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Mental Disorders in European Prison Systems

Arrangements for Mentally Disordered Prisoners in the Prison Systems of 13 European Countries

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Introduction

American and European prison systems are faced with large numbers of mentally ill prisoners. It is estimated that correctional facilities in the United States house twice as many persons with serious mental illnesses as do mental hospitals (Torrey, 1995). North American studies (e.g., Roesch & Golding, 1985; Teplin, 1990) and European studies have found high prevalence rates of mental disorders in penal institutions.

European studies have yielded fairly consistent findings about the prevalence rates of mental disorders in samples of unsentenced prisoners. Lifetime prevalence rates of mental disorders, including substance-related disorders and personality disorders, were found to be 71% in Denmark (Andersen, Sestoft, Lillebaek, Gabrielsen, & Kramp, 1996) and 71% in England (Birmingham, Mason, & Grubin, 1996). Current prevalence rates were found to be 64% in Denmark (Andersen et al., 1996), 62% in England (Birmingham et al., 1996), 63% in England and Wales (Brooke, Taylor, Gunn, & Maden, 1996) and 62% in Ireland (Smith, O'Neill, Tobin, Walshe, & Dooley, 1996). Thus,

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studies in samples of unsentenced prisoners have consistently[1] found a lifetime prevalence of mental disorder of 71% and a current prevalence rate of about 63%.

Studies have yielded diverging findings about the prevalence of mental disorders in samples of sentenced prisoners. A study in England and Wales focused on severe disorders and found a relatively low current prevalence rate of mental disorders of 37% among sentenced prisoners (Gunn, Maden, & Swinton, 1991). A study in Ireland discovered a current prevalence of mental disorder (excluding personality disorders) of 54% (Smith et al., 1996). A study in the Netherlands yielded a lifetime prevalence rate of mental disorders of 78% and a current prevalence of 54% (Schoemaker & Van Zessen, 1997). Another study in the Netherlands yielded a lifetime prevalence of 89% and a 1-year prevalence of 80% (Bulten, 1998). A study in Finland among sentenced prisoners and prisoners on remand revealed a current prevalence rate of mental disorders of 56% (Joukamaa, 1995). A study in Scotland among sentenced and remanded prisoners yielded a lifetime prevalence of mental disorder of 73% (Cooke, 1994). Despite the variations, the studies suggest that samples of sentenced prisoners have about equal lifetime prevalence rates and lower current prevalence rates of mental disorders than do samples of unsentenced prisoners.

Large variations exist with regard to the discovered prevalence rates of specific mental disorders. Many of these variations are due to differing diagnostic instruments and classification systems (e.g., *International Classification of Diseases* and *Diagnostic and Statistical Manual of Mental Disorders*), differing samples (jail or prison inmates, adults or juveniles, mixed populations, etc.), differing scopes (e.g., including or excluding personality disorders or substance-related disorders) and differing periods of interest (e.g., lifetime prevalence, 1-year prevalence, 1-month prevalence). Nevertheless, Table 1 makes clear that roughly 5% (range, 0.8–9%) of all prisoners meet the criteria for a psychotic disorder and about a quarter of all prisoners (range, 6–29%) appear to have an affective disorder or an anxiety disorder. Furthermore, about 40% (range, 19–56%) of all prisoners appear to have a substance-related disorder. In combination with the finding that about 63% of all inmates meet the criteria for a mental disorder, these findings demonstrate that European prisons systems are confronted with large numbers of mentally ill prisoners. Thus, there is no doubt that mental disorders among prisoners are a matter of concern.

