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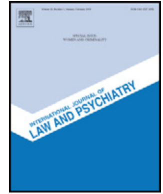

When and why should mentally ill prisoners be transferred to secure hospitals: A proposed algorithm

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ABSTRACT

For reasons well known and researched in detail, worldwide prevalence rates for mental disorders are much higher in prison populations than in general, not only for sentenced prisoners but also for prisoners on remand, asylum seekers on warrant for deportation and others. Moreover, the proportion of imprisoned individuals is rising in most countries. Therefore forensic psychiatry must deal not only with the typically young criminal population, vulnerable to mental illness due to social stress and at an age when rates of schizophrenia, suicide, drug abuse and most personality disorders are highest, but also with an increasingly older population with age-related diseases such as dementia.

While treatment standards for these mental disorders are largely published and accepted, and scientific evidence as to screening prisoners for mental illness is growing, where to treat them is dependent on considerations for public safety and local conditions such as national legislation, special regulations and the availability of treatment facilities (e.g., in prisons, in special medical wards within prisons or in secure hospitals). While from a medical point of view a mentally ill prisoner should be treated in a hospital, the ultimate decision must consider these different issues. In this article the authors propose an algorithm comprising screening procedures for mental health and a treatment chain for mentally ill prisoners based on treatment facilities in prison, medical safety, human rights, ethics, and the availability of services at this interface between prison and medicine.

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1. Introduction

The number of prison inmates is increasing in many parts of the world (Walmsley, 2009). There are different reasons for this development such as laws for preventive detention to ensure public safety (e.g., Canada, Germany, New Zealand, Switzerland) (Merkel, 2010; Simpson, 1998; Swiss Federal Statistical Office, 2009; Wormith & Ruhl, 1986) truth-in-sentencing laws (e.g., Canada or USA), which abolish or curb parole, the serious sex offender act (e.g., Australia) or sexually violent predator laws (e.g., USA) (McSherry & Keyzer, 2009) leading to longer prison stays and aging of this inmate population with age-related comorbidities (Kakoullis, Le Mesurier, & Kingston, 2010; Williams, 2006). In addition, compared with the general population inmates have a higher prevalence of suffering from mental disorders such as psychosis, depression, personality disorder, drug addiction and their comorbidities (Fazel & Baillargeon, 2011).

With admission to prison (the authors subsume under the term prison both prisons and jails) inmates are provided with individual disease prevention measures and treatment by the respective established medical health service. Medical care is organized quite differently throughout the world, depending on the agency with general responsibility for prison mental health services (ministry of justice/prison administration; ministry of health/national health service; mixed responsibility) ideally ensuring financial and staff resources for inmate health care (Graf, 2008; Salize & Dressing, 2008).

On the one hand medical and ethical principles should have the same applicability as outside of prison, irrespective of the particular conditions (Coyle, 2007). This is the view of most mental health professionals on the ethical principles of medical treatment (Restellini, 2007). On the other hand legal and security-relevant aspects should be carefully considered (Konrad, 2010).

The Committee of Ministers of the Council of Europe recommends that for the execution of sentences in Europe the medical care that is provided for inmates must be equal to that provided for the general public (the principle of equivalence) (Wilson, 2004). Furthermore, conditions of imprisonment that are required to preserve human rights cannot be neglected with the excuse of lack of resources (Council of Europe, C. o. M., 2006; Bundesministerium der Justiz et al., 1962–2003, 2004).

The different situations of incarceration, demands and inherent necessities, result in the immense challenge of providing adequate psychiatric and medical care that takes into account consideration of legal, medical, ethical and economic circumstances. The authors' considerations should contribute to a discussion about treatment of mentally ill prisoners based on the recommendations of different institutions such as the World Health Organization or the Council of Europe. For

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example, the Council of Europe gives recommendations referring to inmates' basic rights. These recommendations take European and International provisions (e.g., Standard Minimum Rules for the Treatment of Prisoners (United Nations, 2005); Standard Minimum Rules for the Treatment of Prisoners (Council of Europe, 1973); European Prison Rules (Counsil of Europe, 1987)) into consideration. Most of these organizations have no law-creating power but have de facto established standards with the exception of Switzerland where those recommendations are legally binding. These recommendations are proposed by attorney generals of the member states and represent a guide in corresponding legislation and their implementation. The Committee of Ministers of the Council of Europe is able to demand statements about implementation of these recommendations. Deviations from these require substantiation.

