

Prison is not the right place for people with mental disorders: the Brazilian case

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The large number of individuals with severe mental disorders in prisons worldwide has alarming implications, which leads to the question of the appropriateness of the prison system for people with this type of morbidity. This article discusses these implications, the problems in therapeutic approaches and the legal aspects in the Brazilian context.

Brazil is the fifth most populous country in the world (United States Census Bureau, 2013) and has the fourth largest prison population (Gombata, 2014). The USA, China and Russia occupy the top three positions in number of prisoners, but while their prisons operate within the limits of available places, the same is not observed in Brazil, whose prison system capacity is 281 520 places for some half a million people, meaning that prisons accommodate approximately twice their capacity.

Prison overcrowding in Brazil is exacerbated by the high prevalence of mental disorders among the inmates. A recent study conducted by our group found that lifetime and 12-month prevalence rates of mental disorders among prisoners in the state of São Paulo were 63% (56% among men and 69% among women) and 30% (22% among men and 39% among women), respectively. We found high lifetime prevalence rates of phobic anxiety disorders (42%), drug misuse/addiction (28%) and serious mental disorder (SMD – psychotic disorder, major depression and bipolar affective disorder) (11%) (Andreoli *et al*, 2014).

Lifetime prevalence rates of mental disorders are also high in countries such as Italy (85% among men) (Zoccali *et al*, 2008) and Canada (69.6% among women) (Lafortune, 2010).

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One systematic review of 22 studies found that the prevalence of mental disorders among prisoners was reported to range from 55% to 80% (Brink, 2005). Besides the higher prevalence rates, the severity of mental disorders also tends to be higher in the prison population. In the USA, the

number of individuals with SMD is estimated to be ten times higher in prisons than in psychiatric hospitals (Torrey *et al*, 2014). In Brazil, the prevalence of severe mental disorders is 5–10 times higher in the prison population than in the general population (Andreoli *et al*, 2014) and is similar to that found in other low- and middle-income countries (Fazel & Seewald, 2012).

Brazil: implications of imprisonment for the mental health of individuals with severe mental disorders

Human rights violations have been widely described, especially regarding the health services available to the prison population. These violations occur due to the insufficient availability of human and material resources, which, combined with institutional characteristics, aggravate or even cause health problems (Andreoli *et al*, 2014).

Many prisoners with SMD serve time in correctional facilities that lack the health programmes and human resources required for the diagnosis and treatment of mental illness. Even prison psychiatric hospitals (PPHs) lack the human resources required to care for prisoners with SMD. According to the latest data from the National Register of Health Institutions, there are only five interdisciplinary healthcare teams in nineteen Brazilian PPHs.

The conditions in prison facilities (e.g. poor hygiene, lack of air circulation, and drug use) increase the risk of infectious diseases. Prison overpopulation exacerbates these conditions and hinders the access of health professionals to prisoners, the diagnosis and treatment of mental disorders, and mental health promotion.

The lack of treatment and the consequent chronicity of psychiatric disorders aggravate the problems between individuals with SMD and other prisoners and staff and, as a result, prisoners with SMD become potential victims of various forms of physical and psychological violence (Birmingham, 2003). Additionally, any existing family relationships and work activities after release from prison deteriorate, aggravating the difficulties of adapting to freedom. For prisoners with SMD, the stigma of being a criminal, coupled with the mental health condition, compromise occupational rehabilitation, integration into the community and the quality of family relationships. Thus, the lack of psychiatric treatment during and after

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incarceration increases the chances of recidivism in people with SMD.

Prisoners with SMD are more vulnerable to these adversities because the changes to their functional mental state make them more prone to risk behaviours such as involvement in fights, indiscipline, drug misuse and self-harm.

Moreover, a large proportion of the prisoners who do suffer from mental illness do not seek psychiatric treatment because they are unaware of their condition. For instance, in a study conducted by our group in the prison population of the state of São Paulo, 50% of respondents with SMD denied having a mental health problem. In addition to being unaware of their condition, prisoners with SMD do not seek treatment because of the stigma and for fear of being referred to PPHs (Zoccali *et al*, 2008). Thus, when health demands are insufficiently met, a vicious cycle of illness is created.

Another aggravating factor for prisoners with SMD is coping with stress from incarceration, which, as in any total institution, results in the curtailment of freedom, dissolution of autonomy, social isolation and, consequently, annihilation of individuality. This context is contrary to the ideals of health promotion and social rehabilitation, which are goals of the prison system.

The structural characteristics and dynamics of a prison facility tend to preclude the implementation and continuity of psychiatric interventions. Outdated interventions based on long-term hospitalisation and exclusively pharmacological treatments are still the norm in PPHs, as opposed to occupational and psychological interventions that may promote greater well-being and quality of life (Silva, 2010).