Different Levels of Mental Health Care

Several studies have found that many prisoners who are in need of assistance or psychiatric attention are not recognized as such. For instance, Schoemaker and Van Zessen (1997) found that medical staff in prisons tend to underestimate the need for hospital transfer in prisoners with serious mental illness. Birmingham et al. (1996) noted that prison medical staff identified mental disorder in only 9% of the prisoners, while interviews identified the presence of a mental disorder

[1]In a Scottish sample of 389 remand prisoners in nine remand prisons (Davidson, Humphreys, Johnstone, & Cunningham Owens, 1997), only 2.3% of the prisoners were found to have a current clinical diagnosis of major psychiatric disorder (excluding substance related disorders and personality disorders).

in 23% of prisoners. Birmingham et al. also found that only a quarter of the acutely psychotic prisoners had been identified as the result of screening. Bulten (1998) noted that affective disorders and anxiety disorders especially remain unnoticed by prison staff. Cooke (1994) found that less than 10% of the prison records of prisoners with previous or current psychological difficulty contained any indication of such a history. These findings demonstrate the importance of adequate staff training programs, comprehensive screening programs to detect mental disorder, and adequate provisions for providing forensic assessments (see also Roesch, Ogloff, & Eaves, 1995).

Not all mentally disordered prisoners are in need of psychiatric treatment. Schoemaker and Van Zessen (1997) reported that, according to the judgment of psychologists working within the Dutch prison system, about 12% of the prisoners were in need of professional counseling and support. Birmingham et al. (1996) noted that about 9% of their English sample needed urgent psychiatric attention. Brooke et al. (1996) found that about 9% of their sample in prisons in England and Wales needed transfer to a bed in a National Health Service. Gunn et al. (1991) noted that approximately 6% were judged to require special treatment. These findings suggest that sufficient possibilities of transfer for further assessment and treatment are available when 6–12% of a country's prison population can be transferred.

Many prisoners with mental disorders do not necessarily require urgent psychiatric attention but do need some assistance by health-care services. Birmingham et al. (1996) found that about 30% of the prisoners required some form of psychiatric input. Brooke et al. (1996) found that 55% of the prisoners needed some assistance from health-care services. Other authors also state that large, but unknown, numbers of prisoners are in need of at least some assistance. These findings demonstrate that it is important to have sufficient numbers of adequately trained mental health professionals and regular staff available in each prison. The findings also support the need for intervention programs and supportive facilities that are commensurate with the fact that at least 3 out of every 10 prisoners appear to require assistance by mental health care services.

The remainder of this article addresses the measures taken in 13 European countries for dealing with mentally disordered prisoners. Specific attention is given to screening procedures and staff training programs to detect mental disorder because detection precedes treatment. Failure to detect mental disorder means that the opportunity for treatment is lost and that provisions for providing support may not be directed to those who need such support. In addition, attention is given to possibilities of transfers for further assessment and treatment because the availability of beds in psychiatric divisions or psychiatric institutions may be a problem with 6–12% of the prisoners needing psychiatric treatment (see also Brooke et al., 1996). Attention is also given to overcrowding because this has been found to be one of the contributing factors to mental disorder (Bonta & Gendreau, 1990; Roesch, Ogloff, Zapf, Hart, & Otto, 1998). Furthermore, attention is given to the ratio of prisoners and (mental health) staff because large prison populations and high densities of prisoners, especially in combination with inadequate numbers of staff and time-constraints of staff, may have an effect on the quality of measures to deal with mentally disordered