The Council of Europe consists of 47 member states and is the oldest organization between European countries with the aim to protect democratic safety (e.g., human rights, rule of law) (Europäische Strafvollzugsgrundsätze—Die Empfehlung des Europarates Rec(2006)2; Bundesministerium der Justiz, Berlin, et al., 2006; Bundesministerium der Justiz, Berlin, et al., 1962–2003, 2004).

The legal regulations of psychiatric treatment of mentally ill prisoners are quite different throughout the world. The authors do not claim the algorithm presented here to have universal validity: Rather this algorithm is intended to assist in decision-making that takes into account the many different involved persons, institutions, and authorities with regard to respective local therapeutic options to provide appropriate psychiatric care in prison.

In the following discussion, a proposed algorithm (Fig. 1) is presented to structure and guide the path of decision-making on whether to retain and treat a prisoner within prison or to transfer the prisoner to a secure hospital. The following sections and cross references correspond to specific steps of the proposed algorithm.

In this article the term "authority" denotes the agency that has responsibility for the inmate's housing, which might be, depending on the reason for imprisonment and the underlying legal framework, the police, the prosecution, a court, or the correctional services. For example, in Switzerland there is a distinction between the role of the law enforcement agency represented by the office of public prosecutor, and the authority of enforcement of sentences represented by the correctional services. Decision-making power is reliant on these conditions; all eventualities beside an uncomplicated treatment in prison (e.g., transfer to secure hospital or back to prison, compulsory treatment) must be coordinated and permitted by one of these authorities in any case. Because regulations of jurisdiction are different

