

**DEZVOLTAREA ASISTENȚEI COMUNITARE ÎN DOMENIUL  
SĂNĂȚĂII MINTALE PENTRU DEȚINUȚI**

**Comments on the  
treatment of mentally ill offenders**

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My first and lasting reflection is the similarities between our prison system's problems with mentally disturbed inmates, both basic and detailed. Good treatment ambitions and plans are "sabotaged" by aggression and other disturbances of order and security for the inmate himself, other inmates and the staff, and contradictory goals helps to confuse the work and treatment efforts.

I really agree that services from the community are of fundamental importance for the inmates' health and further rehabilitation. Without that, all the progress and efforts made in prison are wasted! And counterwise, if the inmate does not benefit from proper care and treatment during imprisonment, he will be released with a high risk for relapse.

There is indeed a contradiction between treating all inmates equal (ANP 2008) and to treat the mentally disturbed as a distinct group. I think it reflects a moralphilosophical problem; the demand of fair justice, equal treatment within the same juridical framework for everyone versus individual treatment according to everybody's needs. An "inborn problem of the system", that contributes, as the report says, to the mentally disturbed being more than others at risk of getting met with disciplinary measures, although it is my impression that some progress in this respect has been made in Sweden. -The lack of professional services in emergency cases also is a problem in Sweden, but chiefs and staff is instructed to bring uncertain cases to hospital without delay.

Should medical professionals be involved in decision-making when there is need for restraining and/or isolation? Those are methods that should be used only in extreme situations where nothing else is available or possible. If my memory doesn't fail, the EU- recommendation points out that medicals should not be involved in sheer custodial decisions, and this I think is such a case, or at least a border-case. It must be the prison authorities, not the medicals, that are responsible for decision-making and order and security in the prison. And what to do if medical personnel refuses to recommend those measures, and how to decide when no medical personnel is there? Indeed it is of utmost importance that such cases are examined and diagnosed by medicals as soon as possible, to get to know if it is an acute mental health problem that has caused the situation, and if the inmate perhaps should be brought to hospital.

Team-cooperation between different "elite"-professionals is difficult; a problem of "the unity of opposites". Is it at all possible to integrate individual professional responsibility with sharing of information and cooperate decision-making? How can you even understand each others different theoretical frameworks, ways of expression, different meaning of words in situations where there is an

ever present more or less hidden risk for destructive competition and lack of confidence? Those mechanisms can to some extent explain that section chiefs, 'SEAP' personnel, deputy directors and doctors all give different answers to the same questions, and I think this also is an inborn characteristic of prison work. Also typical is general expressions of overload with few specifications. It is a burden to work with personality disturbed inmates, also if the number of frustrations are impossible to define and count.

It was interesting that suicide- prevention programs involves inmates as "case supporters". Of course this occurs also in Sweden, but only spontaneously as a part of human solidarity in the group of inmates, not as a part of a structured program.

Simulation and medication trafficking can be counteracted by minimizing the amount of euphorizing medication. In Sweden medication prescription patterns are monitored per prison by following the specified bills from the pharmacy. This has lowered the prescription of benzodiazepines considerably and equalized the national pattern; earlier there were large regional differences in therapy traditions. Patterns of analgetic prescription are followed, too. Metadon/Subutex substitution therapy is allowed only when there is a responsible follow-up continuity guaranteed in the release-community. Such prescriptions are rare, and followed by individual reports of every case to the HQ.