care staff can consider basic training for non-specialised staff according to WHO materials (mhGAP Intervention Guide www.who.int./publications/i/item/9789241549790).

3. Mental health staff has to be independent from the prison administration. Health care staff must not be involved in decisions about disciplinary sanctions, punishment, torture, inhuman or degrading treatment of prisoners.

4. The high prevalence of mental disorders calls for the use of routine application of standardized diagnostic screening instruments as a component of the admission procedure in prison, including screening for suicide risk.

5. In accordance with the principle of equivalence, every prisoner suffering from a mental disorder should receive appropriate treatment equal to the care that such a patient would receive were they not in prison.

6. In-prison treatment has to be patient-centered addressing the specific problems and circumstances, including post-release services, based on individual assessment and case formulation.

7. Individuals should not be excluded from accessing such treatment on the basis of specific diagnoses or behaviour associated with their diagnoses, e.g. personality disorders or substance use disorders.

8. Special attention needs to be paid to the needs of vulnerable populations, such as older adults, young offenders, female offenders, LGBTQ+ individuals, refugees, individuals without the legal right to remain in the country, those with cognitive problems, with poor language skills of the local language and sex offenders.

9. Where medically indicated, prisoners suffering from serious mental disorders should be cared for in a hospital facility which is adequately equipped and provides appropriately trained staff. This may be a facility within prison or an outside hospital.

10. Treatment of mentally disordered prisoners needs to include all components of modern, evidence-based mental health care services in a multidisciplinary team comprising psychiatrists, psychologists, psychotherapists, nurses, social workers and occupational therapists. Patients should have access to pharmacological and psychological interventions, including treatment for substance use disorders, as required. Meaningful daily activities and sports should be available. Milieu therapy is an important component of in-patient treatment for mentally disordered offenders, therefore patients' cells should not be locked for more than during sleeping hours at night.

11. The treatment of substance use disorders should include the pharmacological management of withdrawal symptoms as well as methadone maintenance or opiate substitution treatment, where indicated.

12. . Consent to medical treatment should be sought from all patients suffering from a mental disorder who have capacity to consent following the same principles applied to patients not incarcerated. The only exception is in an emergency when the patient is incapable of giving consent.

13. The decision of patients who have capacity to consent but decline treatment after receiving full, detailed information has to be respected. Those lacking capacity need to be supported in their decision making taking into account prior statements where appropriate. These processes require external oversight to safeguard the human rights of individuals.

14. Practitioners need to be mindful of the possibility that treatment refusal may result from a conflict relating to non-medical issues; this is particularly the case when a prisoner goes on hunger strike to protest against a judicial or administrative decision. In this type of situation, the doctor has to assess the state of health of a person on an ongoing basis and record their capacity and treatment decisions. The duty of the psychiatrist, in this case, is to assess accurately if the hunger strike is related to a psychiatric disorder.

15. Clarity of roles in prison psychiatry is crucial for practitioners. Cooperation between the different professionals dealing with the prisoner is necessary and benefits both staff and patients. If, however, confidentiality is not respected, the patient-physician relationship will be at risk. In case of unavoidable disclosure the patient should be informed about the disclosure and the reasons for it.

16. In those cases where the use of segregation of mentally disordered patients cannot be avoided, it should be the last resort, used only for as long as strictly necessary and be replaced with continuous nursing care where appropriate as soon as possible. During segregation frequent human contact (with staff as well as significant others) should be ensured. Activities, including fresh air, should be offered.

17. Follow-up treatment for released prisoners should be provided for by appropriate community services. It is essential that the prison mental health team has ample notice of the forthcoming release of the patient in order that they may arrange a comprehensive package of psychosocial services to maintain mental well-being and mitigate the risk of re-offending. It should be ensured that all necessary documentation is dispatched to the providers of such services with the full consent of the patient.

18. In many countries prison mental health services will need continuous further development. Countries might want to utilise the WHO Prison Health Framework (PHF, The WHO prison health framework a framework for assessment of prison health system performance) which provides a framework to monitor and measure healthcare delivery in a standardized way.

19. Research, education and training in prison settings have been hardly developed in most countries despite an increase in the interest in this topic. University departments should step up their effort to instigate research and education in the field of prison psychiatry. Relevant topics should be included in the training of mental health professionals. These issues require support by the state in addition to independent funding.

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