According to international law, social rights should not be affected by the application of a judicial penalty and should be guaranteed by the state during custody or the execution of the sentence. Thus, prisoners should have guaranteed access to education, social and legal assistance, leisure and health. However, prisoners with SMD are not protected by the law, subjecting them to a double penalty: one imposed by the justice system, which considers prisoners with SMD to be 'common' prisoners, who are forced to serve their time in common correctional facilities; and another imposed when they are victimised by having their rights to physical and mental integrity and healthcare violated (Torrey *et al*, 2014).

The process of forensic psychiatric examination is often slow or nonexistent, either due to a lack of personnel or because of bureaucratic obstacles. Additionally, there are some complicating factors to consider, such as the lack of diagnostic instruments, limited records and observations during forensic examination, and the tendency for symptoms of aggression, anxiety and delirium to be more readily detected than others, such as sadness, isolation and insomnia (Lafortune, 2010).

Arboleda-Flórez (2003) argues that the closure of psychiatric hospitals in some Western countries due to the psychiatric reform process and the

inefficiency of the public health system have increased the demand for forensic psychiatric services and, consequently, the number of persons with a mental illness in prisons. Even though these assumptions have not been tested, the public health system must be better prepared to promote mental health and to detect and prevent cases in which people with SMD are at risk of committing unlawful acts.

The problem of criminal law for individuals with mental disorders and its application

The criminal legislation of many countries excuses individuals with mental illness of accountability and culpability by reason of diminished capacity. Thus, in place of a criminal sentence, the individual is sentenced to a PPH or health institution. This alternative sentence serves both to prevent individuals with mental illness who have committed a criminal offence and whose dangerousness has been demonstrated committing another crime and to ensure that they receive proper treatment.

The contradictions arise from the concept of mental illness and its implications for justice. The law, as a cultural and historical construct, has adopted a stereotyped concept of mental illness that is associated with the notion of danger. Thus, the application of an alternative sentence assumes the dangerousness of the actor, and thus the need to keep him or her in a closed system for his or her own protection and that of society at large, as long as there is a risk of recidivism (Peres & Filho, 2002). Because there is no cure for most SMDs, in the understanding of the law an individual's dangerousness remains high; this, coupled with the lack of treatment and social isolation, as well as the chronicity of the disease, means that a sentence at a PPH invariably represents a life sentence. Thus, there is a discrepancy between the law and psychiatry. For the latter, the focus is not the cure, but promoting autonomy and social rehabilitation.

Final remarks

The data presented here show the unsuitability of prisons for treating and rehabilitating prisoners with SMD. Besides, the prison system can aggravate prisoners' health conditions and it tends to be a more severe sentence for them than it is for prisoners without these disorders. Thus, to prevent such individuals being admitted to general correctional facilities, it is crucial to improve screening procedures and psychiatric examinations, to increase the number of health professionals working in the prison system, to facilitate prisoner transfers, and to reform penal law.

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MANAGING THE MENTAL HEALTH OF PRISONERS

A novel prison mental health in-reach service in Somaliland: a model for low-income countries?

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Prison in-reach mental health services are reasonably well developed in advanced economies, but virtually nonexistent in low- and middle-income countries. We describe the development of a small prison in-reach project in Somaliland, a self-declared independent state which has experienced conflict and poverty in equal measure. After careful planning and cooperation with local agencies, the service provides sessional input to a regional prison, including assessment and treatment of a wide range of psychiatric conditions. The project has had some unexpected benefits, which are described. The success of the project reflects the effectiveness of collaboration between local stakeholders and international agencies, and could be used as a model for the development of in-reach services in other low-income countries.

There are over 10 million people in prisons worldwide. Prisoners are more likely than the general population to experience psychiatric morbidity, with about one in seven having a treatable mental illness (Fazel & Baillargeon, 2011). Substance misuse, personality factors and risk of suicide (World Health Organization, 2007) are particular problems, and prisoners often present with complex and multiple needs (Singleton *et al*, 1998). Over the past few decades, the concept of

equivalence – that prisoners are entitled to the same standard of healthcare as that provided outside prison – has been the main driving force in improving prison mental healthcare (Exworthy *et al*, 2012). Services have attempted to put systems in place to identify at-risk prisoners, both at the time of reception and during their incarceration. For example, in the UK, prisoners are screened for mental health problems on detention and referred to prison in-reach services (staffed by mental health nursing and medical personnel) if required. Detainees can be transferred to the prison health-care wing or moved to an external hospital under the provisions of mental health legislation. Despite this progress, equivalence is still rarely achieved and demand for in-reach services far outstrips supply (Ginn, 2012).

Notwithstanding these difficulties, prison mental health services in high-income countries are much better than those in emerging economies. In many jurisdictions, services appear to be virtually nonexistent. For example, prison-based mental health services in India are unheard of (Sarkar & Dutt, 2006). We are not aware of any in-reach services on the African continent, despite the high prevalence of mental disorders (Audi *et al*, 2008; Naidoo & Mkize, 2012).

It was with this background that we considered the development of a basic in-reach mental health service within a prison in Somaliland, following a