TABLE 1
Prevalence of Mental Disorder Among Prisoners

Study	Sample	Current prevalence	Lifetime prevalence	Any psychiatric disorder
Gunn et al., 1991	1,769 sentenced prisoners in 16 prisons in England and Wales	Psychosis 2%; neuroses 6%; personality disorder (PD) 10%; substance misuse 23%		Current prevalence 37%[a]
Joukamaa, 1995	903 sentenced and remand prisoners in prisons in Finland	Psychoses 3%; neuroses 6%; PD 17%; alcoholism 44%; drug addiction 6%		Current prevalence 65%[a]
Smith et al., 1996	126 sentenced prisoners in Ireland's largest prison	Major disorder (psychosis) 4%; dependence on drugs 20%; dependence on alcohol 25%		
Schoemaker and van Zessen, 1997	135 sentenced prisoners in a large prison in the Netherlands	Affective disorder 16%[c]; anxiety disorder 13%[c]; substance misuse 19%	Affective disorder 41.5%; anxiety disorder 27%; substance misuse 60%; antisocial PD 32%	Current prevalence 54%[a] lifetime prevalence 78%[a]
Bulten, 1998	200 young prisoners serving short sentences in a large prison in the Netherlands	Psychotic disorder 9%[d]; depressive disorder 14%[d]; phobic disorder 9%[d]; panic disorder 6%[d]; antisocial PD 47.5%[d]; alcohol abuse 36%[d]; drug abuse 49%[e]	Psychotic disorder 10%; depressive disorder 16.5%; phobic disorder 15.5%; panic disorder 6.5%; Anti-social PD 60.5%; alcohol abuse 62.5%; drug abuse 58%	Year prevalence 80%[a] IIfetime prevalence 89%[a]
Cooke, 1994	247 male remanded and convicted prisoners in 7 prisons in Scotland	Schizophrenia 0.4%; unspecified psychosis 0.4%; major depressive disorder 6.5%; panic disorder 3.2%; generalized anxiety disorder 7.3%; obsessive compulsive disorder. 7.7%; phobic disorder 13%	Schizophrenia 2%; major depressive disorder 40%; mania 4%; hypomania 6%; alcohol dependence 38%; drug dependence 21%; panic disorder 7%; generalized anxiety disorder 23%; obsessive-compulsive disorder 10%; phobic disorder 15%	Lifetime prevalence 73%[a]

Andersen et al., 1996	228 prisoners in a remand prison in Denmark	Substance-related disorder 44%; psychotic disorder 7%; mood disorder 10%; neurotic 16%; antisocial PD 17%	Substance-related disorder 53%; psychotic disorder 8%; mood disorder 11%; neurotic 18%; PD 17%	Current prevalence 64%[a] lifetime prevalence 71%[a]
Brooke et al., 1996	750 remand prisoners in 16 prisons in England and Wales	Psychosis 5%; neurotic disorder 26%; PD 11%; substance-related disorder 38%		Current prevalence 63%[a]
Birmingham et al., 1996	569 adult unsentenced prisoners in a large remand prison in England	Psychotic disorder 5%; major mood disorder 2%; anxiety disorder 6%; adjustment disorder 3%; PD 7%	Psychotic disorder 7%; personality disorder 12%; nonpsychotic mood disorder 7%	Current prevalence 62%[a] lifetime prevalence 71%[a]
Smith et al., 1996	109 pretrial prisoners in Ireland's largest prison	Major mental illness (psychosis) 5%; other diagnosis 7%; Dependence on drugs 19%; dependence on alcohol 29%		Current prevalence 62%[b]

[a]Including substance-related disorders and PD.
[b]Including substance-related disorders but excluding PD.
[c]Month prevalence.
[d]Year prevalence.

prisoners, particularly on those measures that require contact between prisoners and staff. In this respect, one of the most frequently mentioned problems facing U.S. jails, with regard to prisoners with a mental illness, is the lack of adequate resources and staff (Morris, Steadman, & Veysey, 1997). Finally, this article addresses arrangements in prison systems for providing contacts between prisoners and the outside world because such contacts may serve as a way to relieve stress.

Information about the 13 European countries was obtained from a questionnaire that was distributed among high-ranked officials at countries' Ministries of Justice or Health who were assigned responsibility for mental health promotion in the prison systems. The World Health Organization (WHO) Collaborating Center in London distributed the questionnaire among the network members from the WHO "Health in Prisons Project." Data were analyzed by the first author. Unfortunately, all questionnaires contained responses that were somewhat ambiguous or incomplete. As a result, it was not always possible to make the desired comparisons or to draw firm conclusions about certain measures to deal with mentally disordered prisoners. Nevertheless, it is believed that a considerable amount of valuable information was obtained about the provisions in 13 European countries.