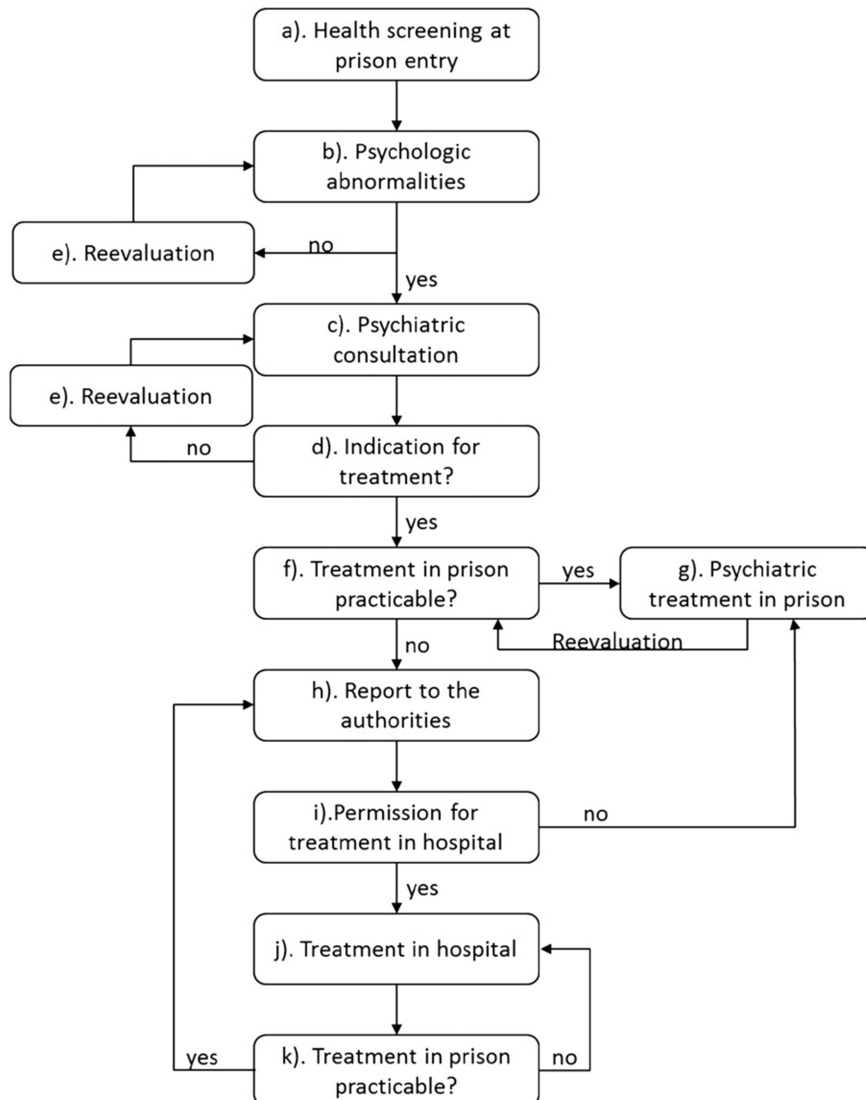

Fig. 1. Decision algorithm: screening procedure for mental health and the treatment chain for mentally ill prisoners.

all over the world (including among European countries) the proposed algorithm should be adapted to the local conditions.

The following terms refer in each case to the algorithm in Fig. 1:

a) Health screening at prison entry and b) Psychological abnormalities

Mental health screening on admission to prison is carried out quite differently in different nations. Screenings are conducted by psychiatrists (e.g., Czech Republic, Sweden), general physicians (e.g., Belgium, Germany, Hungary), and nurses (e.g., Denmark, France); but also non-medical staff (e.g., Cyprus) are assigned to assess the inmate's mental health state. Screening assignments by psychiatrists seem to be the exception (Dressing & Salize, 2009).

In Australia the organisation of mental health services for prisons and the methods applied in screening for signs of mental illness vary with the states' and territories' jurisdictions. In most jurisdictions the mental health screening forms part of a larger health screening, which is generally completed by health nurses, less frequently by mental health professionals (Ogloff, Davis, Rivers, & Ross, 2007). The literature indicates that mental health screening within the criminal justice system has been of doubtful effectiveness (Birmingham & Mullee, 2005; Gavin, Parsons, & Grubin, 2003).

When several publications in the late eighties confirmed many clinicians' apprehension over the increase in mentally disordered offenders in jails and prisons in the United States of America (Teplin, 1990), at least partially due to a shift from hospitals to jails as a result of reduced beds in psychiatric hospitals, the first relevant screening tools emerged: In 1989 Teplin and Swartz (1989) published the *Referral Decision Scale* (*RDS*) since the standard screening tools used in the health care system did not perform well for jail or prison populations. The RDS was later revised and condensed by Steadman, Scott, Osher, Agnese, and Robbins (2005) resulting in the *Brief Jail Mental Health Screen BJMHS*, which was validated for both genders and for different prison and jail populations. The BJMHS consists of eight questions which can be administered by non-medical staff during initial health screening at prison entry. The BJMHS focuses on schizophrenic and affective disorders and has proven to be quite reliable for this purpose with a sensitivity of 65.5% and a specificity of 76.5%. While it still allows non-medical staff (see "*e) Reevaluation*" in the algorithm) to refer the prisoner for rather intuitive reasons (e.g., the prisoner experiences distress during the administration of BJMHS, any other relevant information or a subjective feeling that the prisoner needs mental health evaluation), the BJMHS neglects the following diagnostic categories which are relevant for both the health of the prisoner as well as prison management: Organic brain disorders, substance use disorders, personality disorders and posttraumatic stress disorder.

The authors recommend screening instruments such as the BJMHS where no medical services are available or to supplement the general health screening at prison intake. Due to the above mentioned limitations such instruments are no substitute for a clinical examination by a mental health professional (i.e., psychiatrist, psychologist, psychiatric nurse).

Evaluation by non-medical staff should require a training session about practical and clinical psychiatric knowledge (e.g., psychological interview techniques, symptoms of mental illnesses) and referral for a psychiatric consultation should be initiated with a low threshold. Reported recent or ongoing psychiatric treatment, or current mental problems or symptoms, including conspicuous screening results should call for a psychiatric consultation in any case.

Sometimes the clinical evaluation and screening on admission to prison can be impeded if the inmate speaks a different language. In such cases foreign language information sheets or available staff or fellow inmates, who are able to translate, can provide necessary information to newly admitted inmates about internal procedures and available medical health services. Clinical interviews concerning medical problems should involve a professional interpreter due to doctor-patient confidentiality.

