Cross-sectoral awareness building on mental health needs in the criminal justice system and on release

(2018-1-DE02-KA204-005144)

O1 - State of the Art and Existing Practices Review

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Index of abreviations and acronyms

ADC – Adverse Childhood Experiences

ADHD – Attention Deficit Hyperactivity Disorder

AIDS – Acquired Immune Deficiency Syndrome

APA – American Psychiatric Association

APD – Antisocial Personality Disorder

BAME – Black, Asian And Minority Ethnic

BDI – Beck Depression Inventory

BPD – Borderline Personality Disorder

CBT – Cognitive-Behavioural Therapy

CIT – Crisis Intervention Team

DIS – Diagnostic Interview Schedule

DSM-V – Diagnostic and Statistical Manual of Mental Disorders – 5th Edition

e.g. – Exempli gratia (for example)

FFT – Functional Family Therapy

GAD – Generalised Anxiety Disorder

HIV – Human Immunodeficiency Virus

i.e. – Id est (that is)

IASP – International Association for Suicide Prevention

ICRC – International Committee of the Red Cross

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ICT – Integrated Co-Occurring Treatment

LGBTQ+ – Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, And Asexual People

LSI-R – Level of Service Inventory–Revised

m-ADM – Maintaining Antidepressant Medication

MBCT – Mindfulness-Based Cognitive Therapy

MST – Multisystemic Therapy

MTFC – Multidimensional Treatment Foster Care

NGO – Non-Governmental Organisation

NHS – National Health Service

NMHA – National Mental Health Association

PIPS – Integrated Programme for Suicide Prevention

PPD – Paranoid Personality Disorders

PPO – Prisons and Probation Ombudsman

PTSD – Post-Traumatic Stress Disorder

PRI – Penal Reform International

SCAN – Schedules for Clinical Assessment in Neuropsychiatry

SAD – Social Anxiety Disorder

STD – Sexually Transmitted Diseases

SUD – Substance Use Disorders

UK – United Kingdom

UN – United Nations

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UNODC – United Nations Office on Drugs and Crime

USA – United States of America

WHO – World Health Organisation

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1. Introduction

AWARE Project aims to raise a cross-sectoral awareness on mental health needs in the criminal justice system and on release and adopts an integrated response to non-discrimination and social integration of those who suffer the double challenge and stigma of both a criminal record and mental health problems. Given this, AWARE's first objective is to generate awareness on the current reality of mental health problems amongst offenders (both in the prison and probation context) and to provide an understanding of the main barriers and challenges to the provision of mental health treatment/support in these contexts which, inevitably, have an impact on effective rehabilitation and successful social and vocational re-inclusion into society. Considering that AWARE Project seeks to deliver tools for practitioners to have a greater critical and productive thinking around the complex issues of offenders with this double stigma, it is also crucial to explore and identify the existing tools and good practices for the support of offenders with mental health needs that have a successful impact on their social and vocational reintegration.

Therefore, the present document consists on a state-of-the-art analysis and best practices review in the field of mental health problems needs in the prison and probation contexts. Theoretical literature will be reviewed on the topics of mental healthcare within the Criminal Justice System and descriptive data and good practices will be mapped and analysed.

In order to analyse the different factors that are involved with the prevalence of mental health problems inside prison and to reflect on the facts and figures regarding this topic, the present document follows a structure divided into sections. Therefore, Section 2 presents the existing procedures and services that are in place which enable prisoners' access to mental healthcare and the main barriers they may encounter to access these services. Section 2 also highlights the facts and figures around the number of prisoners who are imprisoned with existing mental health problems prior to incarceration and the multiple factors linked to life inside prison which can be associated to the onset or

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aggravation of mental illness. Section 3 describes how prisoners' mental health needs are screened and assessed and explores these procedures as good practice inside prison. Section 4 focus on the prevalence of mental health problems among prisoners, exploring the most common mental health disorders within this context. Section 5 addresses the topic of prisoners' suicide and self-harm behaviours and provides an overview of the current reality in Europe and in the Project partner countries. Moreover, Section 5 presents multiple risk factors for this phenomenon inside prison and presents successful and effective suicide prevention programmes. Section 6 addresses the topic of co-existing mental health and substance misuse problems as a raising concern inside prisons and Section 7 explores the links between adverse childhood experiences and mental health problems. Section 8 describes the different mental health needs associated with vulnerable groups of prisoners. Section 9 focuses on the three distinct levels of care and Section 10 addresses the various challenges and barriers to mental healthcare provision inside prison. Section 11 addresses the importance of having an integrated and multidisciplinary approach to mental healthcare in prisons. Section 12 explores the different roles of prison staff regarding mental health promotion and provision and Section 13 presents some considerations around resettlement and aftercare. Finally, Section 14 closes the document presenting a conclusion about the main current problems and good practice regarding mental health provision in prisons.

The different subjects approached by this project, such as mental health disorders, self-harm and suicide, comorbidity, vulnerable groups, among others, represent some of the most currently challenging issues for both prison and general populations.

As the concept of health does not only refers to physical health, the World Health Organisation (WHO) included mental well-being, as well, in its definition of health which says that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2014, p. 1). More specifically, WHO describes mental health as "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and

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fruitfully, and is able to make a contribution to his or her community" (WHO, 2004, p. 10), which means that mental health can be defined as a state of complete mental well-being, and not merely the absence of a mental health problems. In fact, the prevalence of mental health problems among the worldwide population is high and in 2015 depression affected 4.4% of the world population, with more than 40 million people suffering from depression only in Europe (WHO, 2017).

In fact, the importance that the concept of well-being has for someone's physical and mental health has been increasing overtime when talking about general health. The assessment someone does regarding their own health status influences his/her assessment of quality of life. According with Steptoe, Deaton and Stone (2015), well-being, while a psychological construct, covers different aspects such as:

1) Life assessment – the assessment a person does regarding his/her overall satisfaction of quality of life;

2) Hedonic well-being – refers to the feelings and moods someone experiences, such as happiness, sadness, anger, stress, among others;

3) Eudemonic well-being – refers to the meaning and purpose of one's life or the judgement people make about these aspects.

Considering this, it is understandable why the authors reinforce the protective aspect of psychological well-being, since a person's overall satisfaction with life, feelings and the judgement about their own lives are important to their health and mental health status (Steptoe, Deaton, & Stone, 2015).

The terminology used to refer to mental health problems can vary greatly. Terms which can be used to refer to mental health problems are, mental illness, mental distress, mental health disorders, among others. Moreover, just like physical illnesses, mental illness can vary significantly in the symptoms (WHO, 2004).

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Although many other approaches can still be understood as valid, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, commonly known as DSM-V, represents the latest scientific thinking in both criteria content and organisational structure of mental disorders. DSM is the manual used by both clinicians and researchers to diagnose and classify mental disorders. The disorders listed in the DSM-V are:

- Neurodevelopmental Disorders;
- Schizophrenia Spectrum and Other Psychotic Disorders;
- Bipolar and Related Disorders;
- Depressive Disorders;
- Anxiety Disorders;
- Obsessive-Compulsive and Related Disorders;
- Trauma- and Stressor-Related Disorders;
- Dissociative Disorders;
- Somatic Symptom Disorders;
- Feeding and Eating Disorders;
- Elimination Disorders;
- Sleep-Wake Disorders;
- Sexual Dysfunctions;
- Gender Dysphoria;
- Disruptive, Impulse Control and Conduct Disorders;
- Substance-related and Addictive Disorders;
- Neurocognitive Disorders;
- Personality Disorders;
- Paraphilic Disorders;
- Other Mental Disorders.

When it comes to mental health and the prison context, over 10.35 million people are incarcerated worldwide, of which half suffer from a daily struggle with personality disorders. According to WHO, approximately one million prisoners experience

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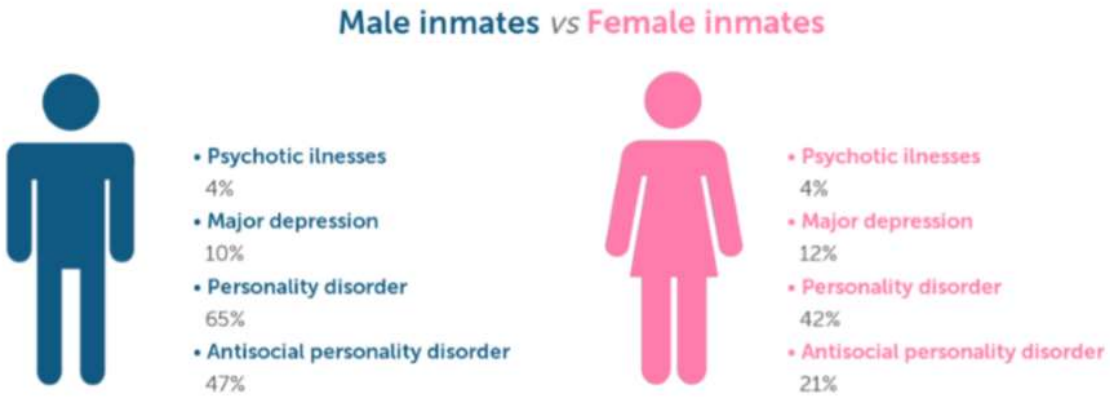
depression or psychosis, while almost all have symptoms of depression. In fact, it has been found that one in seven prisoners suffers from major depression or psychosis (Blaauw & van Marle, 2007).



As empirical data consistently shows, prisoners present higher rates of mental illness when compared to the general population (Durcan & Zwemstra, 2014). About 4% of both male and female imprisoned have psychotic illnesses. In addition, 10% of male inmates struggle with a major depression, and 47% have an antisocial personality out of a total of 65% with personality disorders. On the other hand, 12% of female prisoners show signs of having a major depression, while 21% have an antisocial personality disorder (APD), out of the whole 42% that are diagnosed with personality disorders. (Fazel & Danesh, 2002). Moreover, emotional disorders rates can vary greatly according to the stage of imprisonment. For example, on the first week of imprisonment, where the prisoner is struggling with the new reality and environment, emotional disorders can be prevalent in almost 90%, whereas after 6 months, less than half of the prisoners show those kind of emotional problems (Moreira & Gonçalves, 2010). Adding to this, it is also concerning the high numbers of imprisoned people that take their own lives whilst in prison. In fact, it has been noted that several thousands of prisoners kill themselves each year. Despite all this, WHO recommends that prisons need to provide opportunities for prisoners to be receive support and to work towards personal development, without harming themselves or others (Blaauw & van Marle, 2007).

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2. Mental Health

2.1. Prisoners' access to mental healthcare in prison

Unfortunately, it is commonly noted that mentally ill prisoners do not receive any kind of treatment before arriving at prison and some countries tend to see these custodial contexts as the only answer to the problem. In other words, imprisonment can be seen as a result of mental ill-health. As so, "people with mental health conditions who have not committed a crime, or who have committed a minor offence, are sent to prison rather than given appropriate care" **(**Penal Reform International [PRI], 2018, p. 10).

In fact, the Mandela Rules [Mandela Rule 109 (3)] alert to this fact, stating that "People with severe mental health conditions should never be held in prisons, and there is an absolute prohibition of detention on the basis of impairment. In cases where they are detained, accommodation should, at a minimum, be in facilities with appropriate specialised treatment, in units supervised by healthcare staff". (PRI, 2018, p. 11)

Similarly, the UN Tokyo Rules mention that "Those with less severe mental health conditions should be diverted away from the criminal justice system where appropriate. If diversion is not possible, sentencing alternatives should be considered, in consultation with mental health professionals. Prison should only be used as a pre-trial measure or sanction as a last resort, particularly given the negative impact it has on mental well-being" [UN Tokyo Rules, Rule 6] (PRI, 2018, p. 11).

Considering this and the fact that mentally ill individuals can inevitably and unfortunately end up inside prison, it is understandable that the demand for the provision of mental health services in correctional settings is high, as found by Fleming, Gately, and Kraemer (2012). Their results, from a survey with 146 inmates in Western Australia, showed that 54% of the sample had previously received treatment for an emotional or mental health

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problem (defined as any psychological concern or disorder resulting in the attendance to a medical professional - doctor, nurse, psychiatrist, or psychologist).

Regarding the challenges prisoners might encounter when trying to access healthcare services (including mental health), Rule 25, point 1, states that "Every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation." (United Nations [UN] General Assembly, 2015, p. 12). Indeed, if a prisoner requires specialised mental healthcare that cannot be provided in prison, he or she has the right to be transferred to a hospital under custody, or to a prison hospital – where care can be provided in a secure environment (Blaauw & van Marle, 2007). However, not all inmates with mental disorders need psychiatric treatment. According to different research findings, only 6-12% of the prison population require transfer for further assessment and specialised treatment. Most prisoners (40 to 60%) would gain from mental health promotion activities, while 30 to 50% would require some assistance from healthcare services (Blaauw, Roesch & Kerkhof, 2000).

The high demand for the provision of specialised and non-specialised mental healthcare challenges the capacity of prisons to guarantee the right to equal care, considering that the ratio between prisoners and available nurses/physicians needs to be much higher when compared with the same ratio in the non-incarcerated population. In other words, standards of prison healthcare, equivalent to the ones available in the community, can be scarce when addressing human rights obligations and public health needs (Lines, 2006). In fact, when considering the issues of prison healthcare, often the principle of equivalence of care is denoted, highlighting the importance of prison services aspiring to provide the same level and quality of the basic health services as in the community, including mental healthcare (Blaauw & van Marle, 2007). This principle might be attained

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through different means, including, prison health staff training on mental health; regular visits from a community mental health team or access to healthcare services outside prison (WHO & International Committee of the Red Cross [ICRC], 2005).

The multiple vulnerabilities and risk factors that place prisoners in great need for both physical and mental health services, illustrate the need to involve frontline staff in the process. As argued by Dvoskin and Spiers (2004), correctional frontline staff, even without adequate training, perform "the very difficult role of therapeutic agent, which is often exclusively ascribed to mental health professionals" (p. 56). Considering the vital role this group of staff performs, the authors suggest four specific action regarding mental health provision that have into consideration the involvement of these professionals:

1) "Counselling and psychotherapy, using multidisciplinary treatment teams that include correctional officers who are crucial considering their daily contact with prisoners;

2) Consultation between correctional and clinical staff – talking about prisoners and sharing their observations;

3) Special housing (place mental ill inmates in one location to centralise supervision and treatment services), activities, and behavioural programmes, and;

4) Medication – frontline staff can guarantee appropriate medication intake." (Esgalhado, Pereira, Cunha, Castelo, & Costa, n.d., p. 12).

2.2. Prisoners arrive with existing mental health problems

After trial, several prisoners arrive in prison with previously detected mental health conditions, importing them to a whole new context that often contributes to their exacerbation. In fact, while prisoners' mental health can suffer a deterioration due to prison conditions (as explained in the next chapter), mental health problems can also be

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seen as a risk factor that increases the likelihood of being imprisoned (Lamb & Weinberger, 1998).

Actually, in some countries, people with severe mental disorders are inappropriately locked up in prisons simply because of the lack of mental health services. People with substance misuse disorders or people who, at least in part due to a mental disorder, have committed minor offences are often sent to prison rather than treated for their disorder. These disorders, therefore, continue to go unnoticed, undiagnosed and untreated – and might escalate due to the above-mentioned factors (Fazel & Danesh, 2002).

As mentioned previously, a key principle that applies to all prisoners' worldwide states that incarcerated individuals "are entitled to receive the same quality of medical care that is available in the community" (United Nations Office on Drugs and Crime [UNODC], 2009, p. 13). However, there is a big gap between the standards that prisons systems should embrace and the actual reality of the healthcare services provided. This inadequacy occurs since "prison health services are far too often severely under-funded and understaffed" (UNODC, 2009, p. 13), which result in practices relying solely on medications to manage mental disabilities and its symptoms. Consequently, the inter-disciplinary care and treatment of mental disabilities' supervision end up being neglected.

Besides the principle of equivalence of healthcare, mental healthcare within prison settings should also encompass the provision of mental healthcare resources. Nevertheless, most prisons throughout the world are also "unable to provide any treatment for mental disabilities at all" (UNODC, 2009, p. 13). In addition, individuals who arrive at prison with existing mental health problems are not identified when entering correctional facilities, being left untreated in an environment that can be quite noxious to their psychological well-being. In addition, it is unusual that prisoners' medical files accompany them when transferences between prisons occur, which jeopardises any kind of treatment or medication that was underway (UNODC, 2009).

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Individualised care is the ideal standard when providing effective mental healthcare services and mental health screenings on inmates' arrival to prison, and it should comprise a mental health assessment in order to identify the presence of mental disabilities. As so, the early identification and diagnosis of mental disorders, as well as the provision of timely and appropriate treatment, are vital to reduce the possibilities of aggravating any existing mental health problems into more serious and difficult to manage disorders (UNODC, 2009).

2.3. Imprisonment causes and exacerbates mental health problems

According to WHO, inmates represent a group that are "at a significantly higher risk of experiencing mental health problems" (WHO, 2013, p. 3). As we just explored above, many people come into prison with mental health disorders they were already experiencing in the community. However, in other cases, prisoners without mental health problems end up developing mental issues during their time in prison due to a wide range of factors that they encounter in the correctional context, often associated with the deprivation of liberty and other special factors (Blaauw & van Marle, 2007, p. 133).

Imprisonment can be the cause for the emerging of mental disorders but, for the cases where people come into these contexts with already existing mental health problems, prison, and its unique singularities, can often be a contributing factor for the aggravation of such mental conditions. In fact, the UNODC (2009), has emphasised how prisoners with existing mental problems are at "further risk of acute mental harm. They have fewer resources with which to cope in an environment lacking in privacy, often tense and sometimes violent" (p. 13). Consequently, such risk is higher in tendentiously depressive prisoners, who may become suicidal and psychotic due to the increased emotional deterioration they experience inside prison.

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Therefore, there is a diverse range of factors that negatively affect mental health in prisons. Lack of privacy and deprivation of liberty affect the freedom to make multiple choices such as, where they want to live and whom they wish to associate with. It also affects the personal space and frequency with which they communicate with family and friends, that interestingly is a well-known protective factor for prisoners' mental health and successful reintegration into society (Bobbitt & Nelson, 2004; Campbell & Abbott, 2013). Other factors that often emerge in prisons and that have negative impacts on mental health include, overcrowding, various forms of violence and aggression (physical, verbal, sexual, racial, bullying, discrimination, etc.), enforced solitude, isolation from social networks, lack of meaningful activities, dirty and depressing environments, poor food, lack of or inadequate hygiene and healthcare, availability of illegal drugs, inadequate prison health services, especially mental health-related ones, among others (Blaauw & van Marle, 2007). In fact, prison overcrowding is one of the frequently mentioned factors that affect prisoners' mental health (Huey & McNulty, 2005), considering that prisoners who live in more crowded environments tend to experience greater anxiety and depression (Wooldredge, Griffin, & Pratt, 2001).

Although the prison environment in itself might contribute to the exacerbation of prisoners' mental health conditions, there are particular times or situations that can significantly affect their mental stability. These times and situations should be considered as warning signs/red flags. Prison staff need to be aware of these situations so they can respond adequately and prevent not only the deterioration of prisoners' mental health condition but also the possibility of self-harm or suicidal behaviours (PRI, 2018). In fact, the risk prisoners pose to themselves and others changes over time, as a response to the context and to certain events. Additionally, since prisoners tend to hide their distress from staff and other prisoners, it is important for prison staff to gain awareness and knowledge regarding these particular situations (Prisons and Probation Ombudsman [PPO], 2014). These times and situations of heightened risk can be grouped into three categories: personal factors, criminal justice-related factors and prison life-related factors (PRI, 2018).

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Personal factors can include, learning about the illness or death of a family member or close friend; intimate relationship problems, such as the end of a relationship or gaining information about a partners' infidelity; family problems or concerns about family; major public or religious holidays, such as the Christmas period; receiving a medical diagnosis that carries bad news; worries about financial or debt issues; worries and concerns over release; going through a withdrawal period from drugs or alcohol; and coming to an end of a support programme (Durcan & Zwemstra, 2014; P, 2018). Moreover, anxiety and insecurity about future prospects (work, relationships, etc.) and feelings of guilt or shame about the offences they have committed are also personal factors which have negative impacts on prisoners' mental health (Blaauw & van Marle, 2007).

Criminal justice-related factors include, the pre-trial detention period (research shows that remand prisoners are a vulnerable group and the remand period is a risk factor of suicide); court appearance or court decisions; adjudication hearing resulting from poor behaviour; learning about the decision of prison transfer; and the pre-release period (PRI, 2018).

Finally, prison-life related factors include, being moved to a segregation unit; being subject to disciplinary measures; being subject to the use of restraints or force; worsening of prison's physical conditions; being victim of bullying, harassment or violence, including sexual abuse; incompatibility with cell-mates; and exposure to any situation that triggers the re-experience of traumatic or stressful events (Durcan & Zwemstra, 2014; PRI, 2018).

"The cumulative effect of all these factors, left unchecked, is to worsen the mental health of prisoners and to increase the likelihood of incidents damaging to the well-being of prisoners and staff, as well as to good order and security, such as displays of aggression, bullying, mobbing, suicide attempts and self-harm" (Blaauw & van Marle, 2007, p. 134). Therefore, when prison staff are aware that one or more of the above-mentioned times

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and situations have had an impact on prisoners' behaviours/emotions - putting them in need of extra support - they need to be alert, monitor the prisoner's behaviours and communicate, if appropriate, the identified concerns to the healthcare staff. This will enable prison staff to secure prisoners' well-being, as well as the good order, security and safety of the prison environment by implementing an effective multidisciplinary teamwork approach (Blaauw & van Marle, 2007).

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3. Screening and assessment of prisoners' mental health needs

Research has highlighted the importance and need for screening and assessment of mental health problems among prisoners and according to the UN Nelson Mandela Rules and the Bangkok Rules, this is a required process that should be implemented in prisons (PRI, 2018; Gonzalez & Connell, 2014). In fact, many mental health disorders symptoms may be less easy to detect and identify when compared with physical health problems, especially if prisoners are not assessed by trained mental health professionals. A report on mental healthcare in prison from the National Institute of Corrections of the United States of America (USA) Department of Justice (Hills, Siegfried & Ickowitz, 2004) highlighted that, not only due to legal reasons but also due to humanitarian ones, there is a clear need to implement screening procedures of prisoners' mental health needs.

In order to provide adequate support and treatment to prisoners with mental health impairments, the first step should be the identification of their needs. In 2008, Durcan conducted in-depth interviews with both prisoners and staff and he found that meeting needs such as, access to housing, employment and substance misuse support were considered by the prisoners as the priorities when it comes to improve their mental health. Contrarily, staff considered that medication and psychological therapy should be the focus in order to support mentally ill prisoners. This study emphasised how important it is not only to screen and assess prisoners' mental health but also to conduct a more generic needs assessment given that prisoners mental well-being is impacted by a multitude of factors which need to be adequately addressed by the appropriate services.

Symptoms of mental health problems can be very difficult to detect, especially considering that symptoms such as challenging behaviour, manipulation, irritability, and others, can be seen by prison staff more as a behavioural issue rather than a problem associated with mental illness (PPO, 2016). Therefore, through the initial screening and assessment of newly arrived inmates, prison staff are able to detect the existence of mental health problems and identify the inherent risk factors. This allows for the

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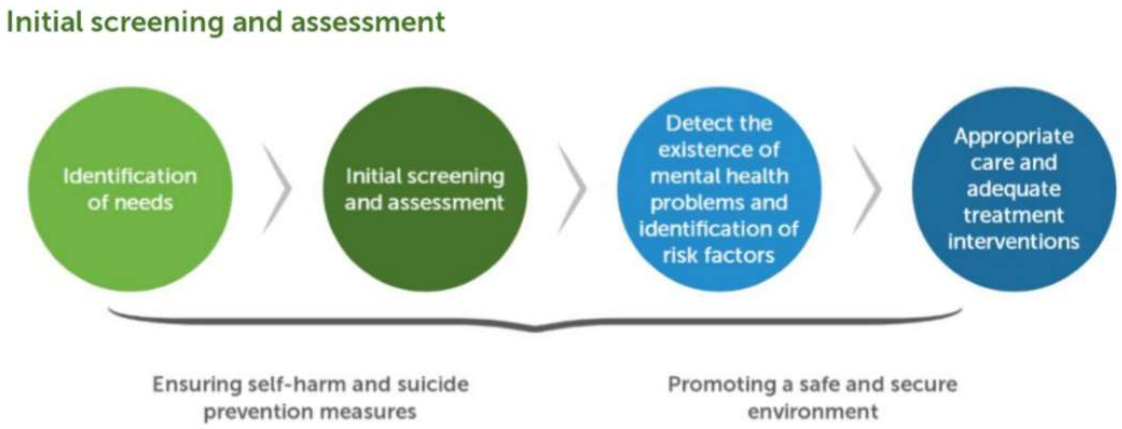
appropriate care to be provided and ensures that staff are putting self-harm and suicide prevention measures into place (PRI, 2018; PPO, 2014).