Prison Systems and Overcrowding

Table 2 shows that in 1997 the Ukraine had by far the largest prison system of the 13 countries, followed by England and Wales, Poland, and France. Malta had a small prison system, with only 246 prisoners in 1997. There are some large differences in the number of beds per cell. Poland and Hungary had a relatively high number of beds per cell, whereas Finland, Malta, and the Netherlands generally had only one bed per cell. Finland, Malta, Northern Ireland, and Poland appear to have had over capacity in 1997, as these countries had an abundance

TABLE 2
Size of Prison Systems and Overcrowding (1997)

	Average daily population	Beds	Cells	Beds per cell	Prisoners per bed	Prisoners per cell
England and Wales	61,154	62,856	56,375	1.12	0.97	1.09
Finland	2,836	3,661	3,650	1.00	0.77	0.78
France	54,268	50,292	40,810	1.22	1.08	1.33
Greece	5,313	4,332	–	–	1.23	–
Hungary	13,068	10,369	2,928	3.67	1.26	4.46
Ireland	2,539	2,500	2,050	1.22	1.02	1.24
Latvia	10,414	9,760	–	–	1.07	–
Malta	246	350	350	1.00	0.70	0.70
Netherlands	14,679	14,697	14,697	1.00	1.00	1.00
Northern Ireland	1,632	2,117	1,905	1.11	0.77	0.86
Poland	57,596	64,978	15,286	4.25	0.89	3.77
Scotland	6,082	5,763	–	–	1.06	–
Ukraine	221,080	202,327	–	–	1.09	–

of beds in relation to the average daily population. In contrast, especially France, Greece, Hungary, Latvia, Scotland, and the Ukraine appear to have had overcrowding in 1997, as these countries had more prisoners than beds. Several of these countries tried to solve the problem of overcrowding by placing extra beds in dormitories in prisons.

Staff

Countries have different arrangements for providing mental health care in prison systems. Table 3 shows that all countries have psychologists, psychiatrists, or psychiatrically trained nurses working in the prison system. Table 3 does not display the fact that some countries also hire these professionals from institutions outside the prison system. Some countries assign responsibility for dealing with mental-disordered prisoners predominantly to psychologists, whereas other countries assign such responsibility predominantly to psychiatrists or nurses. Keeping in mind the size of the prison system of each country, Scotland, Northern Ireland, England and Wales, the Netherlands, and France have a relatively high number of psychiatry-trained nurses working within the prison system. Greece, the Netherlands, and Scotland have a relatively high number of psychiatrists and Finland, Malta, Poland, and Scotland have a relatively high number of psychologists. However, almost all European countries seem to have a lack of staff. In many countries, the workload for mental health professionals is tremendous, as each professional serves hundreds of prisoners. The ratio of prisoners to mental health staff is at least 200:1 in Greece, Hungary, Ireland, Latvia, and the Ukraine and at least 100:1 in England and Wales, France, Malta, Northern Ireland, and Poland. Only Finland, the Netherlands, and Scotland

TABLE 3
Ratios of Prisoners (Average Daily Population) and Staff and Mental Health Staff (in Full-Time Units)

	Psychologists	Psychiatrists	Nurses	All staff	Prisoners per mental health staff	Prisoners per all staff
England and Wales	–	–	320	40,000	–	1.5
Finland	24	5	10	2,595	73	1.1
France	89	114	214	26,191	130	2.1
Greece	0	17	7	2,130	221	2.7
Hungary	35	18	12	6,246	201	2.1
Ireland	6	2.5	0	2,600	299	1.0
Latvia	3	9	7	2,297	548	4.5
Malta	1.5	0.5	–	212	123	1.2
Netherlands	39	40	100	13,109	82	1.1
Northern Ireland	1	1	10	3,000	136	0.5
Poland	230	79	50	22,015	160	2.6
Scotland	23	18	53	4,885	65	1.2
Ukraine	209	105	18	28,571	666	7.7

Note: The ratios are calculated on the basis of the average daily population of prisoners in 1997 and the full-time equivalents of staff in 1998.

appear to have a fairly good ratio of prisoners to mental health staff professionals. From the knowledge that psychiatrists, psychologists, and nurses have different tasks, it is clear that mental health professionals in jails and prisons are faced with tremendous workloads.