For an appropriate assessment of the inmate's mental health status, a substantial understanding of the inmate's verbal and non-verbal communication is indispensable. In addition to translation over the telephone, professional interpreter services should be available in prison. The latter are especially beneficial for necessary explanations of potentially culture-specific, non-verbal features (gestures and facial expressions), which can contribute to diagnosis and treatment (Zayas, Cabassa, Perez, & Cavazos-Rehg, 2007).

c) Psychiatric consultation

Psychiatric consultations should be made available in prison for any inmate who is in need of such service. This would be for the benefit of those who may request a consultation or those who are referred by medical or non-medical professionals (see "*e) Reevaluation*"). Regular psychiatric consultations would be desirable but depend on local circumstances such as availability of psychiatrists. Outside of such consultations or unavailability of psychiatrists other trained professional staff (psychologist, trained nurse) should be accessible to screen the inmate for mental health problems and to refer the patient to a psychiatrist if necessary. The limited numbers of psychiatrists accessible in prison settings emphasize the need for psychologists, trained nurses and the use of screening instruments as essential components of the treatment chain.

d) Indication for treatment

Inmates' indications for treatment of mental disorders do not differ from those of the general population (see (f) below). This also includes further diagnostics (i.e., MRI) outside of the prison if needed. Since a physician's professional attitude should be governed by the ethical principle of adequate treatment for anyone, decisions should be based on treatment needs, not feasibility. This basic principle is termed "independence in professionalism" (Queloz, Riklin, Senn, & de Sinner, 2002). Further diagnosis and treatment of mental disorders in prison should be conducted by a psychiatrist rather than a general physician.

There is a risk of clinicians being deceived by inmates who may report psychological abnormalities of severe intensity or pathological quality to achieve advantages (e.g., to receive medication, to evade duty or criminal responsibility) but who do not suffer from mental illness. There is evidence that malingering occurs frequently among inmates (McDermott & Sokolov, 2009; Norris & May, 1998).

When the validity of the reported or apparent psychological symptoms is in doubt, a comprehensive structured clinical assessment should be conducted by an experienced psychiatrist or clinical psychologist with expertise in validity testing (Rogers, 2008). The clinical interview, history and medical record review are best complemented by applying a structured psychological instrument (e.g., the Structured Interview of Reported Symptoms (Rogers, Sewell, & Gillard, 2010) or the M-FAST (Miller, 2005)) to increase the validity of the assessment results (Schmidt, Lanquillon, & Ullmann, 2011).

Legitimate administration of compulsory treatment (e.g., court ordered antipsychotic medication) is controlled by national or state jurisdictional law. From a psychiatric point of view, compulsory treatment constitutes a complex treatment approach in addition to the medication. For instance it should include improvement of the patient's insight into the necessity of treatment and support in social and psychological needs to advance the patient's status to voluntary acceptance of treatment. An assessment of inmates' needs is necessary to determine the most appropriate treatment setting (e.g., a general psychiatric ward, a forensic psychiatric ward or a forensic psychiatric ward in a prison). From the authors' point of view, a prison without psychiatric specialization cannot provide these requirements.

In any case of a psychiatric emergency with compulsory treatment within the prison setting (without possibility of a prior transfer because of disease severity or logistic conditions), follow up monitoring should be ensured to appropriately treat life-threatening side effects of medication (Graf, 2008). After resolution of the psychiatric emergency, transfer to a hospital must be considered depending on the psychiatric treatment plan (see f).

In the event that the inmate of concern does not wish to be examined or treated, yet treatment seems necessary, although not urgent, from a

medical point of view, a report to the responsible authorities should be made that includes a psychiatric determination about the person's capacity to consider the consequences of his refusal (see i). If no treatment is ordered, the mental health condition of this inmate will require continual monitoring and reevaluation after a predetermined period.

e) Reevaluation

Further screening and reevaluation of the mental state of all prisoners in the course of imprisonment should be an integral part of the treatments offered, enabling detection of newly arising symptoms of mental stress in prisoners without psychopathological findings at the initial screening.

The development of suicidal syndromes illustrates this requirement. It is well known that prisoners have an increased suicide risk compared to the general population and various risk factors have been identified in multiple studies (Dahle, Lohner, & Konrad, 2005; Fazel, Cartwright, Norman-Nott, & Hawton, 2008). Furthermore, studies indicate that the suicide risk varies during the course of imprisonment depending on factors such as sentence length and crime characteristics (Kerkhof & Bernasco, 1990; Rabe, 2012; Shaw, Baker, Hunt, Moloney, & Appleby, 2004). Stressful factors during imprisonment (such as fear of other inmates, lack of prospects) can increase the risk of suicide (Laishes, 1997). This underscores the importance of reevaluation in the course of imprisonment.