Initial screening and assessment of mental health problems ensures that, if needed, adequate treatment interventions will be delivered, while guaranteeing a safe and secure environment for inmates and prison staff. Since prisoners tend to struggle on getting used to the prison environment, support to cope with such difficulties during the initial days of imprisonment should be provided. This puts an emphasis on the need for a comprehensive initial screening and assessment of both needs and risks, which will allow prisoners to disclose their worries and problems (PRI, 2018; PPO, 2016).



As so, there are several reasons that support mental health screening and assessment as important and good practice procedures (PRI, 2018; PPO, 2016; PPO, 2014), such as:

1) Arriving at prison can cause anxiety for many prisoners. The prison induction period can often be the time where most prisoners experience distress. Unsurprisingly, individuals coming into prison for the first time can experience several negative emotions associated with the uncertainty of being in a new and strange environment;

2) Research shows that the remand period is a risk factor for suicide (Konrad et al., 2007), making the initial assessment of remand prisoners' risk factors absolutely crucial;

3) Separation from family and support systems that existed in the community can be stressful for prisoners;

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4) Prisoners might come into prison suffering from substance withdrawal symptoms, which has been identified as a suicidal risk factor;

5) Prior to imprisonment, prisoners had a life in the community and having limited access to what is happening outside might cause different problems to prisoners which can have a significant impact on their mental health. Some common worries prisoners present during their initial days are related to:

a. Accommodation needs. Homes might have been left unsecured or they might have lost a place to live due to being evicted;

b. Health issues. Prisoners might be taking prescribed medication that they do not possess when arriving in prison;

c. Worries about the safety or well-being of family members. Prisoners with primary care responsibilities for family members can experience anxiety given their current situation.

Initial screening and assessment are strongly recommended procedures by WHO (Durcan & Zwemstra, 2014), which should be carried out by healthcare staff or, if adequately trained, prison staff.

Both of these procedures are a great opportunity not only to look for signs of mental-ill health, but also to collect information regarding the prisoner's background. By having these procedures in place, prison staff are able to identify key risk factors and relevant information that can reflect the existence of mental illness or lead to the development of mental health problems. Additionally, there are some factors that need to be taken into consideration when assessing the level of risk for suicidal tendencies (Durcan & Zwemstra, 2014; PPO, 2014). Thus, some of these risk factors are:

- Previous self-harm behaviours/suicide attempts or suicidal ideation;
- Learning disabilities or difficulties;
- History of violence and abuse in the family;
- History of head injury or signs of possible head injury;

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- History of traumatic experiences, such as adverse childhood experiences or sexual abuse;
- History of substance misuse or history of substance misuse in the family;
- Previous diagnosis of mental health disorders or signs of poor mental health in the past;
- History of mental illness in the family;
- History of suicide in the family.

While staff need to be trained to identify mental illness among prisoners, prison management must ensure that adequate support and treatment interventions are available and provided (Durcan & Zwemstra, 2014; Coyle, 2007). Moreover, according to a report from the Prison and Probation Ombudsman (2016) in England and Wales, it is amongst prison staff's responsibilities to make a mental health referral to the specialised treatment services any time they have concerns regarding a prisoner's mental health.

Since prison staff have daily contact with prisoners, they are more likely to notice changes in prisoners' behaviours, attitudes and emotional stability, which can be related with symptoms of existing or developing mental health problems. In order to provide the best care and support possible, it is important that, firstly, the process for making a mental health referral is clear and that staff can easily understand it by following the appropriate required actions, providing the basis for an adequate follow-up. Secondly, it is crucial that prison staff have effective multidisciplinary teamwork procedures in place (PPO, 2016).

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4. Prevalence of mental health problems among prisoners

4.1. Depression

Depression can be characterised as "a mood disorder involving emotional, motivational, behavioural, physical and cognitive symptoms" (p. 196). People who suffer from depression often experience negative emotions and are described as "sad, hopeless, miserable, dejected and discouraged" (p. 197). Loss of motivation and loss of interest towards routinely activities and behavioural manifestations like slowness (including slow speech) are also commonly observed among depressed individuals. Sleep problems such as insomnia or hypersomnia are also commonly reported symptoms, and a negative view regarding self, the world, and the future are also typical symptoms of depression (Davey, 2014).

According to DSM-V, there are different depressive disorders that differ mainly in terms of "duration, timing, or presumed etiology" (p. 155). The depressive disorders characterised in DSM-V are "disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder" (p. 155). Moreover, the "common feature of all of these disorders is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function" (p. 155).

Depression is considered as a common mental disorder by WHO. A recent report, with latest available estimates from 2015, shows that 322 million people live with depression (4,4% of the world population) and the situation is even worse in older adulthood (above 7.5%/5.5% among females/males aged 55-74 years) (WHO, 2017).

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Depression is a mood disorder that influences how people relate with others and with their environment. Inmates suffering from depression can experience feelings of worthlessness and lose interest and motivation in things they used to enjoy. Thoughts of death and suicidal ideation are two common symptoms of major depression. Additionally, it causes not only emotional instability, but also somatic problems as mentioned above, such as chronic pain (PRI, 2018; Gonzalez & Connell, 2014). Unfortunately, since emotional instability and loss of interest and motivation are common among prisoners when they first arrive in prison, prison staff might often fail to identify these as symptoms of mental health problems (Binswanger et al., 2012). Other symptoms associated with major depression are, abrupt weight changes; insomnia or drowsiness; concentration and thinking difficulties; and indecisiveness (Gonzalez & Connell, 2014).

According to WHO, approximately one million prisoners experience depression or psychosis, while almost all prisoners have symptoms of depression (Blaauw & van Marle, 2007). In fact, a systematic review found that one in seven prisoners suffers from major depression or psychosis, which might be risk factors for suicide (Fazel & Danesh, 2002). Another systematic review conducted in 2012 found that out of 16021 male prisoners, 1686 had been diagnosed with major depression (10.2%), while 605 female prisoners (14.1%) from a total of 4028 were diagnosed with the same disorder (Fazel & Seewald, 2012). In addition, when it comes to young offenders, a third of female young offenders has been found to suffer from major depression (Durcan & Zwemstra, 2014). Within the probation context, Brooker, Sirdifield, Blizard, Denney and Pluck (2012) conducted a study aiming to estimate the prevalence of mental health problems in a sample of offenders in probation and found that 18% of these suffered from a mood disorder, including depression.

In fact, considering the prison population, prevalence of depression is undoubtedly higher than in the general population. Empirical scientific research shows alarming rates of depression in prisons. On a study in Ethiopia, 284 out of 649 inmates (43.8%) showed signs of depression (Beyen, Dadi, Dachew, Muluneh & Bisetegn, 2017), while in Brazil

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36.5% of females and 12.3% of male prisoners had/have depression (Andreoli et al., 2014). The authors also explored the factors associated with depression and found that a few variables (e.g., marital status, satisfaction with day to day activity before imprisonment, discrimination due to crime, acceptance of crime penalised for, previous psychiatric problems, social support, suicidal ideation, planning to take their own lives, attempting suicide) were significantly associated with depression. Nwaopara and Stanley (2015), using the Beck Depression Inventory (BDI) found that, in Nigeria, 57 (14.2%) inmates scored for mild depression, 67 (16.8%) for moderate and 37 (9.2%) for severe depression. 8 (2.0%) scored for extreme, meaning that 42,2% of the inmates that were interviewed showed some level of clinical depression. In Norway, a study with 26 inmates found that 12 out of 26 inmates scored for mild depression and 5 scored for depression using the Montgomery Asberg Depression Rating Scale and the Hospital Anxiety and Depression Scale, respectively (Værøy, 2011). Recent data from Portugal, assessing a sample of 83 inmates using the BDI shows that inmates in pre-trial present a mean score of 18.23 (medium depressed), while sentenced inmates in close regime score for slightly depressed (mean of 12.57) and sentenced inmates in open regime show no signs of clinical depression (mean of 9,87) (Carvalho, Lecat, & Sendas, 2016).

In the USA, a study found that 26.2 % of inmates scored for depression (Yi, Turney, & Wildeman, 2016). Inmates in jail, that is, in pre-trial situation and not yet serving a sentence, showed higher levels of depression when compared with inmates in prisons (39.1% and 20.6%, respectively), which illustrates differences according to the facility type and the higher risk for inmates who are still adapting to the prison reality.

Although some existing research seeks to focus on the prevalence and rates of mental health disorders among prisoners and “despite a reported increase of mental health problems among prisoners in Europe and worldwide, official data on the frequency of psychiatric cases or the diagnoses in prisons are scarce” (Salize, Dreßing & Kief, 2007, p. 51). Still, “where studies of mental illness have been conducted with prison populations, the prevalence has been consistently shown to be high” (Durcan & Zwemstra, 2014, p.

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88) which means that it is crucial to reduce mental harm and promote mental health inside prison.

In terms of treatment, there is a varied availability of psychological interventions for the support/treatment of depression. Still, therapies can be grouped and organised in three main categories, being that all emphasise the importance of the role of the therapist.

The first category involves behavioural therapy focused on problematic behaviour and emotions. It used conditioning principles, such as positive/negative reinforcement and punishment, and rejects analytic and humanistic concepts (Hayes, 2004).

The second category of therapies includes cognitive therapies, which have been the most used type of therapies for offender rehabilitation. Cognitive therapy occurs "via the restructuring of maladaptive core beliefs" and patients "are empowered to control and modify cognitive distortions and to 'self-intervene' at the level of individual thoughts and feelings" (Shonin, Van Gordon, Slade, & Griffiths, 2013, p. 366). Cognitive therapy encompasses a broad variety of intervention techniques and these should be used according to the characteristics of the patient. Still, there is a set of core principles that denote the suitability of cognitive therapy (Beck, Liese, & Najavits, 2005):

1) "Unique cognitive conceptualisation of each patient – identification of dysfunctional core beliefs. Analysis of thoughts and emotional, behavioural and psychological responses associated with the current problematic situation;

2) Strong therapeutic alliance – therapeutic relationship is characterised by respect and collaboration. The therapist explains the followed approach, asks for feedback, make sure that the patient understands;

3) Goal-orientation – the patient sets goals at the beginning of the therapy. The therapist evaluates the degree to which the patient aims to achieve the goal and gives feedback about the goals;

4) The initial focus of the therapy is on the present – The therapy should start with the identification of specific problems that the patient identifies as distressing;

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5) Cognitive therapy is time-sensitive – sessions may occur weekly or twice-weekly at the beginning, and then reduce its frequency until the end of the therapy. The patient can return if he/she identifies signs that he/she is about to relapse (e.g., feeling depressed; tempted to use drugs);

6) Therapy sessions are structured, with active participation – therapist check patient's mood, asks him/her to recall important things from the previous session(s), encourages the patient to participate and take notes, and gives homework;

7) Patients learn how to identify and respond to dysfunctional thoughts – at each session, the therapist explains "that patients' thoughts influence how they react emotionally, physiologically, and behaviourally, and that by correcting their dysfunctional thinking, they can feel and behave better" (Beck et al., 2005, p. 488);

8) Cognitive therapy emphasises psychoeducation and relapse prevention – the therapist aims to maximise patients learning, teaching him/her how to best use the learned strategies." (Esgalhado et al., p. 19).

The third category of therapies encompasses the use of mindfulness-based cognitive therapy (MBCT) and relapse prevention, which have demonstrated interesting findings. In Switzerland, a study with 6 patients receiving treatment for depression found that patients engaged in MBCT and in standard relapse treatment later on when compared with patients that only received normal treatment (Bondolfi et al., 2010). Similar results were found when studying depression relapse prevention using MBCT. A study involved a larger sample (n = 121) that was randomly distributed in two groups: the first group was receiving MBCT and support to discontinue antidepressants and the second group was involved in the process of maintaining antidepressant medication (m-ADM). The authors found that "relapse/recurrence rates over 15-month follow-ups in MBCT were 47%, compared with 60% in the m-ADM group", which means that fewer patients relapsed when receiving MBCT (Kuyken et al., 2008, p. 966).

Mindfulness-based programmes have been implemented in prison contexts and studies around this subject have shown statistically significant results in terms of its relationship with a decrease in hostility and mood disturbance and an increase of self-esteem

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(Samuelson, Carmody, Kabat-Zinn & Bratt , 2007). A systematic review found significant improvements when using mindfulness-based programmes in terms of negative affect, substance use, anger and hostility, self-esteem, among others (Shonin et al., 2013).

4.2. Personality Disorders

Extensive research has shown that personality disorder is the most predominant type of mental health problem in prisons (van't Hoff, Møller, van den Bergh, Hayton, & Gatherer, 2007). In fact, out of the nine million people who were imprisoned in 2007, at least half of these suffered with personality disorders (Blaauw & van Marle, 2007). Fazel and Danesh (2002) conducted a systematic review that involved 22790 prisoners across 12 countries and found that 65% of male prisoners and 42% of female prisoners had a personality disorder, including 47% and 21% with APD, respectively. The prevalence of personality disorders among the imprisoned population is a concerning reality and WHO (Durcan & Zwemstra, 2014) has suggested that "all staff working in prisons should have an appropriate level of mental health awareness training, which should cover the specific needs of those with personality disorders" (p. 87). For example, in Germany, a study in 2009 focused on exploring the prevalence of mental health disorders among German prisoners with short sentences, found that among 102 prisoners, 80% presented at least one personality disorder (Dudeck et al., 2009).

The personality disorders which are most common among prisoners are APDs, paranoid personality disorders (PPD) and borderline personality disorders (van't Hoff et al., 2007).

According with the DSM-V, there are different types of personality disorders, which can be arranged into different clusters (A, B and C) according to descriptive similarities between disorders. However, there are four main signs common to all personality disorders. These four features are (American Psychiatric Association [APA], 2013):

1) Distorted thinking patterns (for example, extreme black-or-white thinking or abrupt patterns of idolising and then disregard others);

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2) Problematic emotional responses, such as experiencing no pleasure in things or looking emotionless or detached;

3) Over- or under-regulated impulse control. For example, on one hand, people with Avoidant Personality Disorder avoid trying new things with fear and worry of being ridiculed by others, overly controlling their impulses and sometimes coming across as rigid. On the other hand, they present signs of lack of impulse control, such as not caring about the long-term consequences of their actions;

4) And interpersonal difficulties, when those suffering from a personality disorder struggle with interpersonal relationships and find it hard to form or sustain healthy relationships. This feature is considered by professionals to be the most relevant feature common to all personality disorders.

Personality disorders included in cluster "A" are characterised by social awkwardness and social withdrawal. Some signs of personality disorders in this cluster include, noticeable distrust and suspiciousness of others; perceptible social detachment; significant discomfort in social situations; and limited ability to establish close relationships (APA, 2013).

Personality disorders included in cluster "B" are characterised by emotional and erratic behaviours. Some signs of personality disorders in this cluster are, disregard for the rights of others; deceit; manipulation; attention seeking; exaggeration in emotional expressions; exaggerated sense of entitlement; belief of being worthy of special treatment; arrogance; unstable, intense and quickly shifting emotions, moods and judgements of themselves or others (APA, 2013).

Finally, personality disorders included in cluster "C" are characterised by significant levels of anxiety. Some signs of personality disorders in this cluster include, noticeable social inhibition; hypersensitivity to depreciative remarks; perceptible fear of being criticised or rejected by others; strong need to be taken care of by others; intense fear of

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losing dear relationships or support of others; extreme worry with rules and order; and preoccupation with perfectionism and control (APA, 2013).

4.2.1. Borderline Personality Disorder

Borderline personality disorder (BPD) is a complex psychiatric disorder characterised by a persistent instability in emotion regulation, identity and self-image, relationship problems, impulsivity, and repeated self-injurious behaviour, that affects around 1% of the population (APA, 2013) and it can be chronic and debilitating (Conn et al., 2010). Although literature is lacking regarding BPD in the prison context, more focus needs to be placed in this matter considering that previous research has concluded that BPD is predictive of criminal activity among both males and females (Conn et al., 2010).

A study in the USA in 2007 (Black et al., 2007) found that out of 220 prisoners (both male and female), 29.5% had BPD. This study also concluded that these prisoners suffering from BPD experienced significant psychological stress and presented greater risks of recidivism when compared with nonborderline prisoners. Another study in the USA found a significant high rate of clinical borderline personality features among both male and female prisoners and the authors emphasise how beneficial it would be for frontline prison staff to receive training on this mental health disorder, given that they would be better prepared to identify certain types of behaviours as a sign of mental illness rather than problematic behaviour associated to prison life (Conn et al., 2010). Prevalence amongst 109 male offenders, in Sweden, was 19,8%, and comorbidity was high with APD (91%), major depressive disorder (82%), substance dependence (73%), attention deficit hyperactivity disorder (ADHD) (70%), and alcohol dependence (64%) (Wetterborg, Långström, Andersson & Enebrink, 2015). In the USA, research with 220 male and female offenders reports a higher prevalence of BPD, namely 29,5% in Black et al.'s (2007) sample.

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In fact, a literature review conducted by Sansone and Sansone (2009) concluded that prevalence of BPD is "over-represented in most studies of inmates" (p.16) when compared with the rates of BPD among the general population. The authors also found that "female criminals appear to exhibit higher rates of BPD, and it is oftentimes associated with a history of childhood sexual abuse, perpetration of impulsive and violent crimes, comorbid antisocial traits, and incarceration for domestic violence" (p. 16).

4.2.2. Antisocial Personality Disorder

APD appears to be the most common type of personality disorders among prisoners. APD is characterised by a global and repetitive pattern of misconduct and violation of rights. It has an early onset at childhood or early teen-years and persists until adulthood. Specific behaviours of this disorder can encompass aggression against other people or animals, destruction of goods, fraud or theft and serious violation of the rules. People with APD show no remorse regarding their acts and are frequently manipulative, having no empathy towards others. It is important to consider the fraudulent and manipulative behaviour that people with this disorder display, but it is also recommended to analyse and combine information from other sources when diagnosing this personality disorder (APA, 2013). Analysing APD among inmates, using data from 28 relevant surveys, Fazel and Danesh (2002) found that 47% of male prisoners and 21% of females in prison were diagnosed with this personality disorder. These rates are far above the prevalence in the community which is around 0,2% and 3,3%. However, in forensic settings and among serious alcohol abusers, prevalence can reach 70% (APA, 2013). Furthermore, it has been found that the prevalence of APD in correctional contexts is higher when compared with psychiatric settings (Black, Gunter, Loveless, Allen, & Sieleni, 2010).

In the USA, a study aiming to determine the frequency of APD among 320 newly imprisoned offenders (264 male prisoners and 56 female prisoners) found that 35.3% of the sample met the criteria for APD (Black et al., 2010). The authors examination also concluded that prisoners "with APD were younger, had a higher suicide risk, and had

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higher rates of mood, anxiety, substance use, psychotic, somatoform disorders, BPD, and ADHD" (p. 113). In addition, the scores on the Level of Service Inventory–Revised (LSI-R), for prisoners who presented suffering from APD, indicated that these individuals had a greater risk of recidivism. In Portugal, Brazão, Motta, Rijo and Pinto-Goveia (2015) conducted a study that found that among 294 Portuguese male prisoners, 79.9% of the sample had a personality disorder, being the most predominant APD, with 42.8% of prevalence. Both studies found high rates of psychiatric comorbidity for prisoners with APD, being that in Portugal 10% of the sample met enough criteria to be diagnosed with at least four personality disorders. Relevant research has also been conducted regarding the prevalence of psychiatric disorders, including APD, among German prisoners (Dudeck et al., 2009; Kopp et al., 2009; 2011).

4.2.3. Paranoid Personality Disorder

People suffering from PPD present symptoms such as common distrust and suspiciousness of others, believing their motives are hostile-driven. PPD is characterised by suspicious that others are trying to exploit, harm or deceive the individual and unjustified preoccupation related to loyalty and trustworthiness. Trust issues and unforgiveness are also common signs associated with PPD diagnostic criteria (APA, 2013).

It has been noted that the personality disorders which are most common among prisoners include APDs, PPDs and borderline personality disorders. (van't Hoff et al., 2007; Fakhrzadegan, Gholami-Doon, Shamloo & Shokouhi-Moqhaddam, 2017). In fact, the study conducted by Brazão et al. (2015) in Portugal, which was mentioned in the previous sub-chapter, found that not only APD and PPD were the most prevalent disorders among the prisoner's sample (39.1% and 10.2%, respectively), but comorbidity of APD and PPD was one of the most common types of comorbidity identified.

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In addition, research has found personality disorders to be the strongest predictor for violent behaviours, being that the existence of antisocial, narcissistic or PPD traits presented a significant correlation with violent crimes (Esbec & Echburúa, 2010).

Another study carried out in a Spanish prison aiming to examine the prevalence of personality disorders among 51 male prisoners diagnosed with substance use disorders (SUD), found that APD (45.1%) and PPD (35.3%) were also the most prevalent disorders among prisoners. This study also discovered a high comorbidity between SUD and PPD, being this the case for 35.3% of the sample. The authors highlight that comorbidity of SUD and personality disorders indicates a "a more complex personality profile, with a tendency to carry out more aggressive crimes" (Calvo et al., 2016, p. 178).

At a forensic hospital in the Netherlands it was found that 66% of the patients presented enough diagnostic criteria to suffer from a personality disorder from cluster B (e.g., antisocial and borderline), 29% from a personality disorder from cluster A (e.g., PPD) and 22% from a personality disorder from cluster C (e.g., avoidant and obsessive-compulsive). Out of the 29% who fit the criteria to be diagnosed with cluster A personality disorders, 18% were diagnosed with PPD. Furthermore, it was found that 83% of clients from an outpatients' forensic clinic in the Netherlands met diagnostic criteria to be diagnosed with at least one personality disorder. The most common disorder was PPD with 47% of the patients experiencing this disorder (Ruiter & Trestman, 2007).

Prisoners suffering from personality disorders often struggle to relate and pose a big challenge to others, including peers and prison staff. It has been noted that in terms of treatment of personality disorders there is a lack of evidence demonstrating its effectiveness, especially in prison settings (Durcan & Zwemstra, 2014). This is particularly concerning, considering that they tend to require a lot of time and resources. "Working with offenders with personality disorders can be emotionally very draining and stressful. The reasoning power of those with personality disorder is well preserved;

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hence treating them against their will is not recommended" (Math, Murthy, Parthasarthy, Kumar, & Madhusudhan, 2011, p. 101). In fact, the emotional instability and behavioural problems that these prisoners present can compromise adhesion to treatment (Brazão et al., 2015). Therefore, understanding how personality disorders develop and how to detect them among prisoners is crucial to the adequate management of these prisoners. This might contribute to better outcomes and equip staff to be better prepared to deal with this population (Durcan & Zwemstra, 2014).

Durcan & Zwemstra (2014) state that offering structure and some sort of support should encompass the way prisoners with personality disorders are managed. Best practice states that it is recommended to work in partnership with these prisoners, supporting the development of their autonomy, promoting opportunities for them to make their own choices and keeping them involved in the process of finding solutions to their problems. It is also recommended to encourage prisoners with personality disorders to deliberate on the treatment options available and to ensure that in case of comorbidity (for example, personality disorder and substance misuse problems are present), the appropriate treatment in undertaken. Furthermore, for therapy to be effective, it is fundamental to establish and maintain a good professional relationship, given that a "recent literature review to know the effect of personality disorder on mental illness revealed that the presence of a personality disorder is a poor predictor for response to treatment of mental disorders" (Math et al., 2011, p. 101).