Not surprisingly, prison systems have many uniformed staff members working in the prison systems. Table 3 shows that Northern Ireland has two staff members per prisoner. In contrast, the Ukraine has around 7.7 prisoners per staff member. Overall, the number of prisoners per staff member appears higher in the Eastern European countries but considerable variation is present among the Western European countries. Finland, Northern Ireland, Ireland, The Netherlands, Malta, and Scotland have a relatively low number of prisoners per staff member. The number of prisoners per staff member is relatively high for France and Greece. Most countries have a ratio of about one or two prisoners per staff member. This means that in practice there are about 6–12 prisoners per uniformed staff member on duty because there are usually four shifts in jails and prisons and some uniformed staff members have other duties in which they do not interact with prisoners. Thus, especially Latvia (27:1) and the Ukraine (46:1) may have insufficient numbers of staff to provide adequate measures for dealing with mentally disordered prisoners.

Recognizing Mentally Disordered Prisoners

Table 4 shows that Greece and Hungary do not routinely screen newly arrived prisoners for the presence of a mental disorder. In the vast majority of the other countries, screening for mental disorder forms part of a general intake by nurses, physicians, or uniformed staff. In such cases, the initial screening is usually followed by a further examination by a prison doctor, psychologist, or psychiatrist when a prisoner is considered possibly disordered. However, a general intake does not guarantee that sufficient attention is given to the detection of mental disorders, especially because only the countries in the United Kingdom use a standardized screening device. In Malta, a substance abuse therapeutic unit carries out a separate screening on drugs using the Rosenberg Self Esteem Scale (Rosenberg, 1965), the General Health Questionnaire (Goldberg, 1972) and an indicator for substance abuse. In Latvia, Poland, and the Ukraine, psychiatrists perform a diagnostic interview on newly arrived prisoners. However, as was mentioned before, psychiatrists in especially Latvia and the Ukraine have a tremendous workload, which jeopardizes the recognition of mental disorders.

Only five countries (Finland, Latvia, the Netherlands, Poland, and the Ukraine) provide their uniformed staff with some form of training in dealing with mentally disordered prisoners (see Table 4). Hungary does not provide such training to uniformed staff because the prison system relies on a specific type of personnel, called “educators.” In Poland, aspirant correctional officers are extensively trained at the Central Training Center in the recognition of mental disorders and correctional officers are mandated to participate in an annual refresher training in the recognition of mental disorders. In the Netherlands all aspirant correctional officers receive training in the recognition of and handling of mental disorders and correctional officers at special divisions

TABLE 4
Screening for Mental Disorder and Training of Uniformed Staff in Recognizing and Handling Mental Disorder

	Screening for mental disorder			Hours of uniformed staff training
	At intake	Screening device	Type of personnel	
England and Wales	Yes	Yes	Nurse or physician	0
Finland	Yes	No	Nurse or physician	8
France	Yes	No	Health-care unit	0
Greece	No	No	–	0
Hungary	No	No	–	0
Ireland	Yes	No	Nurse or physician	0
Latvia	Yes	Diagnostic interview	Psychiatrist	6
Malta	Yes	No	Nurse or physician	0
Netherlands	Yes	No	Uniformed officer and nurse	12
Northern Ireland	Yes	Yes	Health-care staff	0
Poland	Yes	Diagnostic interview	Psychologist or psychiatrist or physician	125
Scotland	Yes	Yes	Uniformed officer and nurse	0
Ukraine	Yes	Diagnostic interview	Psychiatrist	4

take additional courses in mental disorders. The Ukraine trains uniformed personnel in recognizing mental disorder, but not in dealing with mental health problems.

Referrals

In all 13 countries it is possible to have mentally disordered prisoners admitted to psychiatric institutions in the community. In some countries, such transfers require permission of the Home Secretary (e.g., England and Wales) or the court (e.g., Ukraine) but in other countries, prison directors, psychiatrists, or psychologists have the authority to direct such transfers. However, all contact persons mentioned that difficulties or delays often arise with referrals to community psychiatric hospitals because of disputes between doctors over the diagnosis or severity of mental disorders, reluctance of psychiatric hospitals to be confronted with security difficulties when asked to receive prisoners, restricted policies of psychiatric hospitals for the admittance of patients of penal institutions, or lack of beds in psychiatric hospitals.