Irrespective of these factors, a first episode of a mental disorder demands appropriate psychiatric treatment (e.g., psychosis, dementia) and can occur at any time during an extended prison sentence (Jarrett et al., 2012; Maschi, Kwak, Ko, & Morrissey, 2012).

From the authors' point of view, it seems advisable to offer a psychiatric examination at regular intervals to those inmates who have been diagnosed with a psychological abnormality but have not yet been considered to be in need of ongoing psychiatric treatment.

Those inmates without psychopathological findings in the initial screening pose greater challenges. Staff without training in detecting signs of mental illness can overlook disorders with a subtle and initially inconspicuous course, resulting in a delay of treatment and an unfavorable prognosis for treatment effectiveness and course of the disease, especially in the case of bipolar disorder or psychosis (Berk et al., 2010; Perkins, Gu, Boteva, & Lieberman, 2005). Furthermore inmates under stress caused by mental illness may be unable or too reserved to actively seek professional help due to factors such as fear of stigmatization or lack of insight into the seriousness of their symptoms.

Access to psychiatric care should be simplified by regulations that lower the barriers for consulting a mental health professional:

- Every inmate should have the right to see a psychiatrist in the framework of regular consultations without giving a reason. Outside of psychiatric consultation urgent referral should be adapted to the referral process (see c).
- In addition to medical and mental health staff other professionals who are in contact with the inmate (e.g., prison staff, attorneys, state prosecutors, judges, pastors, probation service staff, charitable organization staff) may refer the inmate for a professional mental health assessment.

There is no valid reason concerning patient-centered care that invalidates this regulation. But regarding this approach (access to psychiatric care) there are various practical constraints and concerns that hinge on multiple factors such as available financial and personnel resources. On the one hand concerns that psychiatric treatment facilities may be overstretched or abuse of psychiatric services by healthy prisoners may withdraw resources which in turn may lead to insufficient treatment of those who are in need. On the other hand there are ethical aspects that mental health services should be available to all mentally ill prisoners, particularly those who are afraid of stigmatization or ashamed of mental problems. In those exceptional cases the inmate should be given the right to be seen by a psychiatrist even if the inmate denies to give a reason to the prison staff. The guards would first arrange for a first assessment by mental health professionals to decide the level of urgency and schedule an appointment accordingly. Raising the threshold of admission could have consequences on the course of imprisonment (e.g., failed or delayed treatment of mentally ill prisoners with risk of higher suicide rates, security risks for guards and fellow inmates). Also from the authors' point of view the mental health service takes part in detecting and consequently stopping and preventing physical and mental cruelty in prison, be it between inmates or committed by staff members.

Switzerland has the infrastructure to provide appropriate psychiatric services in accord with the laws. Correctional and mental health services for prisoners are adequately resourced and legally obligated to implement the recommendations of the Council of Europe.

In summary admission to mental health services in prison should be offered upon a low threshold, with referral procedures among mental health professionals (i.e., psychiatrist, psychologist, psychiatric nurse) ensuring the most adequate and timely mental health care possible.

The guards are particularly important regarding a referral to the psychiatrist. They are the ones who have the most frequent (daily) contact with the prison inmates and are therefore most likely to notice acute deteriorations in mental health. Moreover, guards are most knowledgeable and capable at providing information about the behavior of inmates over the course of imprisonment.

Guards mostly have a layman's knowledge of psychiatry. Their primary duty is to ensure the daily routine in the prison. Mental disorders can reduce cognitive functions (e.g., impair activities of daily living (ADL)) or can lead to a behavioral change (e.g., insomnia, hostility) that can disturb the required routine in prison. These symptoms can be falsely interpreted as defiant or provocative behavior, when the inmate is assumed to be mentally healthy. To avoid misinterpretations and to improve the quality of patient-centered care for mentally ill inmates, sufficient training of prison staff is essential.