Another example of good practice has been demonstrated by the National Health Service (NHS) in England and the National Offender Management Service in the United Kingdom (UK), who collaborated to compile a practitioners guide for those who work with offenders with personality disorders (Craissati, Joseph, & Skett, 2015). This guide includes practical information and key advice on how to successfully manage these prisoners and addresses how the challenging behaviours these individuals often present might affect staff's well-being. Differences between personality disorder, mental illness and learning disabilities, assessments, models of care and pathway planning are some of

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the topics addressed in this guide. Examples of key recommendations included in this guide are:

- Avoid challenging personality disorders' core characteristics (which usually have an onset at an early age and are difficult to change). Instead, begin by paying attesting to the secondary characteristics, which are usually behaviour-related and easier to change;
- Have a crisis plan in place and include individual and group interventions with a focus on engagement, education and cooperation;
- Consider the history of the prisoner. Often early experiences have a correlation and explain current behaviours;
- Stay self-caring by seeking support and supervision, being realistic about potential changes and celebrating success.

4.3. Psychotic Symptoms

As mentioned previously, many prisoners worldwide also experience psychosis. Research shows that psychosis rates amongst prisoners are significantly higher in low- and middle-income countries when compared with high-income countries, and that psychosis is a significant risk factor for heightened suicide rates (APA, 2013; Fazel & Seewald, 2012).

Individuals suffering from psychosis can experience hallucinations and usually report seeing, hearing or feeling unrealistic things. Other common symptom are delusions, which are false or strange beliefs, such as believing that someone or something is trying to hurt them. Adding to this, people experiencing psychotic symptoms will still firmly hold to these beliefs even when presented to proof of the contrary (APA, 2013; Arciniegas, 2015).

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Psychosis is also characterised by signs such as, overreacting response to sensory information (such as lights seeming too bright or noises sounding too loud); noticeable changes in behaviour (such as bizarre statements or neglected appearance); disorganised thinking or speech (or even absence of the latter); difficulties in processing information (such as finding it hard to understand what others say); trouble in carrying out activities that used to be easy; depression and extreme anxiety; irritable or extreme mood; difficulty to interact in social situations; odd behaviours or movements; among others (APA, 2013; Arciniegas, 2015).

According to Garety, Kuipers, Fowler, Freeman, and Bebbington (2001), psychosis arises from a combination between vulnerable predisposition (of biopsychosocial origin) and an onset of "life events, adverse environments, illicit drug use, or periods of isolation" (p. 189). Considering the prison population, one may expect a high prevalence of psychotic symptoms, because of the vulnerable background that prisoners share, drug consumption rates and the isolation related with being imprisoned. In fact, the prevalence of psychotic symptoms in the prison population was over ten times greater, when compared with a household sample (52 vs 4.5 per thousand) on a sample of 505 inmates and 473 non-incarcerated individuals interviewed with Schedules for Clinical Assessment in Neuropsychiatry (SCAN). However, the prevalence of psychotic symptoms, namely hallucinations and delusions, did not differ between both samples (Brugha et al., 2005).

In Portugal, Moreira and Gonçalves (2010) conducted a study aiming to analyse the prevalence of suicidal ideation and emotional disorders among 66 male remand prisoners. The authors found that 18 prisoners presented suicidal ideation during the first week of imprisonment, and all of them suffered from emotional disorders. In addition, one of their main findings was that the prisoners who experienced suicidal ideation presented high levels of depressive, paranoid and psychotic symptoms. Although these results cannot be generalised, more research and attention are needed when it comes to understand how imprisonment affects inmates who experience this type of

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symptoms or if prison life is the cause for these problems to arise. In fact, Fazel and Danesh (2002) found, in one of their systematic reviews, that prisoners "were several times more likely to have psychosis and major depression, and about ten times more likely to have APD, than the general population" (p. 545). Still, the authors highlight how little is known regarding this issue and how, for example, "the effect of substance abuse on the prevalence of psychosis in prisoners is not known" (p. 548).

4.4. Anxiety Disorders

Anxiety disorders represent, along with depression, the most common mental health disorders in worldwide population. WHO (2017) estimations show that 3.6% of global population suffers from anxiety disorders, being that the prevalence is higher among females (4.6% vs 2.6% among males). In addition, people who are imprisoned are more likely to have any clinical problem when compared with the general population and, due to prison conditions, certain problems have tendency to aggravate, such as anxiety. Anxiety is one of the most common mental health problems that prison healthcare staff encounter in their practices. In fact, a national survey conducted in England and Wales found that 66% of women prisoners suffered from anxiety, compared with a rate of 20% in the community. In addition, it has also been found that prisoners seeking asylum or waiting for deportation also experience additional anxiety levels (Blaauw & van Marle, 2007).

There are over 100 anxiety symptoms and according to the DSM-V there are different types of anxiety disorders, such as panic attacks, generalised anxiety disorder (GAD) or social anxiety disorder (SAD) (APA, 2013).

Anxiety can be defined as intense and persistent feelings of uneasiness, apprehension and fear regarding future realistic or unrealistic situations that the person perceives as threatening. Inmates experiencing anxiety can get easily stressed about daily activities

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and often suffer a physical and psychological functional impairment (APA, 2013; PRI, 2018). However, there are common symptoms associated to anxiety disorder such as, dizziness; excessive worry perceived as very difficult to manage; chest pain; headaches; muscle aches or tension; stomach upset or nervous stomach; shortness of breath; trembling or shaking; restlessness; nausea; difficulties to concentrate; pins and needles; heart palpitations; feeling constantly "on edge"; social contact avoidance; irritability; insomnia; fatigue; agitation; among others (APA, 2013).

A large study with 1192 male and 617 female prisoners in São Paulo, Brazil, found that half (50%) of the women in prison live with anxious-phobic disorders (i.e., phobic disorders, panic disorder, obsessive-compulsive disorder, GAD, and post-traumatic stress disorder [PTSD]), while the prevalence in male prisoners was 32.5% (Andreoli et al., 2014). Another study with 415 inmates across six prisons in Germany, found that phobic and anxiety disorders affected 7.4% and 24.5% of male and female inmates, respectively (Watzke, Ullrich, & Marneros, 2006). In Norway, using two different assessment scales, 34.6% of the inmates scored positively on the Hospital Anxiety and Depression Scale (anxiety subscale) and 30.7% scored positively for anxiety on the Clinical Anxiety Scale (Værøy, 2011).

Psychological therapies for prisoners with mental health problems vary significantly from country to country. Still, with the purpose of conducting a systematic review on psychological therapies for mentally ill prisoners, Yoon, Slade and Fazel (2017) concluded that cognitive-behavioural therapy (CBT) and mindfulness-based therapies showed to have moderate effectiveness for prisoners with depressive and anxiety symptoms, "with mindfulness-based therapies possibly demonstrating higher effect sizes" (p. 790). Still, the authors highlight the need to explore which mechanisms of the mindfulness-based therapies contribute to the effectiveness of treatment, suggesting that "more evidence is required before additional therapies can be recommended" (p. 783).

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4.5. Post-Traumatic Stress Disorder

According to DSM-V, PTSD falls into the category of trauma- and stress-related disorders. Some common symptoms of PTSD are, unwanted and upsetting memories, nightmares or flashbacks of the traumatic event; emotional distress or physical reactions after being exposed to triggers that make the person relive/recall the traumatic event; inability to recall key components of the traumatic event; significantly high number of negative thoughts and assumptions about oneself or the world; exaggerated blame of self or others for causing the trauma; overwhelming shame; irritability or aggression; decreased motivation and interest to engage in activities; avoiding places, activities or people that remind the person of the traumatic event; feeling isolated; insomnia; difficulty experiencing positive emotions; feeling emotionally numb; risky or destructive behaviours, such as substance misuse; being highly vigilant about one self's surroundings; and difficulties to concentrate or focus (APA, 2013).

PTSD has been identified as a major health problem in prisons and research has found high levels of PTSD among prisoners, especially women, with high rates of this disorder being reported among the female prison population (van den Bergh, Plugge, & Aguirre, 2014). People coming into contact with the criminal justice system often present a history of traumatic experiences which involve high rates of exposure to physical, psychological or sexual violence. Ultimately, this can result in the development of PTSD. Moreover, it has been found that prisoners experiencing PTSD that do not receive adequate treatment are at risk of suffering a functional impairment, which can reduce their ability to perform daily activities. Moreover, they present low rates of treatment adherence and increased risks of self-harm and suicide. Research also states that people suffering from PTSD within the prison context are the highest percentage of mentally ill prisoners who were found to have unmet needs (Baranyi, Cassidy, Fazel, Priebe, & Mundt, 2018).

Although there are many different extreme and life-threatening events that can lead to the development of PTSD, the most common are, war combat; childhood physical abuse;

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sexual violence; physical assault; being threatened with a weapon; an accident, such as a car accident; among others (Baranyi et al., 2018; APA, 2013; Mayo Clinic Staff, 2018).

As an example of good practice on how to support prisoners with PTSD and promote their mental well-being, Pennine Care NHS Foundation Trust compiled a self-help guide as a supportive tool for this target group1. The guide begins by explaining in a very clear and friendly language what a traumatic event is and lists common symptoms people experience after being through a traumatic experience. This guide also provides help techniques to cope with post traumatic reactions, namely:

1) Making sense of the trauma. Try and make sense of the event by understanding what really happened more clearly. Talking with someone about it and deconstructing the event while thinking it through with another person might be helpful;

2) Put some time aside and calmly think over unwanted flashbacks and nightmares. Find some time every day to go over the unwanted memories or nightmares you might experience as this can help to decrease their frequency. Making a conscious effort to stay calm while going through these memories it important to help regaining control over these thoughts rather than intensifying them;

3) Try grounding coping techniques. Use your five senses to stay in the present moment:

a. Sight – focus on anything you can visually concentrate on (e.g., colours, a photograph);

b. Sound – focus on auditorily appealing sounds (e.g., music, birds chirping);

c. Touch – use your touch sense to concentrate on textures and surfaces;

d. Smell – try and inhale a strong smell which will help you to get contact with the present moment (e.g., perfume);

e. Taste – seek for a strong taste that brings you to the present (e.g., mint, lemon);

1 For more information, please visit: **https://selfhelpguides.ntw.nhs.uk/**.

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4) Try some coping strategies to manage tension, irritability and anger, such as relaxation techniques, physical exercise, yoga, listening to music or reading a book;

5) Try and identify things you are avoiding and set small goals to change this. It is common to experience anxiety when faced with the things we seek to avoid. By identifying fears and making an effort to address them you might begin to gradually feel calmer;

6) Try and challenge negative thoughts and moods by being able to identify when these negative feelings/thoughts arise and writing down a list of reasons to counter-argument the negativity.

This guide puts an emphasis on the importance of looking after oneself and seek for professional help when people feel unable to cope on their own. An extensive list of useful organisations that prisoners can reach to in case of need is available, re-enforcing the fact that people in prison who suffer from PTSD do not have to go through this alone[2].

4.6. Self-harm and suicide

Research shows that suicide rates within the prison context are higher than in the general population (Matschnig, Frühwald, & Frottier, 2006). According to the key findings from the Council of Europe's SPACE I report (Aebi & Tiago, 2018a), "the prison suicide rate in 2017 was 5.5 inmates per 10,000 inmates" (p. 8). Specifically, among the imprisoned population of each partner country of the AWARE project, during the year of 2017, 2 suicides were registered inside penal institutions in Bulgaria (although this is a non-validated figure), 15 in Portugal and 9 in Romania. In Germany, 76 suicides were registered in 2016. No suicides were registered during the year of 2017 inside Greek prisons (Aebi & Tiago, 2018b).

2 For more examples of self-help guides from NHS, please visit: **https://www.selfhelpguides.ntw.nhs.uk/penninecare/**.

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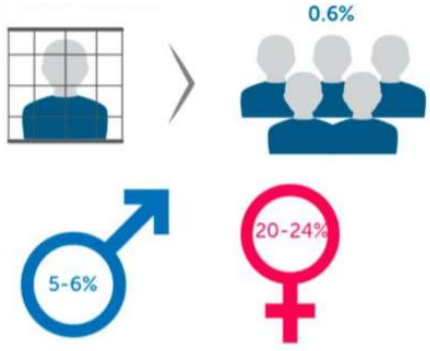
In fact, prisoners present a higher risk of suicide and self-harm when compared to their community counterparts. This is caused by a variety of factors, such as "long-term sentences, single-cell use, mental disabilities, substance abuse" (UNODC, 2009, p. 17), as well as an individual's history of suicidal tendencies. Interestingly, studies in various countries indicate that prisoners who take their own lives actually suffered from some form of mental disorder, which may be allied to substance abuse (Shaw, Appleby, & Baker, 2003).

In addition, prisoners who self-harm usually have a background of being victims of violence, as well as substance dependency (such as alcohol or drugs) (Borrill et al., 2003). Such historical component should require therapeutic responses from the correctional facilities where they are incarcerated, especially since these individuals are more likely to attempt suicide than others. However, self-harm behaviours or suicide attempts are actually penalised is various jurisdictions, which increases inmates' distress and worsens mental well-being. The common approach in the United States of America is an example of this, since prison regimes "routinely criminalise and punish (this kind of) behaviour" (PRI, 2007, p. 5). The same happens "in some countries of Eastern Europe and Central Asia" (UNODC, 2009, p. 18), such as in Kazakhstan, where such behaviours could lead to an extended term of imprisonment.

According to a recent study using data from 24 high-income countries, prison suicide rates compared with those in the general population of the same sex and similar age, were typically higher than 3 in men and 9 in women (Fazel, Ramesh, & Hawton, 2017).



Incarcerated people also show higher rates of self-harm, especially women. A research done in the UK shows that 5–6% of male prisoners and 20–24% of female inmates self-harmed every year, compared to 0.6% of the UK general population (Hawton, Linsell, Adeniji, Sariaslan & Fazel, 2014).

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In detention settings, "suicide is often the single most common cause of death" (Konrad et al., 2007, p. 113).

This poses different challenges to prisons considering that:

1) Administrations have the legal obligation to protect the health and safety of the prison population, which makes them open to judicial scrutiny when they fail to do so;

2) A prison suicide is often fuelled by media attention, and so it may easily escalate into a political scandal;

3) It is a stressful event in the prison life, both for staff and for the other prisoners.

Different theoretical approaches have been proposed to explain the high rates of prison suicide. On the one hand, criminologists, based mainly on qualitative research, believe that social and environmental/situational factors (e.g., overcrowding) play a substantial role in the equation. This approach underpins the hypothesis that inmates already carry many risk factors for suicidal thoughts, "transferring" these with them into prison. On the other hand, research conducted by psychologists and psychiatrics highlights the importance of psychiatric factors, such as high rates of psychiatric morbidity, previous suicide attempts and recent suicidal ideation (Fazel, Grann, Kling, & Hawton , 2011a).

In fact, both criminological and psychiatric factors are important, as evidenced by different studies aiming to explore the factors associated with prison suicide. According to these the strongest risk factors are, occupation of a single cell (such as solitary confinement); recent suicidal ideation; history of attempted suicide; current psychiatric diagnosis; history of alcohol use problems (Kaba et al., 2014; Cloud, Drucker, Browne, & Parsons, 2015; Fazel, Cartwright, Norman-Nott, & Hawton, 2008).

Self-harm inside prison is another important risk factor for suicide among prisoners, especially for male prisoners. A research conducted on self-harm in prisons in England and Wales identified risk factors for suicide after self-harm behaviours occurred. Among male inmates, older age and a previous self-harm incident (of high or moderate lethality)

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are associated with an increased risk of suicide. In female prisoners, the risk factor identified was history of more than five episodes of self-harm within a year (Hawton et al., 2014).

As recommended by the International Association for Suicide Prevention [IASP] Task Force on Suicide in Prisons, all detention facilities should implement a "reasonable and comprehensive suicide prevention policy" (Konrad et al., 2007, p. 133) addressing four key components: training; intake screening; post-intake observation and management following screening.

Properly trained staff are fundamental to any prison suicide prevention programme. Correctional staff play a primary role in this matter given that suicide incidents usually occur in housing units and at times when prisoners are outside the reach of staff (such as weekends and late evening hours). Correctional officers are, in fact, the frontline defence in the prevention of suicide in prison, since they are available 24 hours a day.

Correctional staff (as well as healthcare and mental healthcare staff) should receive initial suicide prevention training and a revised training each year. Initial prevention training should include the following subjects: "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" (WHO & IASP, 2007, p. 9). Moreover, all staff with regular contact with prisoners should receive standard first aid training and training in the use of various emergency equipment.

Prison training should also include the implementation of formal screening for suicide at intake. To be effective, screening should be conducted immediately upon admission (since suicide may occur within the first hours of detention), and again if conditions change. If possible, suicide screening should be conducted by relevant facility-based

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healthcare professionals. When this screening is the responsibility of correctional staff, they should be trained and supported by an assessment checklist. As an example, the following items could be used to indicate an increased suicide risk:

- "The inmate is intoxicated and/or has a history of substance abuse;
- The inmate expresses unusually high levels of shame, guilt, and worry over the arrest and incarceration;
- The inmate expresses hopelessness or fear about the future, or shows signs of depression, such as crying, lack of emotions, or lack of verbal expression;
- The inmate admits to current thoughts about suicide;
- The inmate has previously received treatment for a mental health problem;
- The inmate is currently suffering from a psychiatric condition or acting in an unusual or bizarre manner, such as having difficulty in focusing attention, talking to oneself, or hearing voices;
- The inmate has made one or more previous suicide attempts and/or admits that suicide is currently an acceptable option;
- The inmate admits to current suicide planning; contacts to family and neighboring inmates should also be taken into consideration;
- The inmate admits or appears to have few internal and/or external supportive resources;
- The arresting/transporting officer believes that the inmate is at risk for suicide;
- Facility records indicate that the inmate was assessed as a suicide risk during a prior confinement" (Konrad et al., 2007, p. 116).

It is not enough to screen prisoners at the time of intake since suicides might occur after the initial period of detention. Suicide prevention programmes must indeed involve ongoing observation of inmates in order to be effective. Staff should look for signs of prisoners' risk of suicide during the following periods:

1) At routine security checks;

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2) In conversations with a prisoner at times of court hearings or during other critical periods (e.g., the death of a family member);

3) During supervision of visits with family or friends;

4) Upon entry into segregation units (since a disproportionate number of suicides occur in segregation).

Warning signs of suicidal intent or mental illness include "crying, insomnia, sluggishness, extreme restlessness, or pacing up and down; sudden change in mood, eating habits, or sleep; divestment such as giving away personal possessions; loss of interest in activities or relationships; repeated refusal to take medication or a request for an increase dose of medication" (Konrad et al., 2007, p. 116).

Following screening, a management process must be implemented describing responsibilities for placement, continued supervision and intervention for those inmates at high risk of suicide. More specifically, adequate monitoring should be provided according to the prisoner's level of risk (that is, those prisoners considered actively suicidal must be constantly supervised, while those raising suspicions but who do not admit to being actively suicidal may not require constant monitoring). Monitoring is mainly critical during night shifts, and in places where staff may not be permanently assigned to, such as police lockups.

Communication between staff is also essential for preventing suicide. Communication may occur at three stages (WHO and IASP, 2007, p. 14):

1) Between the arresting/transporting officer and correctional staff. The time of arrest is often the most volatile and emotional time for the person, so arresting officers should pay close attention to suicidal behaviour, anxiety and/or hopelessness. Any pertinent information must be communicated to facility staff;

2) Among facility staff (including correctional, healthcare, and mental health personnel). Correctional staff must share information and make adequate referrals to

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relevant mental health staff. Multidisciplinary team meetings should be regularly scheduled to discuss the status of an inmate at risk;

3) Between facility staff and the suicidal inmate.

In some cases, suicide attempts might be viewed as manipulative, as a way to gain control over the environment (for example, in order to be transferred to a hospital, moved to a less secured environment or to instigate an escape), as a form to draw attention to one's emotional distress. Inmates diagnosed with antisocial or sociopathic personalities might be more inclined to manipulative attempts as they are likely to have difficulty coping with the over-controlled and collective conditions of prison life.

It is important to highlight that, even if it was not the original intent, suicide attempts can result in death and, therefore, should be taken seriously. In specific, "attempts with less suicidal intent should be seen as expressive rather than purposive, i.e., as a dysfunctional way of communicating a problem" (Konrad et al., 2007, p. 116). Therefore, the correct response is not to punish the suicidal behaviour and rather ask prisoners about their problems. Also, segregation of these acting-out inmates might worsen the problem. Close supervision and access to psychosocial support is essential.

When a suicide occurs, the incident must be officially documented and reported following a detailed procedure. Constructive feedback should be provided to improve suicide prevention initiatives. Also, prison staff who have experienced the incident may experience a range of emotions (anger, resentment, guilt, sadness…) that should be dealt with. This means that prison staff should have access to a debriefing and peer or counselling support.

Although rare, suicide clusters may occur in detention settings. Research suggests that this risk is limited to a 4-week period following the first suicide, reducing over time. Especially vulnerable to copycat suicide attempts are the young inmates. Strategies should be in place to prevent the contagious suicidal behaviour, such as:

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- "Provision of secure psychiatric care for prisoners with psychiatric illness;
- Removal or treatment of those particularly susceptible;
- (And) careful management by authorities of the transmission of knowledge that a suicide has occurred" (Konrad et al., 2007, p. 119).

As mentioned previously, there are particular times or situations that can significantly affect prisoners' mental stability and constitute risk factors for self-harm or suicidal behaviours. Refer back to chapter 2.3. "Imprisonment causes and exacerbates mental health problems" to read about the different heightened risk situations.

4.6.1. Suicide prevention programmes

Given that prisoners represent a high-risk group, strategies and programmes need to be implemented in order to prevent suicide inside prison facilities. Although suicide prevention programmes must be adapted to each prison system reality (i.e. available resources and prisoners' needs), there are common components that represent basis for the development of such programmes.

The provision of adequate suicide prevention initiatives is, therefore, paramount in correctional settings worldwide. In fact, studies demonstrate that comprehensive prevention programmes have positive outcomes in reducing suicide attempts and suicides in prisons. The IASP Task Force on Suicide in Prisons developed a set of recommendations which set the basis for the development of a WHO guide on the topic. These guidelines can be divided in three main elements (Konrad et al., 2007; WHO and IASP, 2007), namely:

1) Development of suicide profiles;

2) Suicide risk factors;

3) Programme key components.

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The development of suicide profiles "can be used to target high-risk groups" (Konrad et al., 2007, p. 114) that may need further screening and intervention. An important distinction is made between pretrial inmates and sentenced prisoners, as these represent two groups in heightened risk of suicide.

Pretrial prisoners who take their own lives inside prison "are generally male, young (20–25 years), unmarried, and first-time offenders who have been arrested for minor, usually substance-related, offenses" (Konrad et al., 2007, p. 114). Usually, these prisoners are under the effect of substances at the time of their arrest. In these cases, suicide happens within the first hours of detention (due to sudden isolation and uncertainty about the future) or near the time of a court appearance, mainly when a guilty verdict and harsh sentencing is foreseen.

Sentenced inmates who commit suicide in prison are often older (aged 30 to 35) and violent offenders. It is common for this particular group of prisoners to take their own lives after spending some time in detention (4 or 5 years). The suicide might be triggered by a conflict with the prison administration or with other inmates, a family quarrel, or an adverse legal outcome (e.g., denial of parole).

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It is important to highlight that high-risk suicide profiles may change over time. Also, traditional profiles might vary according to unique local conditions in any detention setting. Consequently, it is recommended to use these profiles as a support tool to identify the potentially high-risk groups, and not without a careful clinical assessment. Moreover, these profiles should be regularly revised and adapted to the context (as to reflect local conditions). Besides contributing to the analysis of specific profiles (and the differences between groups), a clearer understanding of common factors underlying the elevated risk of suicide in prisons can assist in guiding suicide prevention initiatives (Konrad, et al., 2007).