Almost all countries have special beds available within the prison systems to deal with mentally disordered prisoners (see Table 5). However, the number of special beds is less than 3% of the average daily population of prisoners in the

TABLE 5
Special Beds Within Institutions in Prison Systems to Deal with Seriously Disordered Prisoners

	Number of special beds	% of average daily population
England and Wales	350	0.6
Finland	55	1.9
France	260	0.5
Greece	140	2.6
Hungary	794	6.1
Ireland	75	3.0
Latvia	37	0.4
Malta	18	7.3
Netherlands	592 (+835)	4.0 or 9.7
Northern Ireland	15	0.9
Poland	1711	3.0
Scotland	0	0.0
Ukraine	150 + 1–2% of adp	1–2%

adp = average daily population.

majority of the countries. England and Wales have around 350 beds available in therapeutic community facilities for sentenced prisoners and young offenders with personality disorder. Finland has one hospital (40 beds) and one hospital unit (15 beds) for male prisoners. France has hospital services located in 26 prisons (260 beds), whereby access to these services is restricted for prisoners from other prisons. Greece has a Prison Psychiatric Hospital in Athens, which has 140 beds. The Irish prison system contains a secure forensic psychiatric institution with 75 beds in Dublin. Latvia has 37 beds available for mentally disordered prisoners in a psychiatric unit of the Prison Hospital. Northern Ireland has hospital beds in all prisons and a psychiatric unit in Northern Ireland's main prison that is available for all prisoners. Poland has 200 beds in psychiatric subwards and 1,511 beds in 23 wards for mentally disordered prisoners. Scotland has no special institutions within the prison system to deal with mentally disordered prisoners. In the Ukraine, every penal institution has a medical unit for observation and treatment. The total number of beds is up to 1% (remand prisons) or 2% (prisons for sentenced prisoners) of the number of beds in penal institutions. For inpatient treatment, prisoners with mental disorder can be referred to the specialized hospital (150 beds).

In only three countries (Hungary, Malta, the Netherlands), the number of special beds is more than 3% of the average daily population of prisoners. Some prisons in Hungary have "Curing and Educating Groups," with a total of 483 beds for prisoners with mental health problems. Seriously mentally disordered prisoners are examined by the "Forensic Observatory Institute," a psychiatric hospital with 311 beds for offenders only. The small prison system in Malta has a daily general practitioners clinic available with 24-hour coverage. In addition, Malta has a maximum-security division at Mount Carmel Hospital, a psychiatric hospital with a capacity of 18 beds. In the Netherlands, mentally disordered prisoners can be transferred to Special Care Divisions

within remand centers (total capacity about 400 beds), in which divisions more attention is given to prisoners. Prisoners who cannot be handled at Special Care Divisions can be transferred to Individual Guidance Centers (114 beds) where prisoners are provided with a fairly extensive individual approach. Transfer to the Division of Clinical Psychological Observation of the Penitentiary Selection Center (PSC; 18 beds) is indicated when there is a severe imminent crisis of a psycho-social nature (severe guilt over the offence, death of a spouse, et cetera). The PSC has the means for crisis-intervention and psychotherapy. Transfer to the Forensic Observation and Guidance Center (FOBA: 60 beds) is indicated when there is an acute and serious crisis of a psychiatric nature. The FOBA has possibilities for coercive medication and crisis-intervention. In very rare cases, prisoners can be transferred to so-called Ter Beschikking Stelling (TBS)-institutions (835 spaces). TBS is a special hospital order that the judge imposes on people who have been sentenced for a grave crime and who are more or less insane. In all cases, the solution is only temporary because special institutions have the policy to return prisoners to the prisons as soon as this is possible.