Education of staff can increase the alertness for psychologically abnormal behavior or changes in behavior over the course of imprisonment (Dvoskin, Spiers, Metzner, & Pitt, 2003), which should in turn lead to an earlier referral to psychiatric services. Furthermore, individual fears and uncertainty about how to deal with mentally ill inmates can be overcome by enhancing the staffs' professional relationships with mentally ill inmates and encouraging support for adequate and timely treatment.

Training of prison staff in recognizing psychological abnormalities can be provided by psychiatric specialists such as psychiatrists or psychiatric nurses, and practical training can be obtained in psychiatric inpatient centers (general or forensic psychiatric hospitals). Furthermore, regular training, mentoring and supervision should be established for the guards (Marzano, Ciclitira, & Adler, 2012). The overall aim is heightened alertness concerning occurrence of psychological abnormalities in prison.

f) Is treatment in prison practicable?

g) Psychiatric treatment in prison

On the basis of official competence various forms of custody are defined, depending on the respective system of national jurisdiction; for example, fitness for police custody, fitness for remand and fitness for long term confinement in correctional facilities. Here we use the term “fitness for imprisonment” subsuming all forms of custody. This term however is delicate, as it implies weighing different interests, i.e. the public interest in proper law enforcement and in public safety on the one hand and the prisoners' interest in physical and mental health as well as the availability or the lack of the required services. Psychiatric treatment should be mandatory as indicated and feasible under the respective conditions of incarceration, otherwise the mentally ill prisoner should be transferred to a forensic psychiatric hospital, complying with the political demand for equal treatment of imprisoned persons (Council of Europe, C. o. M., 2006). Treatment in prison (e.g., for opioid dependence, paraphilias) should follow the national and international therapy guidelines for the particular disorder. According to the principle of equality, prisoners should receive the same treatment that is available to mentally ill

patients in the general population. (Dahle et al., 2007; World Health Organization, 2009; Weinstein et al., 2000).

The mere existence of a mental disorder does not necessarily result in unfitness for imprisonment from a medical point of view. Neither can a decision about fitness for imprisonment be reached based on the psychiatric diagnosis alone. Take for example the case of an inmate with a known and already medically treated psychiatric illness (e.g., schizophrenia, bipolar disorder) whose mental disorder is currently in remission and who has attained a satisfactory level of functioning (ADL). Upon being sentenced his or her mental condition may remain stable. In contrast, if an inmate were to suffer from an acute stress disorder upon the circumstance of being sentenced and he or she were to experience increasing suicidal ideation, a decision has to be made as to whether appropriate psychiatric treatment can be ensured within the prison setting.

The existence of danger to self or others, with inability to control aggressive impulses against oneself or others and inability to comply with recommended treatment procedures, are critical issues when deciding about the treatability of psychiatric disorders in prison. The particular diagnosis can be less relevant than the acuteness, the characteristics and the severity of symptoms.

To assess fitness for imprisonment, the authors generated a list of criteria (Table 1).

Criteria in the A) section of Table 1 *should be assessed at every psychiatric consultation in the stated order*. Should *all criteria (1–4) of the A) section apply at the same time*, from a psychiatric point of view fitness for imprisonment is not present.

If an inmate without a psychiatric diagnosis is dangerous to self or others motivated merely by obtaining privileges (e.g., receiving potentially addictive medication or a change in cell occupancy) safety precautions are recommended, however psychiatric treatment would be secondary.

If either the first criteria, the first two, or the first three are answered positively, additional factors (see section B) can contribute to the decision about fitness for imprisonment. The gamut of potentially influencing factors is so diverse that trying to develop an exhaustive checklist listing all potentially important factors does not appear reasonable. The relevant factors should rather be determined and assessed through an individual analysis of the specific case and its circumstances.

Psychiatric disorders can lead to cognitive impairment, which influences the capacity of ADL (e.g., grooming, bathing, eating, drinking) (McCall & Dunn, 2003; Semkovska, Bedard, Godbout, Limoge, & Stip, 2004). One should bear in mind these aspects of mental disorders when choosing the appropriate setting for treatment.

Each single case should be considered separately as to whether resources of time and staff in prison are sufficient to ensure necessary support for the mentally ill inmate.

Table 1
A) Psychiatric criteria for judgment of fitness for imprisonment; B) further factors to be considered for judgment of fitness for imprisonment (selection, not exhaustive).