An important part of suicide prevention in detention settings relates to the meaningful social interactions which are provided inside prison, since social and physical isolation relates to a higher risk of suicide. Given that being in segregation or isolation cells increases prisoners' risk of suicide, suicidal inmates should, ideally, be placed in a dormitory or shared cell environment. In some prisons, social support is provided by means of a trained inmate (through a "buddy" or "listener" scheme), which has proven to have a good impact since potential suicidal inmates might trust other inmates more. Family and friends' visits may also be used to promote social support.

Looking at the physical environment and architecture is also a form of suicide prevention, given that most prisoners take their own lives by hanging using bed sheets, shoelaces or clothing. As such, a safe environment would be "a cell or dormitory that has eliminated or minimised hanging points and unsupervised access to lethal materials" (Konrad et al., 2007, p. 117). Also, actively suicidal prisoners can require protective clothing and restraints, although clear policies should be in place regarding the adequate use of restraints.

Camera observation is now a popular alternative to direct observation by staff, although it should be noted that camera blind spots and busy camera operators may lead to a

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negative outcome. Camera surveillance should always be used as a supplement to staff's direct observation.

When a prisoner is considered to be at high risk of suicide, further adequate evaluation and treatment by mental healthcare should be provided. Access to specialised staff is, however, often hindered by limited internal mental health resources, associated with few links to community-based mental health facilities. To properly address inmates' mental health needs, "multiagency cooperative service arrangements with general hospitals, emergency services, psychiatric facilities, community mental health programmes, and substance-use programmes" (Konrad et al., 2007, p. 118) should be established. Multi-agency and integrated care are a topic which will be addressed further ahead.

In case of suicide attempt, correctional staff must secure the area and provide first aid to the prisoner until emergency health staff arrive. Efficient channels of communication and proper emergency procedures must be in place to avoid any delays in response.

As soon as possible, the prisoner must undergo a comprehensive psychological assessment, including an analysis of risk factors, the degree of suicidal intent, underlying problems (chronic and acute), the existence of mental disorders, the probability of further self-harm in the short-term and the type of help needed that the prisoner is likely to accept. The assessment should be conducted in a private and comfortable environment for both the inmate and professional.

In Portugal, the General Directorate of Prison and Probation Services implemented the Integrated Programme for Suicide Prevention[3] (PIPS) in 2009. PIPS is focused on the levels of resilience of prisoners who present a higher risk for committing suicide or who belong to vulnerable groups associated to risk of suicide. The programme includes three target groups, namely, prisoners with history of suicidal thoughts and behaviours (inside

3 Originally known as *Programa Integrado de Prevenção do Suicídio*.

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or outside prison), prisoners who fall into a vulnerable group category and are at risk of taking their own lives and prisoners with self-destructing thoughts. PIPS adopt an integrated approach, involving different teams, such as the Permanent Observation teams, who coordinate the programme nationally and the Suicide Prevention Council that allocates Regional Operationalisation Groups responsible for specific services (vigilance, education or clinical services). All prisoners are screened and assessed for risk factors during prison intake (Ribeiro, 2017).

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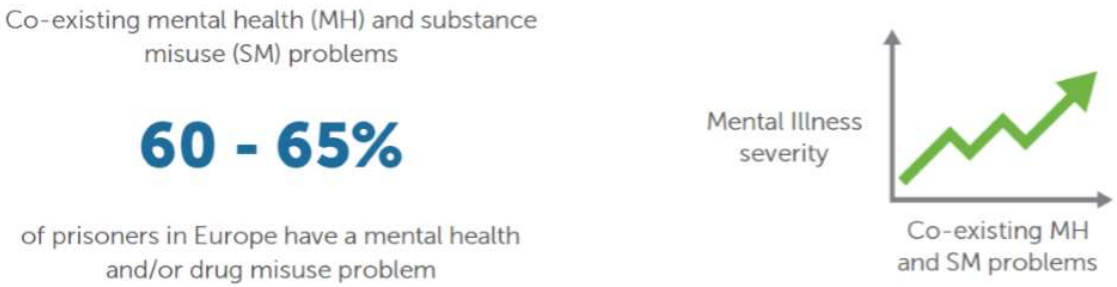
5. Co-existing mental health and substance misuse problems

Rates of co-existing mental health and substance misuse problems are known to be high among prisoners and drug use is among one of the primary problems faced by prison systems (Stover & Kastelic, 2014). In fact, it has been estimated that around 60 to 65% of prisoners in Europe experience mental health and/or drug misuse problems. Such findings should not be overlooked, especially since substance misuse-related diseases have been identified as the number one co-morbid problem is prisons (Fazel, Hayes, Bartellas, Clerici & Trestman, 2016; van't Hoff et al., 2007). Hence, the existence of both mental health and substance misuse problems aggravates inmates' mental health disorders and it is a risk factor for re-offending (or overdosing) after release (van't Hoff et al., 2007). In fact, drug overdoses on release have been reported and increasing in many countries (Montanari et al., 2014). Moreover, it has been found that a significant percentage of violent crimes is committed whilst offenders are under the influence of these substances (Binswanger et al., 2012).



Mental health problems, substance misuse and communicable diseases are closely interconnected, and data shows that a significant proportion of the people who get into contact with the criminal justice system have a history of drug misuse and injecting (Stover & Kastelic, 2014). In fact, similarly to other studies conducted, Togas, Raikou and Niakas (2014) found that among 100 Greek prisoners, mental health disorders, hepatitis C and hepatitis B were the most commonly reported health related problems. The authors also found that a significant percentage of these inmates were engaged in psychiatric treatment (involving medication) and misused drugs. Moreover, while for some

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prisoners who misuse drugs the prison environment might produce positive impacts and lead them to stop or reduce drug usage, for others this will be a place where they switch to more harmful patterns of drug use. “This makes these places important settings for the provision of effective drug-related and bloodborne virus [and mental health] services to help reduce the damage that drug use does to health, prison safety and security as well as the broader community (through increased re-offending and infections on release)” (Stover & Kastelic, 2014, p. 113).

Some people with mental health problems may misuse substances to try and alleviate their mental illness symptoms. Over time, this might worsen the prognosis of the prisoners’ psychiatric disorders. However, the development of mental health problems can be a result of drugs and alcohol use. Both problems can precede or be the consequence of one another (PRI, 2018; Fazel et al., 2016; van’t Hoff et al., 2007; National Institute on Drug Abuse, 2007). A significant percentage of people with co-existing mental health and substance misuse problems present a history of emotional, physical and sexual abuse. This fact highlights the relevance of initial screening and assessment of prisoners’ needs (van’t Hoff et al., 2007).

Patients who experience both problems frequently receive inadequate treatment, since treatment services often tend to respond either to the mental illness problematic or to the substance misuse issues (van’t Hoff et al., 2007). Some common signs of substance misuse are, red or glazed eyes, bloody noses, dilated or constricted pupils, paranoid thinking, abrupt weight changes, decreased coordination, insomnia or sleeping too much, increased aggression or irritability, lethargy or slowed reaction time, mood swings or depressive mood, shakes, tremors, or slurred speech, hallucinations, lack of care for personal hygiene, stop attending work or education, significant drop in performance or abrupt loss of interest, increased risk-taking and involvement in criminal activities, memory problems, a sense of euphoria or feeling "high", agitation, physical health symptoms (such as increased blood pressure and heart rate, constipation, gum disease

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or tooth decay), vomiting, difficulty concentrating or remembering, among others (APA, 2013).

In terms of treatment interventions for offenders with co-existing mental health and substance misuse problems, multiple systematic reviews from January 2004 through January 2014 were reviewed by Maruca and Shelton (2017). The authors found that treatment interventions tend differ greatly on location (whether is inside prison or in the community), intensity, duration, among others. Regarding the effectiveness of the interventions, the authors found that there is a lack of evidence making it difficult to compare interventions and evaluating its effectiveness. Still, it was found that there are certain treatment components that are effective in reducing distress symptoms and improving coping ability, namely, homework activities, time-limited treatment sessions and promotion of continuity of care between prison and the community. The authors also found that cognitive behavioural therapy, behavioural therapy and assertive communication therapy were the most beneficial type of interventions and giving offender the option of choice to engage in treatment improves the therapeutic alliance (Maruca & Shelton, 2017).

Considering not only that substance use is a risk factor for reoffending, but also that relapse and overdose during the post-release period are real issues faced by prisoners, more emphasis needs to be placed on relapse prevention both during the phases of prisoners' arrival and pre-release. A relapse prevention approach is an example of good practice and it is an adequate procedure to adopt when trying to support prisoners who experience both co-existing mental health and substance misuse problems (van't Hoff et al., 2007).

Some relapse prevention tips are (Dowden, Antonowicz, & Andrews, 2003):

- Avoid triggering situations – staying away from any situation that might bring temptation. These situations can be physical or emotional;

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- Develop a positive support network – family and friends are positive influences and can be very supportive;
- Do not give up if relapse occurs – one lapse does not mean people have failed. Reassure them that if they have succeeded in staying abstinent before, they can do it again;
- Focus on replacing past substance use with new activities – get active and engage in exercise or pleasurable activities as it can have multiple benefits.

Moreover, harm reduction policies and programmes have been gaining attention as an approach that aims "to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs" (Stover & Kastelic, 2014, p. 127). It is a type of intervention that considers the potential negative impacts that drug use has on individual's mental health given that the Status Paper on Prisons, Drugs and Harm Reduction (WHO Regional Office for Europe, 2005) considers harm reduction as a concept that seeks to "prevent or reduce negative health effects associated with certain types of behaviour (such as drug injecting) and with imprisonment and overcrowding as well as adverse effects on mental health" (Stover & Kastelic, 2014, p. 127). Harm reduction interventions are based on the recognition that individuals are not prepared to be abstinent from substances in the short term and, therefore, puts an emphasis on reducing the associated and potential harms of drug use (e.g. needles and syringes exchange programmes and provision of disinfectants). Because the harm reduction approach has a special focus on reducing the risks associated to drug misuse, this is also a relevant type of intervention which contributes to the prevention of overdose on release (Stover & Kastelic, 2014).

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6. Comorbidity of mental and physical disorders among prisoners

Managing people with mental disorders within a prison is challenging. Prisoners make complex patients. They have multiple social disadvantages before they enter prison, such as low educational attainment, unemployment, and homelessness, and psychiatric comorbidity is much higher than in the general population (UNODC, 2009).

"Comorbidity simply means the co-occurrence of one or more diseases or disorders in an individual." (Hall, Lynskey & Teesson, 2000, p. 11). Many researchers analysed comorbidity of mental and physical disorders among incarcerated people. An epidemiological study in prison population assessed the prevalence of comorbidity of psychiatric disorders and SUDs of between 3% and 11%, suggesting that this comorbidity has been associated with negative outcomes, including higher rates of depression, suicide, violence, and homelessness (Baillargeon et al. 2010). Such comorbidity between mental illness and substance misuse worsens the prognosis of the individual psychiatric disorders (Binswanger et al., 2010; Harzke et al., 2010).

Moreover, research has suggested that prisoners with personality disorders present high comorbidity with other diagnoses, mainly SUDs and ADHD (Chapman & Celluci, 2007; Coid, Yang, Tyrer, Roberts & Ullrich, 2006; Gudjonsson, Sigurdsson, Adalsteinsson & Young, 2011).

Cote and Hodgins (1990), in a study of 495 inmates from Quebec, observed comorbidities associated with APD and substance use/dependence. While only 1.8% of their sample had only one serious mental disorder, 9.5% had comorbid APD and drug and alcohol abuse/dependence disorders. APD alone was present in 6.7% of the sample but co-occurred with drug and alcohol abuse in 19%. The most frequent combination of disorders was APD with alcohol abuse (15%). They also discovered that major psychiatric disorders most frequently appear in combination with one or more additional diagnoses. For instance, 92% of people with schizophrenia and 94% of individuals with

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major depression had comorbid psychopathology. In fact, three or more distinct disorders were identified in 44% of inmates with major depression and in 55% of offenders with schizophrenia.

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7. Adverse childhood experiences and mental health

Studies are increasingly identifying the importance of early life experiences to people's health throughout their life. Individuals who have experienced adverse childhood experiences (ACEs) tend to have more physical and mental health problems as adults than do those who do not have ACEs and ultimately greater premature mortality (Anda et al., 2006; Bellis et al., 2014). There is a consistent connection between mental health and ACEs (McLaughlin et al., 2012).

ACEs include harms that affect children directly (e.g., abuse and neglect) and indirectly through their living environments (e.g., parental conflict, substance abuse, or mental illness). There are a lot of forms of adversity in childhood, they can include experiences involving harm or threat of harm to the child, such as physical or sexual abuse, domestic violence, or exposure to violence in the community, and experiences that involve deprivation and social disadvantage, such as neglect, the absence or limited availability of a caregiver, poverty and insecure access to food (McLaughlin et al., 2013).

McLaughlin et al. (2012) concluded that, in a sample of 6483 adolescents, the most common ACEs were parental divorce, parental criminality, family economic adversity, and parental mental illness. A notable recent series of research studies on this topic has linked ACEs to a range of mental health outcomes well into adulthood. Mental disorders such as anxiety, depression, PTSD and substance use problems are the most common after going through ACEs (Wolff & Shi, 2012).

ACEs have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. Rates of physical, sexual, or emotional abuse (referred to as 'trauma') during childhood are notably elevated among prisoners (Wolff & Shi, 2012). Studies have shown that these adversities raise the risk of adult misconduct and future incarceration (Wolff & Shi, 2012).

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In Wales, the Prisoner ACE Survey acknowledged high levels of ACEs in prisoners, with 84.1% of them having been through at least one traumatic childhood experience and approximately half reporting having been exposed to four or more ACEs (Ford et al., 2019). Thus, trauma symptoms and ACEs are elevated in incarcerated populations.

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8. Vulnerable groups

Although all prisoners are at risk of developing mental health problems whilst imprisoned, staff must be aware of the existence of specific vulnerable groups which may be more at risk and in need of special treatment (PRI, 2018; Cuéllar, Tortosa, Dreckmann, Markov & Doichinova, 2015). Therefore, in order to guarantee that professionals enhance their work performance by being more knowledgeable and aware of the special characteristics of vulnerable groups of prisoners, prisoners who fall into any of these categories will receive an improved and more adequate support and management. Therefore, it is important to understand their context and the reasons why these are vulnerable groups. It is also crucial to explore where current practices are lacking and existing promising practices and possible responses in line with international standards with the potential of transferability and replicability.

The present chapter covers the needs of twelve vulnerable groups of prisoners namely, women, youngsters, foreigners, ethnic minorities, LGBTQ+ (lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual people), individuals with substance misuse problems, elderly, individuals with disabilities or special healthcare needs, individuals terminally ill, life sentences, remand and in segregation prisoners. Still, the authors recognise that there are other vulnerable groups which are not covered in this document.

8.1. Women prisoners

The female prison population has skyrocketed over the last years, and research has recorded an increasing rate of female prisoners much greater when compared with men. Furthermore, female remand prisoners represent a significant percentage of the women who are imprisoned in many countries. This could be explained due to the fact that prison sentences have been greatly used to punish crimes that were, previously, punished with non-custodial sentences (Bastick & Townhead, 2008).

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Female prisoners' health needs are very different from the needs of male prisoners, especially when it comes to their sexual and reproductive health. Regarding mental health, research shows that women in detention have a higher prevalence of mental disorders compared to male prisoners and the general population. Female prisoners are also much more likely than men to harm themselves or to attempt suicide (Bastick & Townhead, 2008; WHO, 2009). For instance, a research done in the UK shows that 5–6% of male prisoners and 20–24% of female inmates self-harmed every year, compared to 0.6% of the UK general population (Hawton et al., 2014). Furthermore, 46% of women in custody reported having attempted suicide at some point in the past, more than twice the rate of male prisoners (21%) and much higher than in the general population (around 6%) (Ministry of Justice, 2013).

According to WHO, not only high rates of PTSD are reported among female prisoners, but their mental health problems are closely related to their criminal pathways (van den Bergh, Plugge, & Aguirre, 2014). "Typically, they are young, unemployed, have low levels of education and have dependent children. Many have histories of alcohol and substance abuse. A high proportion of women offenders have experienced violence or sexual abuse. At the same time, there tends to be greater stigma attached to women's imprisonment than men's, and women who have been in prison may be ostracised by their families and communities" (Bastick & Townhead, 2008, p. 1). In fact, most female inmates have a history of victimisation prior to imprisonment, including domestic violence, physical and sexual abuse and child neglect (WHO, 2009). Research supports the claim that women in custody are more likely than men to report these concerns, leading to mental health and substance misuse problems (Bloom & Covington, 2008; UNODC, 2014). To be more precise, a study conducted in the UK found that women in custody (53%) were more likely to report having experienced emotional, physical or sexual abuse as a child than their male counterparts (27%) (Williams, Papadopoulou, & Booth, 2012). In the US, a report stated that more than 43% of female inmates had suffered from physical or sexual abuse prior to imprisonment, compared to 12% of male inmates (UNODC, 2014).

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Furthermore, a study concluded that 73% of women and 55% of men in state prisons in the US have symptoms of mental disorders compared to 12% of women in the general population (Covington, 2007). In the UK, 49% of female prisoners were assessed as suffering from anxiety and depression, compared with 23% of male prisoners, and with 16% of the general population. Moreover, 25% of women and 15% of men in prison reported symptoms indicative of psychosis (Ministry of Justice, 2013), compared to 4% among the general population (Wiles et al., 2006). In Australia, research conducted with imprisoned parents concluded that 81% of imprisoned mothers suffered from mental illness, compared to 60% of fathers (Bastick & Townhead, 2008).

Regarding drug and alcohol addiction, compared to their male counterparts, women are more likely to have been incarcerated for drug offences and to have more serious drug-related health issues, such as infectious diseases (European Monitoring Centre for Drugs and Drug Addiction, 2012). In fact, research shows that more than one in four women in European and Central Asian prisons were imprisoned for drug offences (Iakobishvili, 2012). Evidence also suggests that 75% of women arriving in European prisons are problematic drug and alcohol users, and that problematic drug use rates are higher among women than men (The Quaker Council for European Affairs, 2007).

Often, women in detention have co-occurring mental and SUD. For instance, a research conducted in the UK revealed that 83% of remanded and 75% of sentenced female inmates had two or more mental disorders (Singleton, Farrell, & Meltzer, 2003). In the US, a study found that three quarters of the female prisoners who had a mental health problem also met the criteria for substance dependence or abuse (Covington, 2007).

In 2005, a study aiming to explore exposure to traumatic events, mental health functioning and treatment needs of female prisoners found the following results (Bloom & Covington, 2008):

- 36 % had mental health problems;

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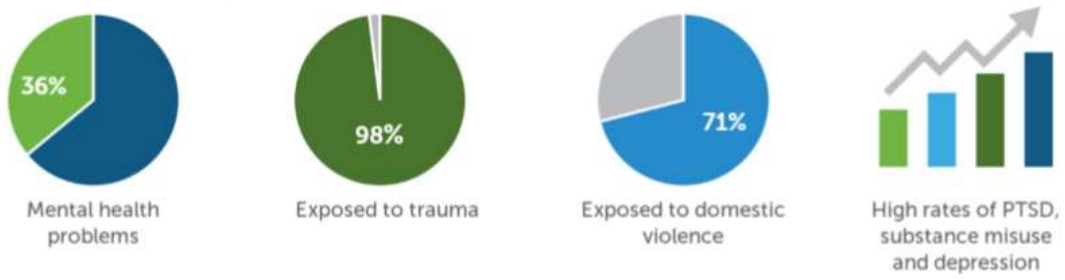
- 98% had been exposed to trauma, from which 90% referred to interpersonal trauma;
- 71% had been exposed to domestic violence;
- High rates of PTSD, substance misuse and depression were recorded.



These facts and figures support WHO recommendations, which states that "trauma-responsive programming needs to be a central component of all mental health services in prisons" (WHO, 2009, p. 34).

Not only the needs but also the things that worry and trouble female prisoners are different from those that worry the male population. Too often female prisoners are the primary care givers of children and carry varied family responsibilities (Bastick & Townhead, 2008; van den Bergh, Plugge, & Aguirre, 2014). In these cases, the conditions of imprisonment often have significant consequences for the family. In fact, "the imprisonment of a mother may have a traumatic and lasting effect on both mother and child, in part due to great distress because of the separation together with a range of emotional and psychosocial problems, and also because they are less likely than imprisoned men to have someone in the family looking after their child and are more likely to lose their housing and children as a result of their imprisonment" (van den Bergh, Plugge, & Aguirre, 2014, p. 162).

Besides, prisons for women tend to be further away from their homes making it difficult to maintain contact with their families. In addition, the visits process can be traumatic for

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both prisoner and visitors, due to multiple factors such as, long waiting times in poor waiting areas and intrusive searches, even of children (Bastick & Townhead, 2008).

Pregnancy and motherhood are two specific situations that make female prisoners a vulnerable group (Cuéllar, et al., 2015; Bastick & Townhead, 2008). In some cases, babies and young children are allowed to live with their mothers in many countries and while some prison establishments have special 'mother and baby units', not all include these. In some cases, prison facilities have no special provision for mother who are in prison and their children. Still, children are only allowed to stay with their mothers inside prison until a certain age limit. After this, children can no longer stay with their imprisoned mothers and are placed in the care of other family members or a state institution. This carries significant impacts to the children and the mother, with research showing that "children who are forcibly separated from their mothers suffer long-term developmental and emotional damage. These psychological and developmental problems tend to stay with children throughout their lives" (Bastick & Townhead, 2008, p. 50).

Therefore, the provision of health services for female prisoners should acknowledge this specific group gender-specific healthcare needs, be tailored to the latter and be delivered humanly. Gender sensitivity training for prison staff working with female inmates needs to involve awareness about their specific vulnerabilities and needs. Practices should promote continuity of care as physical and mental health needs of imprisoned women tend to be long-term (van den Bergh, Plugge, & Aguirre, 2014).

In 2016, a systematic review (Fazel et al., 2016) evaluated evidence-based interventions in prison settings and found the following 'disappointing' results for the imprisoned female population:

- Although trauma-responsive interventions have been created, these seem to have no significant findings;
- A particular trauma-responsive CBT intervention called 'Seeking Safety' has not proved to have significant outcomes when compared with other types of treatment;

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- A comparison made between trauma affect regulation and supportive group therapy had no significant differences regarding the recovery outcomes of both groups.

While the findings of this review might not be satisfying, similarly to WHO, the authors of the review recommend prisons to consider the provision of trauma-responsive and gender-specific interventions (Fazel et al., 2016).

Worldwide, most prisons separate male from female offenders, and given the fact that there is an emerging awareness that women offenders have different needs when compared with male offenders, particular considerations need to be taken when trying to develop programmes and responses for female offenders (Fazel et al., 2016; Covington & Bloom, 2007).

There are specific components that need to be considered when developing and implementing gender-responsive programmes for women prisoners. Some important elements, for successful implementation of mental health services for women prisoners include, the clinical issues that the programme addresses; the therapeutic approaches; the context and environment of the programme (Covington & Bloom, 2007; Bloom & Covington, 2008). Some of the clinical issues which have been suggested to be fundamental to address through the use of therapeutic programmes are trauma and co-occurring disorders (Covington & Bloom, 2007; Bloom & Covington, 2008). Trauma is a significant trigger for women to relapse on substances and it is often associated to the existence of mental health problems. Having experienced traumatic events impacts on how female prisoners related not only with other prisoners, but also prison staff and the programmes' therapeutic environment itself. Women prisoners often feel unsafe and struggle to participate when services are provided (Covington & Bloom, 2007; Bloom & Covington, 2008).

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Therefore, when addressing trauma, it is suggested to (Covington & Bloom, 2008; Bloom & Covington, 2009):

- Educate female prisoners on what abuse and trauma are. Although for professionals the signs of abuse might be clear, for prisoners it might be difficult to recognise if they actually have been victims of abuse.
- Reassure female prisoners that their reactions are normal, considering the experiences they have been through.
- Explore coping strategy skills. There are multiple techniques, such as meditation mindfulness, that female prisoners can practice and use to cope when going through moments where they relive their traumatic experiences.
- Provide a sense of safety and security by avoiding re-traumatisation where prisoners are triggered and re-experience traumatic events.