Contacts with Other People

All countries have arrangements to provide prisoners with spiritual support as they allow prisoners to have frequent (Greece and Northern Ireland) or unlimited access to a vicar, pastor, priest, or another religious representative.

The majority of the countries have installed calling-card telephones in jails and prisons as an arrangement to provide prisoners with social support. In some countries (France, Ireland, Latvia, Poland, and Ukraine), access to these telephones is governed by the regulations of each jail or prison. In other countries, prisoners can make telephone calls for a minimum of 5 minutes per day (Malta), one time a week (the Netherlands), three times a week (Finland), or as long as is possible with the telephone cards (England and Wales, Greece, Hungary, Northern Ireland, and Scotland). In France, unsentenced prisoners are not allowed to make any telephone call. In Latvia, visits can be replaced by telephone calls or a telephone call can be the reward for good behavior.

All prison systems allow prisoners to receive visits from relatives, partners, or acquaintances (see Table 6). However, there are great differences with regard to frequency and duration. In England and Wales, two visits per month are allowed for a minimum of 1 hour each month for sentenced prisoners and a minimum of 6 hours each month for remand prisoners (maximum frequencies are not prescribed). In Finland, prisoners are allowed a visit each weekend. In France, sentenced prisoners are allowed to receive 1-hour visits once a week and unsentenced prisoners are allowed half-hour visits three times a week. In Greece, unsentenced prisoners are allowed to have two visits each week and sentenced prisoners are allowed to have one visit each week (20 minutes per visit). In Hungary, half-hour visits are allowed once every month. In Ireland, remand prisoners are allowed half-hour visits daily, whereas sentenced prisoners are allowed half-hour visits at least once a week. In Latvia, the number of visits is dependent of the type of regime. There are no limits to receiving visits in open prisons. In Malta, sentenced prisoners are allowed to receive one visit

TABLE 6
Contacts with the Outside World

	Visits for unsentenced prisoners		Visits for sentenced prisoners		
	Times a month	Total duration (hours)	Times a month	Total duration (hours)	Intimate visits
England and Wales	2	6	2	1	0
Finland	4	–	4	–	Trustworthy prisoners
France	12	6	4	4	0
Greece	8	2.7	4	1.3	0
Hungary	1	0.5	1	0.5	0
Ireland	30	15	4	2	0
Latvia	0.25–1.17	3–28	0.25–1.17	3–28	Prisoners in open prisons
Malta	30	10	4–8	3–6	0
Netherlands	4	4	4	4	Once a month
Northern Ireland	4	4–8	4	4–8	0
Poland	2	2	2	2	Rewarded prisoners
Scotland	20	15	4	3	0
Ukraine	1	4	1	4	Once every 3 months

per week (45 minutes per visit), but sentenced prisoners who work are allowed to receive two visits per week. Unsentenced prisoners are allowed to receive visits daily (15 minutes per visit). In the Netherlands, prisoners are allowed to have one 1-hour visit each week. In Northern Ireland, prison rules allow for two statutory and up to three privileged visits per month but practically all prisoners are allowed to receive visits four times a month (1–2 hours per visit). In Poland, prisoners are allowed to receive 1-hour visits twice a month. In Scotland, convicted prisoners are allowed to receive a visit once a week and untried prisoners are allowed a visit on every day of the working week (about 45 minutes per visit). Finally, prisoners in the Ukraine are allowed a short-term meeting (maximum of 4 hours) once a month and a long-term meeting (maximum of 3 days) once every 3 months, but long-term meetings are allowed to be replaced by several short-term meetings.

Five countries allow prisoners to have a private meeting with their partner. Finland allows trustworthy prisoners to have an intimate visit occasionally, usually not more than once a month, and Poland sometimes allows intimate visits as a reward for good behavior. In Latvian open prisons, prisoners can cohabit with their families. In the Netherlands, a brief intimate visit is allowed once every month and in the Ukraine prisoners can live with their family for 3 days once every 3 months. In France, intimate visits are not allowed but there is an experimental project with family life units for sentenced prisoners.