A)
1: Psychiatric diagnosis
2: Acute need for treatment
3: Danger to self and/or others
4: Inability to comply with treatment
B)
1: First clinical manifestation of a psychological disorder
2: Lack of medical compliance despite urgent need of treatment
3: Prognosis of treatment in prison vs. hospital
4: Indicated monitoring during phase of initiating medication up to full dose, especially with complex regimes (e.g., treating comorbidities together with the primary main diagnosis)
5: Low/insufficient functional level (ADL) because of psychiatric illness
6: Diagnostic judgment uncertain (i.e., because of missing anamnesis)
7: Stigma with discrimination/repression by fellow inmates
8: Lack of trained staff

Considering medical and ethical aspects as well as problems of health care law (e.g., liability law) the particular resources of treatment in prison should be evaluated on a case by case basis. This then results in the decision as to whether adequate treatment in the specific prison is possible or whether a report to the authorities should be made due to the inmate's lack of fitness for imprisonment. The final decision of referral to a hospital setting is then made by the appropriate authorities.

h) Report to the authorities

The decision whether to transfer ill inmates to a hospital setting must be made by the authorities. The psychiatrist's duty is to offer recommendations based on medical knowledge. The advice should include statements about current resources and facilities of treatment in prison, their limitations (see f) and the necessary treatment conditions from a medical point of view. This assessment should be based primarily on the well-being of the patient, not on issues of feasibility (see d).

This “requirement of cooperation” between the psychiatrist and the authorities in charge and the special confidential relationship between physician and patient must be respected (Brägger, 2011). Ultimately the decision about fitness for imprisonment belongs to the proper authorities who should base their decision both on the psychiatrist's recommendations and on careful deliberation of the legal aspects (e.g., considerations about public safety versus medical recommendation for treatment in hospital).

An ordinary treatment contract between physician and patient is based upon a bilateral relationship, which provides both contracting parties with rights and duties.

In the special case of medical treatment of inmates the physician is obliged to treat all referred inmates (even non-emergency patients) and the inmates do not have the opportunity to choose the physician (though they should have the right to seek a second medical opinion).

Furthermore the regulatory requirements of judicial and enforcement authorities, which serve public interests, must be observed. This results in a triangular relationship (physician/medical staff–inmate – judicial/enforcement authority). (Bundesministerium der Justiz, Berlin, et al., 2004)

This article does not go into detail about the judicial procedures regarding verification of custody forms and the particular legal criteria for fitness for imprisonment, because the respective legislation is a national affair and not universal for all countries. Even within the different nations heterogeneous laws and responsibilities complicate standardization; therefore the proposed algorithm may need adaptation to the respective legal provisions.

i) Permission for treatment in hospital and

j) Treatment in hospital and

k) Is treatment in prison practicable?

Should the recommendation of transferal to an appropriate hospital be denied by the authority requiring that treatment must be carried out within the existing infrastructure, the mental health condition of the inmate must be reevaluated, and, if necessary, the recommendation to the authority should be repeated.

Depending on the available options, treatment may be adequately provided on a special medical ward in prison or in a secure hospital. If neither option is appropriate or available, inpatient therapy on a general psychiatric ward with defined safety precautions should be considered. It is the responsibility of the authorities to provide treatment settings with needed safety precautions (e.g., safeguard by policemen). The inpatient facilities are bound by licensing requirements and the specific rules of the facility (e.g., danger of collusion, risk of absconding).

Whether an extended course of therapy in a hospital is necessary must be decided on the basis of the course of treatment under considerations of point f. When the inmate's condition has stabilized so that therapy can responsibly be continued in prison, the authorities must be informed and decide whether to transfer the inmate back to prison.

2. Summary

Mental health service in prison has to deal with mentally ill inmates between two conflicting priorities: medicine and law. Medical and ethical principles, human rights, availability of mental health services, the treatment chain and concomitant legal provisions cannot be approached separately and are interrelated. Based on this assumption the authors propose an algorithm for screening procedures for mental health and a treatment chain for mentally ill prisoners. Due to the diverse legal regulations on psychiatric treatment of mentally ill prisoners and local treatment facilities throughout the world, the proposed algorithm should serve as a contribution to a discussion and guide the path of decision-making adapted to local circumstances.

Conflict of interest

The authors declare no conflicts of interest.

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