Taking into consideration these aspects is fundamental to the success of treatment programmes (Covington & Bloom, 2007; Bloom & Covington, 2008).

As mentioned previously, co-occurring disorders are common among women prisoners. It has been found that women who have substance misuse problems are more likely to experience two or more of the following disorders: depression; dissociation; PTSD; personality disorders; among others (Bloom & Covington, 2008). For many women, co-occurring disorders are related to serious traumatic experiences and research shows that, for women, substance misuse problems are a multi-dimensional problematic which involves complex issues. Therefore, it is suggested for effective treatment responses to adopt an integrated approach and encompass both mental health and substance misuse treatment needs through the lenses of trauma (Covington & Bloom, 2007; Bloom & Covington, 2008).

Research has shown that different therapeutic approaches and modalities have proved to be successful with women. Regardless of the approach adopted, it has been found that the therapeutic alliance which refers to the relationship between the professional who provides treatment and the client, is a central component that influences the effectiveness

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of the programme (Covington & Bloom, 2007; Bloom & Covington, 2008). Moreover, in order to secure an effective services' provision to women it is recommended mutual collaboration, consistency in caring, availability and confidentiality (Covington & Bloom, 2007; Bloom & Covington, 2008).

Regarding the context and environment of the programme, certain components have been suggested to influence the effectiveness of gender-responsive programmes, namely, individualised treatment; women-only groups; physical environment; psychological environment; and self-reliance- and strength-based model (Covington & Bloom, 2007; Bloom & Covington, 2008). Each women prisoner needs to be treated as unique, with specific recovery pathways, circumstances, treatment goals and needs. It is important to be sensitive to each prisoner singularities and recognise that there are differences, not only due to age, ethnicity and sexual orientation, but also because each women's life experience is different (Covington & Bloom, 2007; Bloom & Covington, 2008).

Research suggests that women-only groups, facilitated by women, tend to be more effective when responding to the needs of women with co-existing mental health and substance misuse problems. There are particular topics which women struggle to freely discuss about when men are present, such as mental health and substance misuse problems, sexual histories, relationships, childcare, among others (Covington & Bloom, 2007; Bloom & Covington, 2008). Moreover, it is suggested that women respond better if the treatment is held in a friendly and welcoming environment for them and their children. Fostering a multicultural environment and having a child-friendly space when children are included in the programme, has also been identified as components which influence the effectiveness of therapeutic approaches for women (Covington & Bloom, 2007; Bloom & Covington, 2008).

The therapeutic environment should have a positive impact on women's emotions and feelings, not reinforcing the dysfunctional systems that they have previously experienced. Therefore, some components have been identified as fundamental in both prison and

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community settings such as, a culture of belonging; a culture of safety, respect and dignity; a culture of openness; a culture of participation and citizenship; a culture of empowerment (Covington & Bloom, 2007; Bloom & Covington, 2008). Additionally, sense of privacy and a space where women are allowed to contemplate and reflect, instead of being activity-driven, are considered to be other important aspects of successful gender-responsive programmes (Covington & Bloom, 2007; Bloom & Covington, 2008).

This treatment model focuses on support and identification of the different issues' women are facing, aiming to reinforce their coping strategies instead of categorising their multiple problems. It is believed to be an important component to the successful and effective implementation of mental health services given that it seeks to help women to acknowledge their own strengths and skills, instead of having to confront their defence mechanisms (Covington & Bloom, 2007; Bloom & Covington, 2008).

8.2. Juvenile prisoners

It is important to acknowledge that young offenders are particularly at risk of mental ill-health (PRI, 2018). Prison administrations recognise the need to give special consideration to this particular group due to their young age range. In England and Wales, 95% of young offenders have a mental health disorder and many of them are lacking the appropriate support at a vulnerable time in their development (Campbell & Abbott, 2013). In fact, the prevalence rate of mental disorders in youngsters within the juvenile justice system is considerably higher than the rate found among the general adolescent population (Grisso & Barmun 2000).

Estimates also show that between 50-75% of the 2 million young offenders currently under supervision of the juvenile justice system can actually have a mental health disorder (Rijo et al., 2016; Shufelt & Cocozza, 2006; Underwood & Washington, 2016; Grisso, 2008). And if we consider juvenile offenders facing incarceration who have, at least, one diagnosable mental health condition, this number can rise up to 80% (Teplin et al., 2006). Common mental health disorders among youth offenders include, affective

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disorders (major depression, persistent depression, and manic episodes), psychotic disorders, anxiety disorders (panic, separation anxiety, generalised anxiety, obsessive-compulsive disorder, and PTSD), disruptive behaviour disorders (conduct, oppositional defiant disorder, and attention-deficit hyperactivity disorder) and SUD (Underwood & Washington, 2016; Grisso, 2008; Teplin et al., 2006; Mallet, 2006).

More specifically, among young people involved within the juvenile justice system, it is estimated that between 11% to 32% have traces of posttraumatic stress disorder; from which 15% to 30% have evidenced signs of depression or dysthymia (pervasive depressive disorder), a similar percentage to the ones showing attention-deficit/hyperactivity disorder. Although not common as the previously mentioned disorders, some youngsters also show indications of suffering from a bipolar disorder (approximately between 3% and 7%) (Underwood & Washington, 2016).

"Young people at the boundary between the Criminal Justice System and mental health services are a particularly vulnerable group" (Harrington et al., 2005, p. 10) that face not only problems while trying to include themselves within their society peers, but are also at an increased risk of stigmatisation and labelling. In fact, "there is increasing evidence that young offenders are falling between gaps in services" (Harrington et al., 2005, p. 10). Young offenders are found to have high levels of needs that are indissociably related with their increased risk of suffering for a mental impairment, such as significant problems regarding education or work. Additionally, these youngsters tend to have a history of "social care placements, family breakdown and school exclusions" (Harrington et al., 2005, p. 7).

A study conducted in England and Wales concerning this particular group demonstrated why these youngsters are exceptionally vulnerable. Specifically, it was found that (Harrington et al., 2005):

- 33% had, at least, one particular mental health need;
- 20% were depressed;

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- 25% had learning difficulties (with an intelligence quotient below 70);
- 10% of these young people reported a history of self-harm within the last month of analysis;
- Another 10% revealed high anxiety levels and post-traumatic stress symptoms (PTSD);
- Hyperactivity was reported in 7% of the cases;
- Psychotic-like symptoms were shown in 5%.

Therefore, understanding the relationship between mental health difficulties and youth offending is absolutely paramount for addressing these individuals' needs and to provide an effective treatment response. This is of the utmost importance, as there is growing evidence that mental impairments are direct and indirectly related to fostering delinquent behaviours that might culminate in future criminal offences (Heilbrun, Lee, & Cottle, 2005).

"The high prevalence of mental disorders within the juvenile justice system does emphasises the need for different levels of mental healthcare with varying treatment options" (Underwood & Washington, 2016, p. 3). While on the one hand some youngsters who have some kind of mental disorder only experience it temporarily and, therefore, only require emergency services, others, approximately 10%, represent a group with chronic mental health needs who will likely need clinical care alongside their personal development into adulthood (Roberts, Atkins, & Rosenblatt, 1998). However, some of

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these young individuals actually function well despite their symptoms, while others present limited functionality. "Regardless of the diagnosis, youth will present within the juvenile justice system differently, with different mental health needs requiring differing levels of care" (Underwood & Washington, 2016, p. 4). Hence, since each case has different peculiarities which are inherent to each individual, a comprehensive screening and assessment process is required, alongside effective and varied treatments options (Underwood & Washington, 2016).

Therefore, the identification and treatment of young offenders should be a top priority within the criminal justice system, since "youth are largely recognised as having the right to receive mental health services while incarcerated" (Penner, Roesch, & Viljoen, 2011, p. 223). However, in order to guarantee idealised mental health service standards, "juvenile justice systems must engage in mental health screening, assessment, and treatment" (Penner, Roesch, & Viljoen, 2011, p. 223), while ensuring their continuous availability both within justice facilities and upon these individuals' return to society during the post-release period.

"Best practice recommendations suggest that treatment programming should include multimodal and multidisciplinary care and be based on the outcome of youths' comprehensive assessments" (Penner, Roesch, & Viljoen, 2011, p. 224). As so, the most effective treatments tend to include professional clinical care alongside the use, only if needed, of psychopharmacology concepts (Grisso, 2008). Such approach should be taken under a non-stressful environment (Grisso, 2008). Moreover, it is not only recommended for each treatment plan to contain clear implementation guidelines, but also that it must be as individualised as possible, based on each young person's mental health needs (Penner, Roesch, & Viljoen, 2011). Nevertheless, "while evidence is limited for the efficacy and effectiveness of some approaches, there are a few specific therapeutic models with promising evidence for their effectiveness with youth offenders with mental disorders" (Underwood & Washington, 2016, p. 4).

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Cognitive-Behavioural Therapy, also known as CBT, focuses on teaching "youth awareness of social cues and promotes delaying, problem solving, and nonaggressive responding strategies" and tend to be "particularly effective with juvenile offenders" (Underwood & Washington, 2016, p. 4). In fact, research as shown that CBT's effectiveness as a method specialised in reducing future delinquency for youth individuals' suffering from a wide range of depressive and anxiety disorders (Kendall, Reber, McLeeer, Epps, & Ronan, 1990; Kaslow & Thompson, 1998; Shelton, 2005).

On the other hand, the Integrated Co-Occurring Treatment (ICT) (Cleminshaw, Shepler, & Newman, 2005) follows an integrated treatment programme approach, since it "is a component model of care that uses treatment and service elements that are effective with similar population but adapted to the specialised needs of youth with co-occurring mental health and substance abuse disorders. (…) ICT uses a stage progression treatment approach (engagement, persuasion, active treatment, and relapse prevention) and engages motivational interviewing as a method to facilitate readiness for change" (Underwood & Washington, 2016, p. 4).

The Functional Family Therapy (FFT) was developed back in the 1960s and, as its name implies, is a family-centred approach providing a response to youth (and their families') multiple needs. It is often used for youngsters between 11 and 18 years old who are "at risk for and/or presenting with delinquency, violence, substance use, conduct disorder, oppositional defiant disorder, or disruptive behaviour disorders" (Underwood & Washington, 2016, p. 5). In fact, research has found that young individuals under the FFT model presented a re-arrest rate of only 25%, a considerably lower rate than the one observable for those who didn't undergo any treatment programme, which is between 45% and 70% (Shelton, 2005).

Multisystemic Therapy, commonly known as MST, is considered as "one of the best available treatment approaches for juvenile offenders with mental health treatment needs" (Underwood & Washington, 2016, p. 5). Its intensive approach is not only family-

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based, but also multimodal, fitting "treatment with identified causal factors and correlating factors of delinquency and substance use" (Underwood & Washington, 2016, p. 5). Research clearly supports the effectiveness of the MST model when intervening with juveniles characterised by having several behavioural or emotional disorders, since reductions in re-arrest rates are as high as 70%, and up to 64% in out-of-home placements (National Mental Health Association [NMHA], 2004). In addition, improvements have also been seen in family functioning (NMHA, 2004).

The Family Integrative Transition (FIT) programme "combines empirically supported interventions such as, Multisystemic Therapy, Motivational Enhancement therapy, Relapse Prevention, and Dialectical Behaviour therapy" (Underwood & Washington, 2016, p. 5). It is a rigorous treatment intervention that begins within a 2-month period prior to the youngster's release date, continuing for approximately 6 months during his/her reintegration into society (Aos, 2004).

A different approach for treating mental illnesses among the younger offender population in the Wraparound Approach. It is known as a "philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualised for that child and family to achieve a positive set of outcomes" (Burns & Goldman, 1999, p. 27). Specifically, the Wraparound Approach leans on the fact that to effectively deal with the complexity of the emotional and behavioural problems of young offenders, more than simply one system of care needs to be involved (Underwood & Washington, 2016). Therefore, "wraparound services link the youth's strengths and needs to services and supports within his or her community" (Underwood & Washington, 2016, p. 6), acting as a facilitator within the system-of-care framework.

Aiming an intervention specifically focused in adolescents with severe and chronic behavioural and emotional problems, the Multidimensional Treatment Foster Care (MTFC) is the ideal method as an alternative to group, residential, secure-care, or

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hospitalisation treatment (Underwood & Washington, 2016; Shelton, 2005). In the MTFC, "adolescents are placed with trained, local, and supervised families for approximately 6 to 9 months" (Underwood & Washington, 2016, p. 6), which fosters the conduction of family-based therapy.

The Crisis Intervention Team, or simply CIT, is a 2010 model developed in the United States of America. Specifically, it is a specialised law enforcement-based programme for youth with mental illness (Doulas & Lurigio, 2010), and was created as a "response to the fragmented and often inadequate behavioural health services for youth across the educational, juvenile justice, and mental health systems" (Underwood & Washington, 2016, p. 6). In addition, this model became quite needed since a proportion of youngsters in the US who suffer from, at least, one mental disorder, were actually never diagnosed or treated (Doulas & Lurigio, 2010).

Research shows that the "most effective treatment models that have demonstrated delinquency-reducing benefits for youth with mental disorders include Functional Family Therapy, Treatment Foster Care, and Multisystemic Therapy. Interestingly, all of these therapeutic models are similar in that they involve families and youth, are community-based, and deal with problem behaviours and stresses as a systemic family unit" (Underwood & Washington, 2016, p. 7), representing an integrated system of care that contributes to recidivism reduction amongst youth with mental disorders (Grisso, 2008).

8.3. Foreign national prisoners

The number of foreign national prisoners in Europe has been increasing significantly and at a fast pace (Gatherer, Atabay, & Hariga, 2014; UNODC, 2009). Some of the reasons that make foreign national prisoners a vulnerable group of inmates include issues related to the language barrier, which impacts the access to educational and training activities, cross-cultural difficulties, religious differences, social isolation, lack of social networks, difficulties maintaining contact with family, discrimination, lack of awareness of legal

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rights, lack of access to legal counsel, economic marginalisation and the possibility of deportation (Cuéllar et al., 2015; Gatherer, Atabay, & Hariga, 2014; UNODC, 2009).

Problems with communication are identified by WHO as "the most serious challenge" foreign individuals face when imprisoned (Gatherer, Atabay, & Hariga, 2014, p. 155). Misunderstandings or misinterpretations during communication may lead to inaccurate clinical assessments and, consequently, health complications. Language barriers not only hinder communication with other prisoners and staff but carry implications for foreign nationals' accessibility to educational and training activities. In addition, misunderstanding of prison rules and having to make requests in writing can generate different complications and lead to unintentional breaking of rules, isolation, frustration and aggressiveness (UNODC, 2009). Providing any type of translation support is crucial to reassure the prisoner that whatever their needs are, these are being considered and addressed by prison staff. Moreover, there is the possibility that foreign national prisoners carry a disease that can be endemic in their country of origin and rare in the country where they are imprisoned, meaning that specialists should be involved when diagnosing and assessing health needs (Gatherer, Atabay, & Hariga, 2014).

For female foreign national prisoners, their vulnerabilities are particularly associated with the strong impacts that the separation from their families and community has on them, as well as due to a tendency for isolation and fear of being abused either in pre-trial detention or inside prison (UNODC, 2009). Lack of contact and support from families and their communities is an important factor contributing to the vulnerability of foreign national prisoners. The lack of this type of contact which is crucial for their well-being, attitude towards life inside prison and reintegration, can have multiple impacts on prisoners. Furthermore, "many foreign nationals serve long sentences for drug trafficking and the lack of contact over many years can have a very harmful effect on the mental condition of such prisoners" (UNODC, 2009, p. 82). In fact, foreign national prisoners "are also at particular risk of developing mental healthcare needs in prison, due to isolation, discrimination and the anguish caused by their legal status" (UNODC, 2009, p. 86).

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Discrimination is another main reason why foreign nationals are considered a vulnerable group of prisoners. Whether this is perpetuated by physical or verbal abuse, foreign national prisoners tend to be discriminated by the level of security they are allocated to, number of disciplinary punishments, searching procedures and type of prison activities they are offered to engage in (UNODC, 2009).

Regarding existing practices for the support of this specific vulnerable group, WHO highlights the need to disseminate information (including health-related) and harm reduction resources (e.g., leaflets) in multiple languages, using an approach and vocabulary adequate for the level of literacy and education of prisoners (Gatherer, Atabay, & Hariga, 2014). Furthermore, prejudice and discrimination must be addressed by the prison systems. There should be initiatives in place to promote a non-tolerant attitude towards any type of discrimination as well as prison staff straining on these matters. To guarantee that this vulnerable group is supported and their safety is assured, prisons should also thoroughly consider where these prisoners are accommodated inside the establishment, trying to mitigate the risks of putting them close to prisoners "who may represent a risk to their safety due, for example, to nationalistic views and violence based on such views" (Gatherer, Atabay, & Hariga, 2014, p. 155). Contact with the outside world is also recommended as this is particularly important to reduce the impact of isolation (UNODC, 2009). In addition, and among the several recommendations proposed, the UNODC (2009) recommends for prison management to "consider forming foreign national support groups in prisons, to enable peer support and to channel requests from foreign national prisoners to the prison administration" (p. 91).

8.4. Prisoners from ethnic minorities

Prisoners from ethnic minorities and indigenous people are overrepresented in many countries (Gatherer, Atabay, & Hariga, 2014; UNODC, 2009). Discrimination is a main factor that, similarly to foreign national prisoners, contributes to the vulnerability of this

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group (UNODC, 2009). A review found that, in England and Wales, black, asian and minority ethnic (BAME) individuals are less likely to be identified with mental health problems during the prison induction period and less likely to engage in offender behaviour programmes (Lammy, 2017). This has been found to be related with the discrimination and marginalisation experienced by this group, inside and outside prison, considering that "ethnic and racial minorities often face discrimination in access to, and treatment in, mental healthcare and support services. Indigenous populations are frequently ignored, with no specialist development of psychiatric and support services despite acute needs that are manifest in increasing suicide rates and overrepresentation in high-security mental health facilities" (UNODC, 2009, p. 62).

In fact, ethnic minorities and indigenous prisoners' likelihood of being overrepresented among prisoners with mental healthcare needs is due to the discrimination they experience, which constitutes serious barriers to accessing support services, putting them at greater risk of getting substance misuse problems. In addition, there is a greater likelihood for indigenous female inmates of being victims of domestic violence in some societies (UNODC, 2009).

Furthermore, due to the socio-economic marginalisation experienced in the community and inappropriate medical care prior to being in prison, ethnic minorities are more at risk of carrying and spreading sexually transmitted diseases (STDs) and having health problems associated with substance misuse. In fact, research has shown that among this vulnerable group special needs, rehabilitation programmes for substance misuse problems is one the primary needs. Thus, if treatment and support are not provided, these situations will most certainly worsen when imprisonment occurs (UNODC, 2009).

For adequate support to be provided to this vulnerable group, the International Convention on the Elimination of All of Racial Discrimination (Office of the United Nations High Commissioner for Human Rights, 2013) states that all criminal justice systems should "guarantee such persons the enjoyment of all the rights to which prisoners are

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entitled under the relevant international norms, in particular rights specially adapted to their situation: the right to respect for their religious and cultural practices, the right to respect for their customs as regards food, the right to relations with their families, the right to the assistance of an interpreter, the right to basic welfare benefits and, where appropriate, the right to consular assistance. The medical, psychological or social services offered to prisoners should take their cultural background into account" (p. 10).

Furthermore, and considering that prisoners from ethnic minorities might have experienced discrimination and physical and verbal abuse, it is recommended to:

1) Provide translation support whenever needed;

2) Include voluntary agencies who are experts on the needs of this vulnerable group;

3) Provide written and/or visual health information in case they speak a different language;

4) Promote and foster trust and respect between inmates and professionals.

This will not only contribute to a better provision of healthcare services and support but also guarantee that these prisoners have the equivalent level of access to services as any other prisoner (Gatherer, Atabay, & Hariga, 2014). Healthcare screening at prison intake is also a practice which is re-enforced by the literature, as well as taking into consideration cultural backgrounds and traditions of these prisoners when providing mental health treatment and support services (UNODC, 2009).

The provision of substance misuse treatment programmes is fundamental as addiction problems have been identified as a main need among ethnic minorities and indigenous. It is also recommended for prison staff to work collaboratively with community agencies who are experts in the needs of this particular group, in order to tailor the programmes to their specific needs, making them more effective and easing continuity of care upon release. This will also generate value by creating and maintaining links between prisoners and the community (UNODC, 2009).

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For prison management, the UNODC (2009) makes three clear and important recommendations:

- "To make clear their commitment to racial and ethnic equality, to make this an integral component of prison management policies and to display a statement to this effect prominently in prison establishments;
- To establish mechanisms, such as forming multidisciplinary and multicultural teams representing major services, and formalising cooperation with representatives of minority groups and indigenous peoples in the community, to advise on the introduction of appropriate policy and regulations to eradicate discrimination and improve social reintegration initiatives in prisons;
- To put in place mechanisms for the ongoing monitoring of discrimination based on ethnicity, race and descent and to ensure that disparate treatment of prisoners, based on race, ethnicity and descent, is eliminated" (p. 76).

8.5. Lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ+) prisoners

LGBTQ+ prisoners are considered a vulnerable group due to the heightened risk they are subject to inside prison of discrimination and abuse (including sexual assault and rape) (Cuéllar et al., 2015; Gatherer, Atabay, & Hariga, 2014; UNODC, 2009). This particular group incurs another risk which is not shared by other vulnerable groups, namely, the fact that consensual sexual intercourse between adults with the same sex is a crime under the law of some countries (Gatherer, Atabay, & Hariga, 2014; UNODC, 2009). This puts an important focus on the existence of prison policies which outline how to proceed and manage this group of vulnerable prisoners. In fact, LGBTQ+ prisoners are especially vulnerable to violence (including sexual violence) which means that their place of accommodation inside prison should be thoroughly assessed to ensure their safety, mental well-being and physical integrity (Gatherer, Atabay, & Hariga, 2014).

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Other reasons of vulnerability include issues related to prejudice and stereotypes that LGBTQ+ individuals usually suffer in prison. Moreover, LGBTQ+ prisoners are more likely to be victims of sexual assault and more likely to suffer from STD's. Their healthcare needs might also include specialised medical care (e.g. hormone therapy) and counselling for mental health needs associated with victimisation (Gatherer, Atabay, & Hariga, 2014; UNODC, 2009).

An additional issue regarding this group of prisoners is that the monitoring of sexual orientation is not very effective since most inmates "may be fearful of victimisation from other prisoners and discriminatory attitudes from staff if they tick anything other than the 'heterosexual' box" (Dunn, 2013, p. 5). This leads to a culture of non-disclosure by prisoners and non-acknowledgement by staff. As a result, the support and provision of care, including mental health care, decreases due to the invisibility of this community in prison. Furthermore, when the care is provided it is usually not specific to LGBTQ+ inmates as prison staff claim that "we don't have many here" (Dunn, 2013).

Moreover, it is common for prison staff to place prisoners at risk of being harassed and victimised, like LGBT+ inmates, in segregation or protective custody as a preventive measure. However, the long-term consequences of isolation may harm their mental health (Grassian, 2006). Therefore, this measure should be revised since in most cases it worsens the problem and it constitutes a violation of Constitutional rights (Carr, McAlister, & Serisier, 2016).

In Ireland (Mayock, 2009), research on mental health shows that LGBT inmates have "extremely negative sense of self, causing many to experience depression, and a significant minority to engage in self-injurious behaviour and to have, and in some cases act upon, suicidal thoughts" (p. 135). Undoubtedly, there is a higher risk of suicide and self-harm in LGBT+ prisoners in comparison to the wider prison population, due to their exposure to discrimination, stigmatization, harassment, physical violence, abuse and sexual violence behind bars (Carr, McAlister, & Serisier, 2016).