Discussion

The questionnaires yielded moderately reliable data about the number of prisoners, uniformed staff, mental health staff, beds, and cells in prison systems because countries do not always keep good registration of these characteristics of prison systems. In addition, the questionnaires yielded information about regulations and procedures in the entire prison system, which may not necessarily tell all about the actual daily practice in separate jails or prisons. Furthermore, the questionnaires yielded information about the situation in 1997 and 1998. Arrangements may have changed since then. Nevertheless, even fairly large adjustments in a more desirable direction cannot cover up the fact that a grim picture emerges about the arrangements in European countries for dealing with mentally disordered prisoners.

It is clear that screening procedures are often impaired. Some countries do not screen prisoners for the presence of mental disorders and many countries do not use standardized screening instruments. The countries with standardized screening devices are often confronted with a tremendous workload among those who do the intake. In addition, several countries have a shortage of uniformed staff and uniformed staff is often not trained in the detection of mental disorders. Thus, it is not surprising that several studies (e.g., Birmingham et al., 1996; Bulten, 1998; Cooke, 1994; Schoemaker & Van Zessen, 1997) have shown that many mentally disordered prisoners are not recognized as such.

Although studies have indicated that between 6% and 12% of the prisoners are in need of psychiatric treatment (see Birmingham et al., 1996; Brooke et al., 1996; Gunn et al., 1991; Schoemaker & Van Zessen, 1997), none of the 13 prison systems have sufficient beds available in specialized divisions or institutions to ensure that 12% of the prisoners population can receive psychiatric treatment. Three countries have the possibility of transferring 6% of their prisoner population to institutions within the prison system that specialize in dealing with mental disorders. All the other countries rely on the availability of beds in psychiatric institutions in the community. However, it is likely that all countries are confronted with the problem that prisoners who are eligible to be transferred to a psychiatric hospital, even psychotic prisoners, are fairly often rejected for admittance (see Robertson, Dell, James, & Grounds, 1994), and that many of those who require urgent psychiatric treatment do not receive such treatment (see Birmingham et al., 1996; Coid, 1988).

Based on the notion that at least 3 out of every 10 prisoners require assistance by health-care services (Birmingham et al., 1996; Brooke et al., 1996), it is clear that prison systems need good prison health services, sufficient numbers of mental health staff, and sufficient numbers of adequately trained uniformed staff. The responses to the questionnaires indicate that exactly these conditions are not met in many countries. Less than half of the countries provide the uniformed staff with training in dealing with mentally disordered prisoners. Many countries struggle with overcrowding, high prisoners-to-staff ratios and high ratios of prisoners to mental health staff. In some countries, prisoners can hardly fall back on their partner, relatives, and friends because they have few possibilities to frequently call these sources of social support or receive frequent visits from them. Assuming that mentally disordered prisoners draw the

attention of uniformed staff and mental health staff away from prisoners with less serious disorders (because such disorders are generally less alarming), many prisoners may not receive the attention they need.

The results of our survey show that countries have adopted different ways to deal with mentally disordered prisoners. Instead of focusing on all measures, countries tend to pay relatively more attention to separate measures, such as screening (e.g., Poland), training programs for uniformed staff (e.g., Poland and the Ukraine), uniformed staff to prisoners ratios (e.g., Northern Ireland), mental health staff to prisoners ratios (e.g., Scotland), maintaining a one prisoner per cell policy (Finland, Malta, and the Netherlands), possibilities for transfer (e.g., the Netherlands) and contacts between prisoners and relatives (e.g., Latvia, Northern Ireland, and Scotland). In addition, many countries provide education programs, labor opportunities and exercise possibilities in the prisons and some countries have "listener schemes" (England and Wales), anti-bullying measures, policies against sexual harassment, temporary release schemes (e.g., Ireland and Northern Ireland) or therapeutic wards for drug-addicted prisoners (e.g., Hungary, Malta, the Netherlands, and Poland). All in all, countries may benefit from the experiences of other countries in their efforts to try to deal with mentally disordered prisoners.

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