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Similarly to previously mentioned vulnerable groups, literature recommends liaising work between prison staff and community-based agencies specialised in LGBTQ+ healthcare services to guarantee that their needs are being addressed with the support of specialised help, counting with the experience and skills of professionals working with LGBTQ+ issues (Gatherer, Atabay, & Hariga, 2014).

Prison staff should receive guidance and training on how to manage and support this particular vulnerable group, not only due to the fact that there are multiple specific needs that require special consideration, but also due to the fact that these prisoners are not likely to report victimisation, violence and humiliation due to fear of retaliation (Gatherer, Atabay, & Hariga, 2014; Cuéllar et al., 2015). Therefore, prison procedures and policies should include special protection for prisoners against retaliation (Gatherer, Atabay, & Hariga, 2014; Cuéllar et al., 2015). Moreover, literature re-enforces that, "in cases of rape, intensive psychological support is needed" (Cuéllar et al., 2015, p. 31). In fact, prisoners who have been victims of sexual assault inside or outside prison, or who have suffered from discrimination and humiliation, will require psychological and mental healthcare support to address the negative impacts these events might have to their mental well-being. "LGBT prisoners who have been victims of rape may be at risk of self-harm or suicide, for which they will require special supervision and care" (UNODC, 2009, p. 108).

8.6. Prisoners with substance misuse problems

Substance abuse is an important topic affecting mental health and, despite the challenges in collecting data, it is generally accepted that drug use is a common activity in prisons around the world (Stöver, 2007). In fact, it is important to highlight that problems associated with "the use or abuse of drugs are a matter of physical and mental health" (Cuéllar et al., 2015, p. 25). The reasons given by prisoners for using drugs during their sentence are commonly associated with boredom relieve, release of tension, and coping

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with being in an overcrowded and often violent environment (Jürgens, Nowak, & Days, 2011).

A systematic review of thirteen studies with a total of 7563 inmates found that an estimation of prevalence for alcohol abuse and dependence in male prisoners ranged from 18 to 30% and 10 to 24% in female prisoners. Furthermore, this systematic review found that for drug abuse, the prevalence estimates varied from 10 to 48% in male prisoners and 30 to 60% in female prisoners (Fazel, Bains, & Doll, 2006).

Studies show that substances available outside prison can also be found inside prison, with the same regional variation in patterns of use. The quality of these drugs is often poor compared with that drugs in the community (Co-operation Group to Combat Drug Abuse and Illicit trafficking in Drugs, 2013). In fact, one of the reasons why substance misusers constitute a vulnerable group of prisoners includes the high risk of developing health problems due to the impurity of substances that get inside prison. Additionally, prisoners can get into debt and conflicts with other prisoners due to the difficult access to substances (Cuéllar et al., 2015).

In many prisons, the most commonly used drug besides tobacco is cannabis, which is used for relaxation purposes. While some studies have shown that more than 50% of the inmates use cannabis while in prison, a much smaller percentage reports injecting drugs in prison and a substantial number of drug users having first started to inject while in prison (up to 21%). Studies of drug users in prison suggest that between 3% and 26% first used drugs while they were incarcerated (Co-operation Group to Combat Drug Abuse and Illicit trafficking in Drugs, 2013).

Drugs use inside prison can lead to the adoption of risk behaviours. Although it has a lower prevalence among inmates, injecting drug use is of particular concern, given the potential for transmission of HIV (human immunodeficiency virus), tuberculosis and viral hepatitis. Those who inject drugs in prisons often share needles, syringes and other

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injecting equipment, which is an efficient way of transmitting HIV and other diseases (Jürgens, Nowak, & Days, 2011).

Moreover, increased risk of death by overdose, increased risk of passing on infections acquired in prison, increased risk of re-offending on release (Co-operation Group to Combat Drug Abuse and Illicit trafficking in Drugs, 2013), and increased risk of potentialising mental health disorders represent other harms associated with drug users in the criminal justice system (Azbel et al., 2015).

In fact, inmates who take their own lives usually have a background of being victims of violence, as well as substance dependency (such as alcohol or drugs). Such historical component should require therapeutic responses from the correctional facilities where they are incarcerated, especially since these inmates are even more likely to attempts suicide than others (UNODC, 2009).

Therefore, it is important to recognise that drug dependence (whether opiates, cocaine, tobacco, alcohol or other drugs), is a chronic disease (not a criminal or hedonistic behaviour), characterised by a long process of relapses and attempts at stabilisation. It is also important to raise awareness regarding the fact of substance misuse being a disorder that consequently requires a continuing care and support approach and should be treated in the same manner as other chronic illnesses (including diagnosis, treatment plan, control of progress, monitoring, etc.) (Stöver & Kastelic, 2014).

Regarding the responses available to support this vulnerable group of prisoners, evidence shows that prison-based work with drug users can reduce reoffending and drug dependency (Mitchell, Wilson, & MacKenzie, 2012). In general, drug services in prisons seek to cover three very important components, namely, prevention, treatment and harm reduction. Indeed, "the complexity of the drug use/abuse problems and the therapeutic approach require that prison administrations offer diverse opportunities for treatment" (Cuéllar et al, 2015, p. 28). Commonly used strategies for drug prevention in prisons

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include drug testing (the frequency as well as the mode of testing can vary considerably from country to country), health education and promotion and drug detection equipment (to detect drugs that visitors or correctional staff might try to bring into the prison) (Stöver, Weilandt, Zurhold, Hartwig, & Thane, 2008; Feucht & Keyser, 1999). Regarding treatment interventions for drug and alcohol dependence, these tend to vary greatly throughout Europe. Still, some of the most commonly used interventions include 12 steps programmes, acupuncture, therapeutic communities, methadone provision, cognitive-behavioural interventions, and educational programmes (Stöver et al., 2008).

Inmates who continue to use drugs in prison often do so in a more high-risk way, by sharing syringes which increases the risk of infection. For these reasons, it is of utmost importance to implement effective harm reduction strategies in prisons (ex.: needle exchange programmes) (Kolind & Duke, 2016). However, harm reduction, and especially needle exchange programmes, are still highly controversial in prisons despite the evidence of their efficacy. Other measures to prevent the transmission of infectious diseases among drug users include, for example, provision of opiate substitution treatment, availability of condoms and lubricants, implementation of vaccination programmes against hepatitis A and B, face-to-face communication (counselling, personal assistance, assistance from and integration of outside agencies for AIDS help or bloodborne viruses), and safer use training for drug users (Stöver & Kastelic, 2014).

In addition, it is also important to consider pre-release and aftercare programme interventions given that evidences show that the success of treatment programmes in prison is closely linked to the especially good-quality aftercare that covers the vulnerable period from release until the first months of re-entry into the community (Zurhold, Haasen, & Stöver, 2005).

8.7. Elderly prisoners

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Older prisoners are the fastest growing age group in many prison systems around the world (Baidawi, 2016). For instance, it has been documented that there was a 282% increase in the USA federal and state prisoners aged 55 or older between 1995 and 2010, while the number of all prisoners grew by less than half (increasing 42%) (Fellner, 2012). While there is still no consensus in the literature regarding how the 'older' or 'elderly' inmate is defined, many criminal justice systems consider prisoners to be older, or geriatric, by the age of 50 or 55 years (Baidawi, 2016). This is because many medically and socially vulnerable adults (such as homeless or impoverished people, refugees and inmates) experience accelerated ageing, that is, they develop chronic illness and disability approximately 10–15 years earlier than the rest of the population (Williams, Ahalt, & Greifinger, 2014). Underlying factors include, on the one hand, the individuals' poor physical or mental health prior to imprisonment (often owing to substance abuse, lack of access to healthcare or inadequate care, poverty, and lack of education). On the other, the physical and psychological stresses of prison life itself, such as separation from family and friends; the threat of victimisation; and the prospect of living most of one's life in confinement (Chiu, 2010).

It has been estimated that the cost of incarcerating someone aged 50 or older is two to five times the cost of incarcerating someone 49 and younger (Sullivan, 2017). The difference is often explained by the escalating medical costs associated with this age group. In fact, older prisoners are more likely to suffer from a variety of medical conditions, including, decreased sensitivity to heat, cold and pain; disinclination to eat leading to weight loss; pressure injuries and falls; increased problems with heart disease; decrease amount of activity; increase amount of medications; age related changes in the nervous system (e.g., tremor, shaking, dementia, stroke); poor sight and hearing; decreased muscular strength and physical fitness; bone and joint related disorders such as arthritis and osteoporosis; urinary track problems; and cancers of various types (Porporino, 2014). As a consequence, they require more contacts with healthcare providers and, typically, longer and more frequent hospitalisations (American Civil Liberties Union, 2012).

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There is little research focusing on the mental health and well-being of older prisoners, especially on the phycological impact of imprisonment on the elderly. The existent research suggests that older inmates suffer a more difficult adjustment to prison life compared to their younger counterparts. They experience varied types of 'psychological' stressors in prison, such as the fear of dying in prison, and victimisation or being diagnosed with a severe physical or mental illness. Moreover, alcohol abuse and depression are also common among this population, which affects their mental well-being (Gatherer, Atabay, & Hariga, 2014).

Adding to this, some researchers have coined the phrase 'institutional thoughtlessness' to refer to the staff's neglect in the treatment of older offenders. Since they are more cooperative and less disruptive, elderly inmates are less of a problem for staff which may lead to them being neglected or forgotten (Maschi et al., 2014).

Another pain of imprisonment is the need to manage what Crawley and Sparks (2005) refer to as a 'spoiled identity': the loss of a sense of purpose or coherence in life which can lead to a total disengagement from social activities and routines, including personal care (Porporino, 2014). However, the emotional and psychological coping needs of the elderly inmates will vary considerably depending on how much time they may have served and how much time they have left to serve, their health conditions, available social support networks, and their status within the prison hierarchy.

Other factors that make elderly prisoners a vulnerable group of prisoners are the difficulties they often experience associated with mobility around the prison and the multiple needs for adequate medical care due to the diseases they may suffer from, such as hearth problems, hypertension, Alzheimer's disease, memory loss, among others (Gatherer, Atabay, & Hariga, 2014). Moreover, elderly prisoners who have spent a long period of time in prison often lose contact with their families, which impacts not only

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their mental well-being but their prospects of potential successful resettlement upon release (UNODC, 2009).

An important aspect that needs to be highlighted and makes older prisoners vulnerable, is the fact that research has shown that lack of social support is associated with suicidal ideation among elderly prisoners. Vanderhorst and McLaren (2005) conducted a study with 111 older adults and found that lack of social support among this population was associated with higher levels of depression and suicidal ideation.

Therefore, any effective response to these issues requires some level of individualised case management and sensitivity to the particular needs of the person (Porporino, 2014). "Older prisoners are likely to require a number of healthcare services, including medical, nutritional and psychological treatment. Some may be in need of constant medical monitoring and delivery of medications to their cells/dormitories on a regular basis" (UNODC, 2009, p. 136).

Some of WHO's recommendations include (Gatherer, Atabay, & Hariga, 2014; UNODC, 2009):

- The use of multidisciplinary teams including specialist staff, namely, a minimum of a doctor, a nurse and a psychologist;
- Close liaison with community health services, in order to ensure that the most appropriate care is provided;
- The use of a physical difficulties screening tool at the time of prison admission;
- Guarantee special dietary needs.

Furthermore, to support older prisoners and in an effort to respond to their healthcare needs, prisons should include special programmes that focus on elderly prisoners' needs such as "instruction on healthcare for older persons, counselling related to growing old, fear of death, isolation and substance abuse and special education courses that meet the needs of this age group. Specialised counselling may also include those designed for

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prisoners with terminal illness and those who have received a life sentence without parole" (UNODC, 2009, p. 136).

Day Centres are also a good example of good practice when supporting this vulnerable group of prisoners. The provision of a Day Centre allows older inmates to have "a space in which they can interact with others, be able to make good use of their time by taking part in sessions" (Eadie, Grainge, Jackson, Safe & Wilkes, 2017, p. 24) that fulfil their interests in a quiet, relaxed and safe environment. Moreover, each Day Centre can have a flexible scope in terms of prisoner and prison needs. For example, they can include sessions on health and well-being, promote social inclusion, as well as they can also be used as a platform for older prisoner forums (Eadie et al., 2017).

On the other hand, day services provide an opportunity for older prisoners to have 'out of cell' opportunities as regards getting advice, information and healthcare (Le Mesurier, 2011a). Providing a wide range of day services, including talks, crafts and games, enables social opportunities which are critical to improving the mental health and well-being of prisoners. Moreover, "older prisoners are able to learn basic skills that will help them cope with entry to the community, such as preparation of simple meals" (Le Mesurier, 2011b, p. 12).

Considering the heterogeneous nature of the older population, the adaptation of programmes to the individual needs and circumstances of this demographic is essential by, for example, creating spaces for older prisoners to read, play cards or associate with each other. It is also important to assess older prisoners' own wishes and abilities to determine the level of outdoor exercise they participate in.

"Other prisoners' assistance in helping care for older prisoners may be sought, after careful screening and assessment. This approach would lighten the burden of staff, who are usually overstretched due to personnel shortages, and provide selected prisoners with a meaningful activity" (UNODC, 2009, p. 138).

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On the other hand, engaging community services and NGOs is of great value as regards reducing the sense of isolation prevalent among older prisoners, as well as in filling resource gaps in the correctional system in designing and delivering programmes and activities for older prisoners (UNODC, 2009).

As far as good practices are concerned, the True Grit Programme which was implemented in the States of New Jersey and Nevada (USA), had promising results in bridging older adults from prison to the community. The reason being that it mainstreams principles of social justice and human rights, such as dignity and worth of the person throughout its activities. The True Grit Programme evolved gradually throughout its 10 years of existence, and has been assisting elderly offenders in their emotional, mental, physical and spiritual growth, including rehabilitation and eventual re-entry into society. Its key facets are (Maschi et al., 2014):

- Older inmates are housed together in a separate unit;
- Different diversion activities (e.g., knitting, beading);
- Cognitive therapy activities (e.g., theatre arts group, creative writing, etc.;
- Peer support groups in emotional support and/or substance abuse;
- Physical fitness activities;
- Pet therapy in the contexts of end of life care;
- Discharge planning.

8.8. Prisoners with disabilities or special healthcare needs

Although the ageing of the prison population is associated with the increased number of prisoners with physical disabilities, this is just one part of the prison population with disabilities or special healthcare needs. Prisoners with disabilities or special healthcare needs experience, similarly to elderly prisoners, difficulties associated with mobility around the prison (especially, in cases of physical disability) and the risk of being victim of abuse and bullying by other prisoners. In fact, the self-defence limitations that

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prisoners with intellectual disabilities experience puts them at risk of being abused by other prisoners, causing greater harm to this vulnerable group of prisoners. These prisoners also experience particular health problems, such as pressure sores (e.g., in cases of limited mobility or wheelchair use), that must be adequately detected and treated (Gatherer, Atabay, & Hariga, 2014).

Prisoners with disabilities or special healthcare needs are vulnerable and their mental healthcare needs is one of the reasons. This has been particularly noted in cases of prisoners with sensory disabilities (i.e., disabilities that impair one or more of the five senses), where their condition tends to contribute to isolation and increased risk of psychological abuse and bullying. Also, increased difficulty in accessing services such as mental healthcare and counselling programmes, poses risks for the prisoners' mental health due to, for example, communication difficulties in cases where prisoners have a hearing or speaking impairments (UNODC, 2009).

Moreover, "some prisoners with disabilities, especially those with sensory disabilities, are at risk of developing mental healthcare needs, as the isolation experienced by such individuals may be intensified in the prison environment. Taking into account the problems with communication faced by prisoners with sensory disabilities, assistance should be provided to ensure that they have equal access to counselling programmes" (Gatherer, Atabay, & Hariga, 2014, p. 153). Indeed, the prison environment intensifies the multiple difficulties that people with disabilities were already experiencing in the community. The closed and restricted milieu of prison, the violence and lack of adequate prisoner individualisation and supervision are some of the factors that contribute to the exacerbated difficulties prisoners with disabilities experience. Furthermore, "prison overcrowding accelerates the disabling process, with the neglect, psychological stress and lack of adequate medical care, characteristic of overcrowded prisons" (UNODC, 2009, p. 43).

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Discrimination is another very important component that makes prisoners with disabilities or special healthcare needs a vulnerable group. It is common for people with such characteristics to experience discrimination in the society which is, in turn, aggravated inside prison. They face difficulties not only in accessing services, but in complying with rules and adapting to the layout and architectural structure of prisons, as well as engaging in activities that do not consider their specific needs. Adding to this, if prisoners with disabilities or special healthcare needs are either foreign nationals, from an ethnic minority or LGBTQ+, they are at greater risk of being victims of discrimination, abuse, sexual assault and other forms of violence whilst in custody (UNODC, 2009).

Similarly to other groups of vulnerable prisoners, WHO (Gatherer, Atabay, & Hariga, 2014) recommends for prisons to implement a close collaboration with community healthcare services to guarantee the most adequate services according to the prisoners needs. This particular group of prisoners might need specialist healthcare interventions and support, from speech and language therapy to hearing aids and wheelchairs. Sometimes, this type of specialist healthcare is only available in the community and this is why it is recommended that prison establishments cooperate with services in the community (UNODC, 2009).

In addition, it is very important to guarantee that prisoners with disabilities or special healthcare needs have equal access to activities, namely any educational or vocational programmes, counselling and recreation (UNODC, 2009).

8.9. Prisoners with terminal illness

As the number of older prisoners increases, the number of prisoners dying in custody will increase correspondingly. For example, in the UK the number of prisoners dying of natural causes was recently reported to have doubled in only 8 years (Turner & Peacock, 2016).

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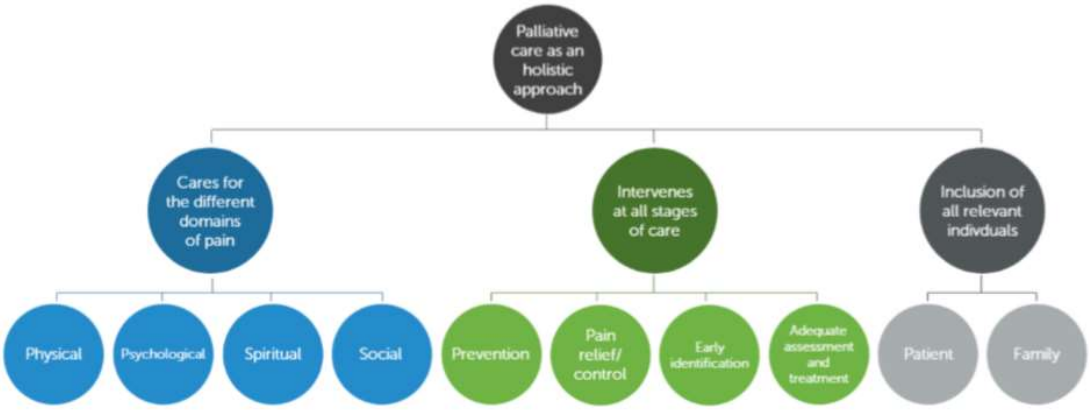
Managing terminally ill inmates poses a significant challenge for prison services, especially due to the needs of ensuring that the quality of care provided to seriously ailing prisoners meets human rights and community standards and providing adequate and humane hospice care for the dying inmates (Porporino, 2014). This particular group of vulnerable prisoners are often in need of ongoing palliative care and experience significant physical and psychological pain.

Palliative care seeks to improve the quality of life of both adult and young patients whose disease is not responsive to curative treatment or who suffer from a life-threatening or life-limiting illness. Its main focus is to prevent and relief the patient's physical, psychological, spiritual and social suffering. It is an approach that cares for the control of pain and other symptoms, values the early identification, adequate assessment and pain relief treatment of any problems, regardless of prognosis (Williams, Ahalt, & Greifinger, 2014). Palliative care is holistic in its approach given that it goes beyond the provision of care to suffering patients and involves the family by supporting them to cope during their family member illness. Palliative care promotes dignity, focuses on preserving quality of life and considers dying as a normal process (Radbruch & Payne, 2009; WHO, 2016).



Palliative care can be provided in parallel with curative treatment, such as chemotherapy, antiretroviral and heart disease treatment, offering a personalised and multidisciplinary approach (McAteer & Wellbery, 2013). One of palliative care's aims is to improve

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patients' quality of life which might encompass the involvement of different types of treatment provision as part of an integrated model of care.

Hospice care focuses on providing care to patients who are facing the end of life, usually when life expectancy is less than six months. Just like palliative care, hospice care seeks to support patients and ease their pains, regardless if they are physical, psychological, spiritual or social. It respects personal choice and promotes dignity, peace and pain relief during patients' terminal stage (Radbruch & Payne, 2009; Williams, Ahalt, & Greifinger, 2014). Hospice care is provided when curative treatment is no longer considered beneficial or the patient no longer wishes to receive it and focuses on bringing comfort to the patient and his/her family (McAteer & Wellbery, 2013).

Research which has been carried out on prison-based palliative and hospice care tends to emphasise the need for more of this type of care provision in prison. The two main evidences that support this are (Cloyes et al., 2017):

- The fact that older prisoners are the fastest growing age group in many prison systems around the world;
- The fact that there is a high prevalence of serious and chronic illnesses, several comorbidities, and physical and mental health problems among prisoners.

In the USA, it was found that, when compared with the community, prisoners were more likely to suffer from chronic conditions such as hypertension, asthma, arthritis, cervical cancer and hepatitis (Binswanger, Krueger, & Steiner, 2009). In England and Wales, a study was carried out aiming to assess the health of male prisoners aged 60 and over. This study found that 85% of the elderly prisoners had one or more major illnesses and 83% disclosed suffering from at least one chronic illness. Psychiatric, musculoskeletal, respiratory and cardiovascular diseases were found to be the most common chronic conditions among this population (Fazel, Hope, O'Donnell, Piper, & Jacoby, 2011b).

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Palliative care is a human right, since all human beings are entitled to dignity, respect and fair treatment. Still, the Prison and Probation Ombudsman in England and Wales has raised multiple concerns regarding the way in which chronically and terminally ill prisoners are treated. There was also a significant concern around the inappropriate use of restraints with these prisoners (Maschi, Marmo, & Han, 2014; Turner & Peacock, 2017).

Although some prisons already provide palliative care facilities and have implemented hospice care programmes, little is known regarding the palliative care needs of prisoners and how and if these needs are being met (Turner & Peacock, 2016). However, particular considerations need to be addressed when trying to meet the particular needs of this population. Furthermore, challenges and barriers inherent to prisons which have a significant impact on the provision of palliative and hospice care need to be identified.

Pain has been identified as one of the most common symptoms among chronically and terminally ill patients and pain relief is a core value for the provision of palliative care. Pain, regardless if physical, psychological, social or spiritual, is a real problem that palliative care seeks to prevent and relief (Mehta & Chan, 2008). However, research and investigations have described several examples of poor palliative care provision in prison. Cases of prisoners suffering in isolation and painful deaths without access to pain relief treatment have often been reported. In fact, the intrinsic characteristics and restrictions of the prison regime pose a significant challenge to the delivery of palliative care, including the delivery of pain relief medication. The potential misuse of pain medication has also been identified as an obstacle to the successful implementation of prison hospice programmes (Maschi, Marmo, & Han, 2014; Turner & Peacock, 2017; Stone, Papadopoulos, & Kelly, 2011). As previously mentioned, palliative care is an integrated approach that encompasses the involvement of both patient and family and focuses on caregiving. Still, in a prison setting, this seems to be difficult to reach due to the main focus that prison systems put on custody and security. Prison policies end up having non-intentional negative outcomes for chronically ill and end-of-life prisoners,

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since they are separated from their families and may face strict visits procedures due to security issues (Maschi, Marmo, & Han, 2014; Turner & Peacock, 2017).

The goals of compassionate care, which involve providing comfort and social support, often conflict with the goals of prison systems (Maschi, Marmo, & Han, 2014). Additionally, lack of trust between staff and prisoners, and negative public attitudes towards compassionate care for this specific group have also been described as barriers to the adequate provision of palliative care and pose a challenge to pain management of these prisoners. In fact, staff might struggle to adapt and change their roles from prison officer to a more supporter- and carer-focused role (Maschi, Marmo, & Han, 2014; Stone, Papadopoulos, & Kelly, 2011; Williams, Ahalt, & Greifinger, 2014).

Due to their health conditions, chronically and terminally ill prisoners might face difficulties in moving around the prison facilities. In fact, the design, layout, and facilities of prison buildings often present challenges to prisoners. A study carried out around this problematic in 2017, had the contribution of a prison governor who stated that although the prison was 'not fit for purpose', there were no financial resources to upgrade the facilities. Furthermore, access to showers, clean bedding, and clothing have proved to be real challenges for this group of prisoners, which does not correspond to the core values of palliative care (Turner & Peacock, 2017). Palliative and hospice care have a patient centred philosophy, respect personal choice, and promote dignity. Still, research shows that prisoners lack autonomy and ability to make their own decisions about medical care and treatment (Maschi, Marmo, & Han, 2014; Williams, Ahalt, & Greifinger, 2014).

Additionally, a study from 2005 found that women prisoners faced challenges in making medical treatment care decisions due to low levels of literacy. In order to tackle this issue, strategies, programmes and research have been initiated, to develop a model of palliative and hospice care for prisoners that can be shared in the future with other prisons and improve practice. An example of this is the 'Both sides of the fence' study which developed

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a leaflet with information specifically for older prisoners approaching the end of life (Maschi, Marmo, & Han, 2014; Turner & Peacock, 2016).

According to WHO, the most effective means of providing prison palliative and hospice care are not well understood (Williams, Ahalt, & Greifinger, 2014). However, research carried out about this matter has identified the most common services and care models adopted by prison systems. In fact, there are a group of key components which have been found to improve the way in which palliative and hospice care are provided to prisoners. Although research shows that some prisons only adopt certain care models or particular essential components, it is suggested that an integration of all provides better outcomes and contributes to an effective approach to the dying prisoners' needs (Maschi, Marmo, & Han, 2014). Therefore, for a successful provision of palliative and end-of-life care in prison, the following components should be considered (Williams, Ahalt, & Greifinger, 2014; Yampolskaya & Winston, 2003; Pazart et al., 2018; Stone, Papadopoulos, & Kelly, 2011; Cloyes et al., 2017):

- Prison palliative/hospice units;
- Partnership with community palliative/hospice care providers;
- Use of peer volunteers;
- Interdisciplinary teams.

Prison hospice units or prison hospice programmes were introduced in the USA in the 1980s. Its main goal was to allow terminally ill prisoners to have a death with dignity and to receive the appropriate support during this phase of their lives in the best way possible. In the USA, around 70 prisons have hospice units which were built following the care models adopted by community-based hospice programmes. However, in Europe, there are very few prison hospice services operating on-site (Maschi, Marmo, & Han, 2014; Stone, Papadopoulos, & Kelly, 2011). According to the literature, in 2011, the UK had only one prison hospice unit. Since then, some prisons have developed palliative care rooms by adapting cells and adding to these, hospital beds and other fundamental equipment. To address some of the palliative care needs of prisoners, these cells are

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usually equipped with bathroom facilities as well as a family room, which can have significant positive outcomes for the prisoners and their families (Stone, Papadopoulos, & Kelly, 2011; Turner & Peacock, 2017). In fact, permitting terminally ill prisoners to spend more time with their families has been found to be essential for an effective approach (Yampolskaya & Winston, 2003).

Given the raising concerns about how care is being provided to prisoners who are reaching the end-of-file, prisons have explored how these services can be optimised and some facilities and services have been implemented, such as the example described above. However, and even though prisoners themselves are supporters of the development of good prison palliative care, more research is needed, since these services appear to not have undertaken appropriate impact evaluation (Stone, Papadopoulos, & Kelly, 2011; Turner & Peacock, 2017).

In 2003, a study found that American prison-based and community-based hospice services share basic components for the provision of end-of-life care, although prison-based services had to adapt to their particular environment. In order to secure equality and fairness between prison and community services, prisons had to adjust and make the following changes (Yampolskaya & Winston, 2003):

- Combine comfort care with the goals of prison system;
- Agree to loosen rules for the terminally ill patients while assuring security;
- Focus on the prisoners and their families as the unit of care;
- Keep a caregiver role in place.

One of the UN's recommendations for prison management involve having a multidisciplinary team with interactions between different specialties, who work in partnership with community palliative and hospice care services. In fact, a partnership between the multidisciplinary team operating inside prison and community service providers is frequently identified as an important component and promising practice in prison hospice programmes (Maschi, Marmo, & Han, 2014; Pazart el at., 2018). The UK,

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for example, adopts a care model which includes to provide palliative care to prisoners mainly through community service providers. Prison staff makes referrals for community palliative care teams who will later, assess the prisoners' needs and provide expert support. In fact, it has been observed a growing close work relationship between prisons and local specialist palliative care providers (Williams, Ahalt, & Greifinger, 2014; Stone, Papadopoulos, & Kelly, 2011).

Using prisoners as peer volunteers has been implemented in several prison end-of-life services, through a peer care programme, across the USA and the UK. Moreover, the involvement of prisoner peer volunteers has been identified as an effective contributing factor to the improvement of these programmes and allows prisons to provide a more comprehensive and individualised end-of-life care (Maschi, Marmo, & Han, 2014; Yampolskaya & Winston, 2003; Pazart et al., 2018; Cloyes et al., 2017). In fact, it has been noted that using prisoner peer volunteers in caregiving roles contributes to positive feelings among prisoners and enhances the atmosphere which can be emotionally challenging at times (Stone, Papadopoulos, & Kelly, 2011;). A study in 2017 found some key factors essential to the successful implementation of prison hospice programmes involving prisoner peer volunteer. These key factors are (Cloyes et al., 2017):

- Formal training and education;
- Supervised and practical experience;
- Formal and informal peer mentorship;
- Interactions with healthcare staff and prison officers.

Potential prisoner volunteers learn hospice care through formal training and education. More specifically, they learn about basic clinical competencies, the dying process and hospice philosophy, among others. They also undertake shadowing training, where they shadow more experienced volunteers. When shadowing more experienced volunteers, opportunities for ongoing learning arise whilst new volunteers undergo a supervised 'hands-on' training period. In fact, the opportunity to provide hospice care through intimate patient contact was identified as a very valuable component to their experiences

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as volunteers. It was also disclosed that the act of caring for an ill patient is a surprising experience, since practical experience carries valuable teachings that formal education and 'book learning' cannot (Cloyes et al., 2017).

Mentorship was seen by volunteers and staff as a core value to the success and sustainability of prison end-of-life services. Additionally, mentorship was considered by prisoner peer volunteers as a positive factor to the prison culture and for those prisoners who want to care for others and uplift themselves. More experienced peer volunteers develop a strong supportive and mentoring relationship with new volunteers, which helps to ease any fears or concerns of providing hospice care and encountering challenging situations. The knowledge and emotional support that more experienced peer volunteers can provide, was considered fundamental (Cloyes et al., 2017).

Healthcare staff and prison officers have a critical role in supporting prisoner peer volunteers and training them to deliver hospice care in this challenging and particular environment. Healthcare staff acknowledged the importance of being available for peer volunteers' questions and curiosities and to provide them with accurate knowledge and detailed information. They also recognised how important it is to foster and maintain interactions between healthcare staff and peer volunteers to enhance their skills and ensure they deliver the best patient care possible. Additionally, prisoner peer volunteers were regarded by prison officers as an important source of knowledge regarding future potential volunteers (Cloyes et al., 2017).

The use of an interdisciplinary team approach has been found to be a promising practice and key component to the implementation of prison end-of-life services (Maschi, Marmo, & Han, 2014; Yampolskaya & Winston, 2003; Pazart et al., 2018). In fact, research has highlighted the importance of having an interdisciplinary team that includes different specialities, so a shared understanding can be achieved regarding the most effective models of end-of-life care. It has also been suggested that it is the interactions between the different specialities in care planning that contribute to a successful provision of

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palliative and hospice care for prisoners (Maschi, Marmo, & Han, 2014; Turner & Peacock, 2017). According to the literature, the interdisciplinary team should include a minimum of a social worker, nurse, chaplain, dietician, physician, psychiatrist, prisoner peer volunteers, and prison officers (Maschi, Marmo, & Han, 2014; Pazart et al., 2018; Stone, Papadopoulos, & Kelly, 2011; Turner & Peacock, 2017; Yampolskaya & Winston, 2003).

An emphasis is put on the importance of staff training and support for all healthcare workers, prison officers and volunteers. In fact, a project carried out in the UK where 90 healthcare and prison staff were trained in palliative care, found multiple benefits for both staff and prisoners (Maschi, Marmo, & Han, 2014; Turner & Peacock, 2017). Moreover, a partnership between the interdisciplinary team operating inside prison and community palliative and hospice care providers is an important component and promising practice in prison hospice programmes (Maschi, Marmo, & Han, 2014).

8.10. Prisoners under life sentence

This group of vulnerable prisoners, which are commonly named 'lifers', must be regarded as individuals who will spend the rest of their lives in prison. In fact, according to Johnson and McGunigall-Smith (2008), this experience can be as painful as the death penalty, since they are condemned to death by incarceration instead of execution.

Life in prison entails the desocialisation and institutionalisation of individuals, which may carry risks for their mental health. Additionally, "lack of any hope of release has an extremely harmful impact on the mental health of prisoners" (UNODC, 2009, p. 130). Such impact increases the likelihood of prisoners to commit suicide (UNODC, 2009).

In a study conducted by Motiuk and Porporino (1991), a sample of 2,185 inmates from several Canadian prison was randomly selected. Using the Diagnostic Interview Schedule (DIS), they reported the prevalence, nature and severity of mental health problems. One

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of the findings was that long-term offenders, particularly lifers, had a higher likelihood of experiencing at least one episode of a depressive disorder during their life.

Women prisoners disproportionately exhibit a high rate of mental health issues, which are exacerbated by life imprisonment as they face higher stigma and are disproportionately affected by the impact incarceration has on their children (Crewe, Hulley & Wright, 2017). They also found that nearly six times as many life-sentenced women 'reported self-injury or attempted suicide since their conviction' as their male counterparts.

8.11. Remand prisoners

The rates of mental disorders in remand prisoners are higher than in sentenced prisoners because they are often imprisoned in custody waiting for psychiatric reports (Birmingham, Mason & Grubin, 1996). The suicide rates are also superior in this population than in other inmates due to one third of the self-inflicted deaths happened in the first seven days into prison (Shaw, Baker, Hunt, Moloney & Appleby, 2004). Furthermore, remand prisoners usually exhibit more neurotic symptoms since there needs for services aren't being fulfilled while awaiting trial, as well as, prevalence of psychotic disorder, anti-social personality disorder and substance misuse (Coid et al., 2002).

Reasons for vulnerability include the distress and anxiety associated to not knowing the court's decision regarding their sentence. Additionally, remand prisoners might be in prison for the first time and this strange environment can affect their mental stability.

8.12. Prisoners in segregation

Segregations are prisons within prisons, they include prolonged periods of isolation and lack of access to activities. Men in long-term segregated prison housing tend to develop psychiatric symptoms, if not full-blown decompensation, and they universally report an

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accumulation of often uncontrollable rage (Cote & Hodgins, 1990). Therefore, both the duration of isolation and the uncertainty of time length endorse helplessness and feelings of hostility and aggression. However, it is impossible to effectively predict how a certain individual will react under such conditions, since different individuals have different capacities for resilience (Durcan & Zwemstra, 2014).

Although prisoners in this situation reported multiple mental health problems, such as anxiety, depression, anger management, concentration issues, insomnia and an increased risk of self-harm (Browne, Cambier, & Agha, 2011). Instead of providing treatment, many prisons segregate inmates with mental illness, restricting treatment and almost all human contact. Most inmates experience exacerbated symptoms of mental illness as a result of the conditions in segregation.

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9. Levels of care

Mental health conditions represent a different level of need when compared with physical health needs among prisoners. For instance, tuberculosis transmission is a physical health hazard to all inmates and staff. Therefore, prison administrators must ensure that individuals suspected of having tuberculosis obtain proper assessment and subsequent access to healthcare. However, symptoms inherent to many mental health disorders may be less obvious to prison staff, especially without assessment by trained mental health professionals (PRI, 2018). Otherwise, mental health "is inextricably linked with human development, both because the social and economic determinants of human development are strongly associated with mental health and because poor mental health will compromise longevity, general health, and creativity" (WHO, 2004, p. 42).

According to the WHO and the ICR (2005) "Access to assessment, treatment, and (when necessary) referral of people with mental disorders, including substance abuse, should be an integral part of general health services available to all prisoners." (p. 3). When looking at the issue of prison healthcare, often the principle of equivalence of care is referred, highlighting the importance of prison services aspiring to provide the same level and quality of the basic health services as in the community, including mental healthcare (Durcan & Zwemstra, 2014). This principle might be attained through different means, including prison health staff training on mental health, regular visits from a community mental health team, and access to healthcare services outside prison (WHO & ICRC, 2005). For example, if a prisoner needs specialised mental care that cannot be provided in prison, he or she has the right to be transferred to a hospital under custody, or to a prison hospital, where care can be provided in a secure environment (UNODC, 2009). Prisoners must access the level of healthcare that matches their needs, enabling them to

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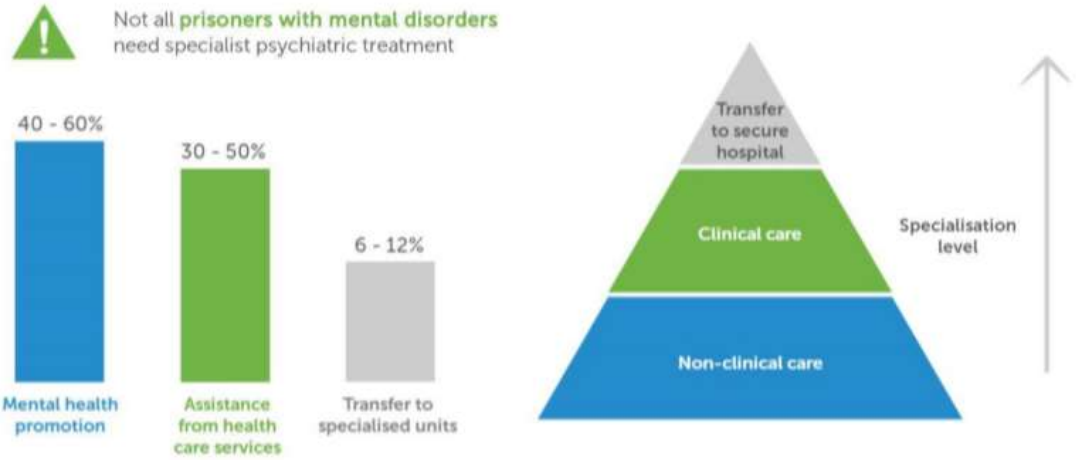
voluntarily escalate to a more specialised care. Hence, there is an unquestionable need to have clearer hierarchical levels of mental healthcare within prisons.



9.1. Non-clinical mental health services

Mental health is a positive sense of well-being, so it requires an underlying belief in our own and others' dignity and worth. Not all mentally disordered prisoners need psychiatric treatment (Durcan & Zwemstra, 2014). Mental health promotion is the first level of care that should be taking into account when managing a correctional facility. In order to do that, prisons should provide "adequate space, nutrition, clean drinking water, sanitation, heating, fresh air, natural and artificial light" (UNODC, 2009, p. 24).

In order to promote mental health, and according to Blaauw and van Marle (2007, p. 138), prisons should meet prisoners' basic needs, which are: "personal development and respect from other people […] being loved, appreciated and cared for: a desire for intimate relationships that provide emotional sustenance and empathy […] activity and distraction: the need for maximising the opportunity to be occupied and to fill time […] safety […] environmental stability and predictability […] privacy and autonomy." The best way to assure this is by carefully selecting and adequately training prison staff in mental health promotion and awareness (Blaauw & van Marle, 2007). Despite the importance of

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this matter, health promotion in prisons is a misunderstood practice provided with insufficient resources (Watson, Stimpson & Hostick, 2004).

According to the WHO and the ICR (2005, p. 3) "training on mental health issues should be provided to all people involved in prisons including prison administrators, prison guards and health workers. Training should enhance staff understanding of mental disorders, raise awareness on human rights, challenge stigmatizing attitudes and encourage mental health promotion for both staff and prisoners. An important element of training for all levels of prison staff should be the recognition and prevention of suicides. In addition, prison health workers need to have more specialized skills in identifying and managing mental disorders".

9.2. Clinical mental care services

Concerning the clinical services available in prisons, the standard for prisoner mental healthcare should be equivalent to that which is expected in the community. However, since the prevalence of poor mental health among prisoners is much higher than in the community, prisons require more intensive and integrated services than in the general population (Blaauw et al., 2000).

Every prisoner should have a proper initial screening when they first arrive in prison, then a follow-up including mental health assessments and treatment plans (UNODC, 2009). However, in most prison systems these procedures are often lacking or insufficient, thus prisoners "are therefore not identified on entry and left untreated in an environment that is particularly harmful to their mental well-being" (UNODC, 2009, p. 14).

Services within prisons require a multidisciplinary team, including general practitioners, mental health nurses, clinical psychologists, allied mental health staff and psychiatrists (Durcan & Zwemstra, 2014). Although in reality, staff working in prisons obtain low

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wages, have a low status and have to deal with a stress and troublesome workplace. Consequently, prison health services are often understaffed. So, access to medical health staff by prisoners is more difficult, since they need to write a request and after that it could take weeks until they actually have their appointment (UNODC, 2009).

9.3. Transfer to secure hospital

Going to the hospital means that the prisoner required inpatient treatment outside the prison system. Every prisoner that necessitates more than primary care must be transferred from prison to hospital to receive it. It includes all prisoners needing involuntary treatment and all inmates willing to accept treatment voluntarily but with a psychiatric disorder that could not be managed adequately and safely in prison. This is an incredibly challenging matter since it is common for prisoners to be held in prisons, certified for transfer to hospital, but unable to leave the prison due to a lack of hospital beds in the community (Reed, 2003).

Not all cases require transfer, prisoners with mental disorders that need intense care "should be temporarily transferred to psychiatric wards of general hospitals with appropriate security levels" (WHO & ICRC, 2005, p. 3). Moreover, in cases of self-harm prisoners may need transfer to hospitals with higher security and level of care and it is estimated "that every 100 acts of self-harm result in 36 transfers to a higher level of care and 10 hospital admissions" (Kaba et al., 2014, p. 446).

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10. Challenges and barriers to mental healthcare provision

Within the whole prison population, inmates diagnosed with some kind of mental impairment are disadvantaged in their access to justice. The reasons for that to happen are actually quite simple: often, they are unaware of their legal rights, are unable to "gain access to legal counsel without assistance" (UNODC, 2009, p. 12), plus they face the usual issues of discrimination, labelling and stigmatisation (UNODC, 2009).

In fact, while facing charges or during incarceration, these individuals tend to be coerced into confessing a crime they did not commit "much more readily that other (inmates)" (UNODC, 2009, p. 12), especially if they are not in the presence of their mandatory legal assistance (such as a lawyer) (UNODC, 2009).

Furthermore, since these inmates usually face various difficulties "in accessing legal counsel, (both) police and prison authorities should (provide) them access to legal aid" not only "during the period of arrest, prosecution and pre-trial detention" (UNODC, 2009, p. 27), but also afterwards, which is especially relevant in cases where the sentence specifies the need of any kind of medical treatment (UNODC, 2009).

Additionally, a key principle that applies to all inmates worldwide states that incarcerated individuals "are entitled to receive the same quality of medical care that is available in the community" (UNODC, 2009, p. 13). However, there is a big leap separating the standards that prisons systems should embrace, from the actual provided healthcare services harsh reality.

This inadequacy occurs since "prison health services are far too often severely under-funded and understaffed" (UNODC, 2009, p. 13), which results in practices relying solely on medications to manage mental disabilities and its symptoms. Consequently, the inter-

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disciplinary care and treatment of mental disabilities' supervision ends up being neglected (UNODC, 2009).

Besides the principle of equivalence of healthcare, mental healthcare within prison settings should also encompass the provision of mental healthcare resources. Nevertheless, most prisons throughout the world are also "unable to provide any treatment for mental disabilities at all" (UNODC, 2009, p. 13). Mental health screenings should comprise an assessment undertaken by qualified medical professionals, in order to identify the presence of mental disabilities. As so, the early diagnosis of mental disorders, as well as the provision of timely and appropriate treatment, are absolutely vital to reduce the possibilities of enhancing any existing mental health problems into more serious and unavoidable disabilities. However, inmates with existing mental impairments are not identified when entering correctional facilities, being left untreated in an environment that, as we have seen before, is quite noxious to their psychological well-being. In addition, it is unusual that inmates' medical files accompany individuals when transferences between prisons occur, which jeopardises any kind of treatment or medication that was underway (UNODC, 2009).

Individualised care is the ideal standard when providing effective mental healthcare services. Nonetheless, besides understaffing and under-skilled issues, prisons mental health professionals' wages and status are low. These issues, combined with an unpleasant and unsupportive working environment, do not contribute to the overall healthcare effectiveness (UNODC, 2009).

10.1. Prison regime and constrains

The environment that encompasses prison settings is quite unique, holding singularities that are hard, or even impossible, to match. Consequently, a large number of these singularities have repercussions on inmates' mental stability, physical composure and behaviour.

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Prisons tend to be breeding grounds for diseases (Restrum, 2005), and some studies have actually demonstrated that prisons house one of the highest concentrations of poor physical, mental and social health, characteristics that are more often than not related to substance abuse (Møller, Stöver, Jürgens, Gatherer, & Nikogosian, 2007; Fazel & Baillargeon, 2011).

Despite such findings, most prison systems are unable to provide an environment that promotes inmates' physical and mental well-being. In fact, various countries house prisoners within overcrowded settings, unventilated divisions and unsanitary conditions. Therefore, besides enabling the propensity of violence and abuse, such conditions enhance stress, depression and anxiety levels, which could develop into serious mental health conditions (UNODC, 2009).

However, inmates' right to health is a fundamental human right, encompassing the right to proper healthcare as in the community, in addition to the right to live in a mental and physical non-disease generator and exacerbator environment (UNODC, 2009). Inmates with existing mental impairments are at "further risk of acute mental harm. They have fewer resources with which to cope in an environment lacking in privacy, often tense and sometimes violent" (UNODC, 2009, p. 13). Consequently, such risk is higher in tendentiously depressive inmates, who may become suicidal and psychotic due to an increased emotional deterioration.

Nonetheless, despite this emotional sensitivity, prison systems tend to house these inmates separately, not only with fewer conditions than general population housing, but also with restricted access to food, hygiene and health facilities. Some countries even tend to use physical-restraint procedures with mentally ill inmates, such as adopting the use of chains (UNODC, 2009).

In addition, female inmates "without any mental health problems prior to imprisonment may develop a range of mental disabilities in prisons, where they do not feel safe,

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conditions are poor, dormitories overcrowded and staff not trained to deal with their gender-specific psycho-social support requirements" (UNODC, 2009, p. 13).

10.2. Discrimination, stigmatisation and bullying

Individuals with any kind of mental impairment are much more discriminated and stigmatised than the remaining general population. In addition, these problems tend to be exacerbated when living in a closed environment, such as prisons or other similar correctional facilities, since most inmates are often unwilling to be seen or associated with inmates with mental problems. Consequently, this leads not only to isolation, but also to the further deterioration of their previous mental health condition.

The role of prison staff is absolutely key in this particular area, since prison staff professionals should be keen on promoting constructive relationships among inmates and not replicating similar discriminatory behaviour as most inmates tend do to. Therefore, knowledge and understanding about how to deal with inmates with mental health problems is paramount for avoiding labelling and stigmatisation issues amongst the prison population (UNODC, 2009). In fact, it is worth mentioning that "all (inmates), including those with mental disorders, have the right to be treated humanely and with respect for their inherent dignity as human beings" (WHO & ICRC, 2005, p. 4).

"Mental health legislation can be a powerful tool to protect the rights of people with a mental disorder" (WHO & ICRC, 2005, p. 4), such as inmates. Nonetheless, various countries' "mental health laws are outdated and fail to address the mental health needs of the prison population" (WHO & ICRC, 2005, p. 4). "(Inmates) with mental disorders should also be provided with procedural protections within the criminal justice system equivalent to those granted (to)other (inmates)" (WHO & ICRC, 2005, p. 4) without any mental impairment.

10.3. Toxic masculinity

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Toxic masculinity has been described as "the constellation of socially regressive male traits that serve to foster domination, the devaluation of women, homophobia, and wanton violence" (Kupers, 2005, p. 714). In prison, this phenomenon erupts in altercations on the prison yard, aggressions to officers, and even prison rape. Nonetheless, the prison code that dominates in men's prisons is simply an overstatement of the unspoken "male code" on the outside (Kupers, 2017, p. 430).

According to Kupers (2005), toxic masculinity norms are a feature of life for men in American prisons, where they are reflected in the behaviour of both staff and inmates. The qualities of extreme self-reliance, domination of other men through violence, and avoiding the appearance of either femininity or weakness, comprise a code among prisoners. Suppressing vulnerable emotions is often adopted in order to successfully cope with the harsh conditions of prison life, defined by punishment, social isolation, and aggression. These factors likely play a role in suicide among male prisoners.

Both self-reliance and the stifling of emotional expression can work against mental health, as they make it less likely for men to seek psychological help or to possess the ability to deal with difficult emotions. According to prison code, a man does not display any kind of weakness or emotion, he is never vulnerable, nor snitches (Kupers, 2017).

10.4. Environmental factors

Being in prison can be a very difficult experience. Key features of the prison environment that are likely to lead to mental illness include the chronic loss of free choice, lack of privacy, daily stigma, frequent fear, need to wear a constant mask of invulnerability and emotional flatness to avoid exploitation by others, and the requirement, day after day, to follow externally imposed strict rules and routines (Durcan & Zwemstra, 2014).

Prisoners may be deeply affected by many emotions including distress, concern for their children (that are away from them), concern for their personal future, humiliation, vulnerability, powerlessness, and fear of guards. Along with these feelings, inmates must

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deal with common problems in prison such as bullying, boredom and overcrowding, which worsen their mental status (Ginn, 2012). Undoubtedly, the prison environment, with all its rules, regulations and lack of personal control, impacts prisoners' mental health.

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11. Integrated and multidisciplinary approach to care

Prison staff, particularly prison officers, are usually the first point of contact for prisoners with health concerns, so they must know when and how to make a mental health referral. Although they are not expected to diagnose specific disorders or to fulfil the duties of mental health professionals, their responses to prisoners' worries and early detection are crucial to prevent minor issues from becoming more serious conditions. Also, it can be very helpful to prevent suicide and self-harm (PRI, 2018).

Therefore, all staff should be prepared to identify warning signs of serious mental health conditions in individuals that require immediate attention, such as confused thinking and speech, sudden mood or behaviour changes, and erratic behaviour. Staff must then speak in an emphatic way with the individual to try to understand their situation, inform the prison healthcare staff and, if necessary, take urgent defensive action if there is any danger to the prisoner or others (PRI, 2018).

Afterwards, and in order to provide the best care and support, staff should have effective multidisciplinary teamwork procedures in place. It is recommended a joint work between different professionals within prison staff, such as frontline staff (e.g., prison officers), healthcare staff (e.g., doctors, nurses), mental health professionals (e.g., psychologists, psychiatrists), substance misuse practitioners, physical education staff, religious staff (prison chaplains such as priests or imams), educational staff, among others. All of these should not work separately. They must pair up and help each other understand the patient better (PRI, 2018). This demands the development of a joint strategy and communication mechanisms within the multidisciplinary team of prison specialists, as well as a close coordination between prison and service providers from the community (UNODC, 2009).

Hence, an integrated and multidisciplinary approach to care across the whole criminal justice system is essential as well as a good cooperation between prisons and the

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community. Good health and well-being are key to successful rehabilitation and resettlement (UNODC, 2009).

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12. The role of multi-agency staff

A multi-agency and inclusive approach increase information sharing processes and decision-making actions. Prison staff can play a decisive and critical role in the anticipation of mental illnesses and can, therefore, improve the well-being and welfare of the prisoners as part of their work as mental health support providers (UNODC, 2009). The way staff treats and interacts with inmates can prevent, cause or aggravate mental health. A positive communication between professionals and prisoners may help in identifying signs and potential triggers related to mental health problems. Although it is not always easy, staff must reconcile their roles as both guards and helpers (Durcan & Zwemstra, 2014).

12.1. Prison officers

Within the prison system, prison officers are a vital part of the process for delivering healthcare to inmates. As Appelbaum, Hickey, and Packer (2001) noted, the correctional officer interacts with inmates and observes their behaviours 24 hours a day, making officers the first to observe conduct and demeanour that may connote mental illness. Not only do they facilitate the workflow, they also represent many eyes and ears throughout the facility to alert health staff to inmates with possible health issues. Because correctional personnel are often the first to respond to problems, they must be aware of the potential for emergencies that may arise, know the proper response to life-threatening situations and understand their part in the early detection of illness and injury (Appelbaum, Hickey, & Packer, 2001).

Recommendations concerning the importance of increased communication between prison officers and healthcare staff regarding the mental health status of each inmate are made by the WHO and the International Association for Suicide Prevention (2007). More recently, Frater and Bartlett (2017, p. 1) stated that "in prison, evidence supports [...] mandatory mental health awareness training for prison officers". For example, in Norway most of the correctional officers are educated in the prison school. This is a two-year

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programme which includes theory and practical training. One fifth of the theoretical programme concerns environmental work with inmates. These subject taps into communicational skills with focus on motivational interviewing and cognitive behavioural therapy. It also gives the students' knowledge of theories of learning, motivation, groups and identity. The students are taught how to recognise signs of common psychiatric disorders such as depression, anxiety, ADHD, personality disorders and psychosis. Focus on risk factors of suicide and suicide prevention is incorporated in this part of the programme. Furthermore, students gain necessary knowledge of how the health system works and how to help inmates to access necessary health services when needed. The correctional officers who work with inmates in different programmes aimed at preventing drug abuse, violence and sexual offending have more detailed training in psychological health.

12.2. Healthcare staff

Healthcare staff in prisons ought to never forget that their first responsibility to the prisoner is clinical, which means their primary duty is the care and treatment of their patients (Durcan & Zwemstra, 2014). They base patients' assessments on their medical and psychological needs, and their ethical commitments consist on respecting the autonomy and best interests of the prisoner. Besides that, they are required to evaluate, protect, promote and improve the health of inmates (PRI, 2018).

In fact, there are fundamental rules that healthcare staff should respect, such as (PRI, 2018, p. 15):

- "Ensuring that medical assessments include screening for mental health conditions and the risk of suicide and self-harm." [Mandela Rule 30]
- "Ensuring there is continuity of care, including the transmission of files in cases of transfer, and close links with community healthcare services." [Mandela Rules 24(2) and 26(2)]
- "Protecting medical confidentiality and ensuring informed consent for any medical treatment." [Mandela Rules 26, 31 and 32(b), (c)]

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- "Referring any cases requiring specialist treatment to relevant professionals." [Mandela Rule 27(1)]
- "Reporting to the prison director any adverse effects on mental health from restrictive measures, and advising if the measure should be terminated or altered." [Mandela Rule 46]

12.3. Technical staff

In the community, mental healthcare settings incorporate psychiatrists, psychologists, social workers, psychiatric rehabilitation professionals, educators and other mental health professionals. However, in a prison setting, sometimes healthcare staff do not include these types of professionals, depending on the organisation of the correctional system (Appelbaum, Hickey, & Packer, 2001). Alternatively, they integrate the technical staff, being an essential component for a prison to function at its full potential. Technical staff have two tasks to accomplish within prison settings: to provide security and to restore rehabilitative functions (Garland, Maccarty & Zhao, 2009). More specifically, psychologists carry out assessments of the prisoners' mental health, provide counselling and plan effective treatments for mental disorders, which in turn alleviate the stress experienced by prison staff who supervise them (Durcan & Zwemstra, 2014).

On the other hand, prison educators play a significant role in inmates' life and mental health. According to Rosmilawati and Suherman (2019) prison educators can play different roles. As co-learners and mentors because they "share their knowledge based on the lived experience and delivery the content of the subject with informal style and relational in nature" (p. 273); as counsellors since they express "care and concern toward inmate students with a problem [...] a guide who helps facilitate inmate student's personal growth and positive change through self-understanding" (p. 273); as second parent because "there are circumstances that some inmate students are voluntary sharing their problem to the teacher as they talk to their parent" (p. 274), and as provocateur and police officer, "this strategy is commonly practiced by prison educators to address offending behaviours" (p. 274).

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Within the correctional prison system, social workers have a set of unique job responsibilities that are strongly focused on the rehabilitation. They use their knowledge and skills to prevent recidivism by addressing the psycho-social issues, providing education, and offering social service recommendations to successfully reintegrate into the community upon release (PRI, 2004), For instance, in Mexico, social workers "observe the inmate's relationship with the outside world[…] For example, when an inmate's family no longer visits, the social worker will visit the inmate's community to find out why the family no longer comes to the prison. This helps to reassure the indigenous person and it helps to maintain and improve social relationships within the detention centre." (PRI, 2004, p.117).

12.4. Religious staff

The role of religious staff is to be aware and to answer prisoners' spiritual needs. Their main purpose is to administer religious programmes and provide pastoral care to inmates and institutional staff. In the past, this meant that the common duties were to provide religious services, counsel troubled inmates, and advise inmates of bad news from home or from correctional authorities. Recently, the role of religious staff has been expanded to include coordination of physical facilities, organising volunteers, facilitating religious leave of absence visits, contracting for outside religious services, and training correctional administrators and staff about the basic tenets, rituals, and artefacts of non-traditional faith groups (Clear et al., 1992). In addition, due to their privileged credibility when communicating with inmates, they have also been incorporated in some deradicalization/disengagement programmes (e.g., Saudi Arabian Deradicalisation programme; Kutner, 2016).

Religious staff play an important role in prisoners' mental and physical health, since religious belief and practice are a very individual matter and exacerbated by the psychological complexities of living in prison. A very important reason why inmates

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become involved with religion is to improve their own self-concept. Lack of a positive self-concept is a common problem with correctional inmates who may suffer from guilt related to failures in life, remorse from criminal acts, or from the pain of a dysfunctional family background (Kerley, Allison & Graham, 2006). Because the core of many religious beliefs includes acceptance and love from a higher being, and from members of the faith group, inmates often feel better about themselves if they practice religion while incarcerated. In addition to the many psychological and emotional benefits, inmates also can use religion to help change their behaviour. Following the principles and discipline that is required in the serious practice of religion can teach inmates self-control. Having self-control helps inmates avoid confrontations with other inmates and staff, and it helps them comply with prison rules and regulations (Thomas & Zaitzow, 2006).

12.5. Peer supporters

'Peer to peer' support schemes in prison, where prisoners are trained to support other prisoners with social care needs by providing basic care, are based on a relationship of mutual encouragement. Peers supporters are people with similar experiences who offer each other assistance, especially as they move through difficult or challenging experiences, such as imprisonment. It is reported to play a significant role in emotional well-being, by contributing to a culture change which is more strengths-based and works to empower people to play a central role in any care and support they receive (Durcan & Zwemstra, 2014; UNODC, 2009).

A good example of this happened for the first time in 1991 in England. They implemented a peer support service by the name of 'the Listener scheme'. The purpose of it is to reduce suicide and self-harm in prisons (PRI, 2018). Volunteers will select, train and support prisoners to become Listeners. Consequently, Listeners will then offer private emotional support to their fellow prisoners who are struggling to manage prison life. Now, nearly every prison in England, Scotland and Wales has one (Jaffe, 2012).

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In specific, the "collaboration with people living with HIV, and with prisoners themselves in peer-based initiatives, can also play an important role in boosting the credibility and effectiveness of HIV and AIDS programmes in prisons" (Møller et al., 2007, p. 68). Also, the development of peer support, peer education and peer self-help groups (UNAIDS, 1999), "in which members of the population themselves are trained to act as supporters and educators for their own peer group – can also make valuable contribution to effective HIV and AIDS services" (Møller et al., 2007, p. 69).

12.6. Volunteers

Volunteers are playing an increasingly bigger role in correctional institutions; they act as role models for prisoners. Volunteering in prisons is a selfless way for citizens to help rehabilitate prisoners seeking a better life during and after incarceration. Citizens can gain the opportunity to fulfil an important public service role, by volunteering in a correctional facility. Additionally, this activity is highly rewarding, because it makes a measurable difference in the lives of people who actively want to better themselves. With an emphasis on rehabilitation and reintegration, prisons are resorting increasingly to prison volunteers to provide services to inmates ranging from emotional support to educational seminars. Volunteers often bring a wide variety of skills that help inmates learn what it means to be an engaged, productive member of society (Edgar, Jacobson & Biggar, 2011).

12.7. Management staff

Management staff have a significant role in the prison climate. They need to guarantee a constructive and well-organised system. Management staff are role models for other prison staff and prisoners, if their institutional culture is one that acknowledges individual differences, promotes mental health and does not accept judgement and discrimination, this will define a safer and more tolerant environment for all (PRI, 2018).

Crucial to this is a good communication between management and all prison staff, in order to deliver the best care for prisoners. The best managed prison systems are likely

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to be those which have a clear understanding of their objectives, mission and values. If staff at all levels are aware of, and subscribe to, the mission and values of the organisation, this will contribute to the experiences of inmates with mental health problems (Durcan & Zwemstra, 2014).

An efficient prison management should include promotion of the mental health of prisoners as well as staff, and the protection of human rights. "A prison that is responsive to, and promotes the mental health of prisoners, is more likely to be a workplace that promotes the overall morale and mental health of prison staff and should therefore be one of the central objectives of good prison management" (WHO & ICRC, 2005, p. 2).

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13. Resettlement and aftercare provision

Since prison is usually just a phase of someone's life, reintegration and resettlement are to be considered and the same goes for mental health treatments. After release, inmates must deal with issues such as housing, dysfunctional families, unemployment, registration of residence, social stigma and negligence. In the middle of all that, there isn't much time to prioritise their health, especially mental health. For this reason, prisoners need to be followed by their local health centre. However, that almost never happens (Durcan & Zwemstra, 2014).

Caring about mentally ill inmates should be a top priority within the general management strategies in place by the prison administration, since most of ex-offenders return home to a poor (and sometimes unsupportive) family background, with tremendous difficulties on finding a job that can supply their basic needs. "If such support is not provided on release, there is a high probability that (these individuals) will (eventually) re-offend" (UNODC, 2009, p. 18).

However, most prison systems are unable to guarantee continuity of care for newly arrived inmates that were under treatment while in the community, inmates that are on the verge of being released, or inmates being transferred between prison establishments. This could have extremely adverse consequences for these inmates, since it could enhance the deterioration of their mental wellbeing. Hence, close relationships between the community mental health services and prison systems must be established, which will foster the information sharing process and allow a rapid exchange of medical records, while ensuring both the continuity of treatment and the equivalence of care between the different environments (UNODC, 2009).

To diminish the interruption of care and treatment in released inmates, it is suggested that post-release follow-up should be implemented. Prison health staff and case managers ought to coordinate the follow-up of released inmates. They should know where they live, if they have a job, and most importantly, if they carry on treatment. They

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should also alert the family about the importance of adherence to treatment and the costs of leaving or interrupting it (Durcan & Zwemstra, 2014).

13.1. Information sharing

As mentioned before, information sharing processes are essential in multi-agency approaches to care, particularly mental health care, in order to provide continuity of treatment after release (UNODC, 2009). Additionally, this exchange can be used to efficiently assess and manage risk. Data regarding ex-prisoners with mental health issues should be shared between prison, police and other community agencies (Parker et al., 2018). The purpose of exchanging this information is to "improve support to people with mental ill health, foster better relations between agencies and between the police and people with mental ill health, identify hard-to-find at risk people with mental ill health and protect the public from offenders with mental ill health" (Parker et al., 2018, p. 5).

An example of this exchange of information is the Multi-Agency Public Protection Arrangements (MAPPA) produced in England and Wales. The agencies collaborating with MAPPA are the police, other law enforcement agencies and mental health services. They work together to manage ex-offenders, share information about them, assess risk and management, organise multi-agency meetings and case reviews (Home Office, 2012). Despite of the fact that MAPPA is applied to protect society from harm by violent, sexual and other dangerous offenders, it is a good practice that should broaden its target population and its purpose. This method should be employed to follow up mentally ill ex-offenders to ensure communication through different agencies and to continue care outside of prison.

13.2. Continuity of care for prison transfer

Although the frequent transfer of inmates between prisons makes it more difficult to access services, a report of ongoing mental health treatment should be transferred with the prisoner. Continuity of care is ensured if there is transmission of files in cases of

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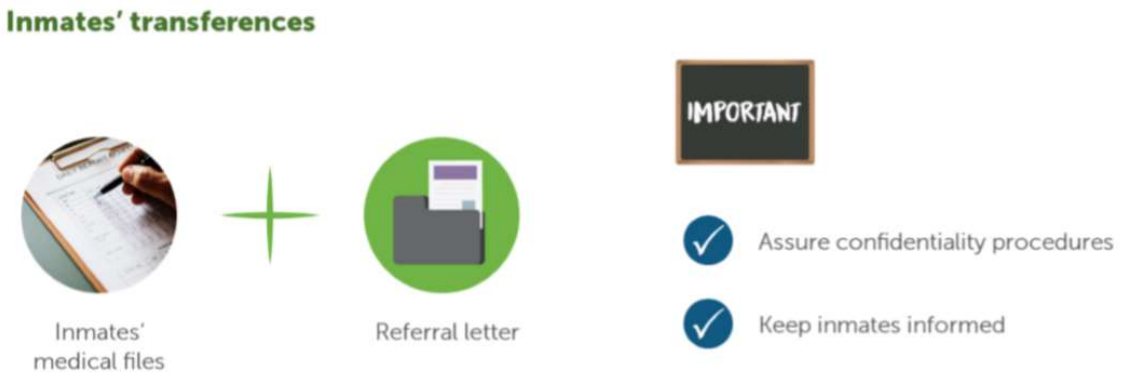
transfer. This requires ongoing communication between the mental health team and the manager of prisoners so that all steps can be planned in time and all necessary information can be transferred with the prisoner (PRI, 2018). Essentially, information exchange is crucial to ensure continuity of care.

For an effective continuity of care policy, "direct contact and planning with community health services should (be established, in order) to ensure a smooth transition to care in the community" (UNODC, 2009, p. 35). But how about communication and cooperation between prisons? How is continuity of care being addressed when inmates' transferences occur?

As a matter of fact, it is unusual that inmates' medical files accompany individuals when such transferences between prisons occur. Therefore, this process tends to jeopardise any kind of treatment or medication that was underway, or even to disregard the level of monitoring that each inmate falls into (UNODC, 2009).

Ideally, all transfers that occur from one prison to another should be accompanied not only by each inmate's full medical records, but also by referral letters explaining his or hers current health problems, as well as the treatment plan that is underway. In addition, these records should be transferred under certain particularly secure procedures, mainly due to issues regarding confidentiality. Furthermore, inmates should be informed that their medical records will be transferred alongside them (UNODC, 2009).



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13.3. Preparation for release and post-release support

The post-release period is a particularly risky moment for many inmates which family and community supports are untrustworthy. Unsurprisingly, this period is even more challenging for mentally ill inmates and the lack of support after their release could jeopardise the effectiveness of a treatment that was underway (UNODC, 2009).

In some cases, the cooperation between prison and civil health services is inefficient or even non-existent. "Thus, the continuity of care, essential to the management and alleviation of many mental disabilities, becomes virtually impossible." (UNODC, 2009, p. 18).

Preparation for release is just as important as any phase of imprisonment. First, management should check if post-release support programmes are ready. Then visits with family and friends should be facilitated, and even the possibility of home visits as the release date approaches. Regarding mental health, professionals should guarantee that treatment is continued after release, if needed. The same help and support that was given inside the prison should continue outside. This could prevent recidivism and help the patient reintegrate the community (Durcan & Zwemstra, 2014).

Clearly, inmates suffering from mental illnesses have a much harder time fitting in than those without such problems. They may find it difficult to maintain a job or a house, and their ability to successfully join the world outside prison may be put in jeopardy, even more if their condition remains untreated health (PRI, 2018). Therefore, post-release provision must be integrated and guarantee continuity of care, both in mental and physical health.

Although sparse, research (Draine & Herman, 2007; Jarrett et al., 2012) has also been showing interest in adapting - for the prison context -, intervention models that promote ideal continuity of care standards within the community for mentally ill individuals, such as the Critical Time Intervention model (also known as CTI).

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"CTI is a nine-month, three-stage intervention that strategically develops individualised linkages in the community and seeks to enhance engagement with treatment and community supports through building problem-solving skills, motivational coaching and advocacy with community agencies" (Draine & Herman, 2007, p. 1577). In this intervention model, professionals connected to CTI "can increase the number and strengths of (ex-inmates') ties to community resources, especially […] behavioural health providers" (Draine & Herman, 2007, p. 1577).

In sum, CTI's aim is twofold:

- To strengthen former inmates' long-term commitment to services, family and friends;
- And to provide emotional and practical support, as well as advocacy services, during the difficult time of transition (Draine & Herman, 2007).

In addition, it is supported by enhancing the quality of the personnel, and community connections involved, in order to establish or foster strategies in place for "connecting individuals to housing, employment, and education and creating positive social ties to reinforce these connections" (Draine & Herman, 2007, p. 1578).

Nevertheless, despite some research try-outs to further develop this concept, a recent study highlights that "contextual and environmental influences of the prison setting, the local resources, and the population affected CTI implementation" (Barrenger, Kriegel, Angell & Draine, 2015, p. 117). In fact, "pre-CTI engagement is especially difficult when the institutions are physically isolated and not easily negotiated by outsiders" (Barrenger, Kriegel, Angell & Draine, 2015, p. 117). However, "further research on the range of strategies in making linkages" (Barrenger, Kriegel, Angell & Draine, 2015, p. 117) must be conducted and problems with links between prison and community must be addressed, as the "continuity of care, supported by prison health discharge planning, could play an important role in the aim to reduce re-offending or prevent the revolving

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door of prison release and re-arrest" (Dyer & Biddle, 2013, p. 9), especially for those ex-inmates whose offending behavioural pattern is often associated with their already diagnosed mental health issues (Centre for Mental Health, 2011; House of Commons Home Affairs Committee, 2005).

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14. Conclusion

Raising awareness for mental health disorders and the importance of their treatment in prisons are vital measures for prisoners' rehabilitation and safe reintegration back into the community. Although there is still a lot of stigma and discrimination surrounding mentally ill people, especially those inside prison walls, protecting and promoting mental health in prisons should be a top priority. Obviously, this constitutes a big challenge globally, particularly in countries where there are no suitable resources to take care of the mental health of prisoners and staff.

Another important issue that should be addressed is the lack of training and support of prison staff on how to deal with mentally ill inmates. Adequate responses to prisoners with mental health problems build a better work environment and a more secure and reliable workplace for all. Therefore, it is important to train prison staff to recognise, refer and/or treat moderate to severe mental health problems within the confines of daily prison and probation systems.

Furthermore, it is vital to foster a better integration between agencies working in prisons and probation regarding health, mental health, substance abuse, and resettlement. By improving cooperation with community mental healthcare services it will ensure equivalence of care and continuity of treatment, consequently delivering more effective outcomes for the successful resettlement of prisoners.

Considering inmates' mental health, it is important to reinforce the high demand of this population for healthcare services. Therefore, countries need to provide specialised care to this population, assuring a ratio of healthcare professionals for inmates that takes into account the prevalence of illnesses in this population instead of just assuring equal standards of care for inmates and the community.

To sum up, the present document aimed to provide an up-to-date view of current practices in prison mental healthcare and finding best practices by investigating the state

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of the art. While doing this the authors provide recommendations regarding prison policies, especially those related to enhance the competencies of management and prison staff when dealing with this special, at-risk population growing old with a fragile physical and mental health.

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