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ME.D.I.C.S.



MEntally Disturbed Inmates
Care and Support



Ministero della Giustizia
DIPARTIMENTO AMMINISTRAZIONE PENITENZIARIA
Nucleo Progetti FSE

ME.D.I.C.S. Project 1stStudy Visit and 2ndWorkshop Barcelona, Catalonia, 27th- 30th October 2015

WEDNESDAY 28 OCTOBER 2015

Visit to the Granollers prison for young adults

Participants: **ME.D.I.C.S. Project delegation (Palmisano, Starnini, De Risio, De Tiberiis, Dionisi, Beccarini, Russo, Raguz, Humet Matilla, Martin Barberan), Prison Governor and deputy Governors, prison healthcare service director**

Granollers prison accommodates young adult offenders. In Catalonia penal system, the age of criminal liability is 14. From 14 to 18 years of age, offenders are to be considered as minors and are treated by Juvenile Justice. In this prison there are young offenders between 18 and 23 years of age. That class of age in Spain deserves a specific treatment and the law puts a great focus is on employment. If young offenders do not show enough maturity, they will stay in this kind of prison until the age of 23.

The maximum capacity of Granollers is 450 inmates. The real capacity is 368. The occupancy average was 370 prisoners in the past. Today there are 246 inmates. The reasons for that decrease are that most prisoners are foreigners and today, in Catalonia, there are fewer foreigners than in the past years, due to the economic crisis and to a strong policy of foreigners' exclusion.

This is an ordinary prison, similar to the medium security prisons for adults. It is structured into residential modules with common rooms dedicated to common activities. There is a unit of "maximum security", one school, an infirmary, a gymnasium and some workshops. The philosophy at the basis of the treatment approach in this prison is that the "delinquency career" of a young offender has to be stopped at any rate.

There are more staff members than in a prison for adults: we have about 50 workers for treatment, including educators, psychologists (who are employed by the Ministry of Justice and not by the Healthcare system; the Governor himself is a psychologist), social workers, trainers and sport instructors. Security staff is composed of about 220 persons.

Each module in the establishment is staffed with a multi-disciplinary team of workers: 4 jurists, 8 psychologists, etc. There are on-going programmes for relapse prevention and for detoxification from substance abuse. Observation of offenders is very intensive and it aims at identifying the criminogenic characteristic of the inmate: that aspect has to be faced and treated first. 70 % of inmates are finally sentenced, while 30% is waiting for their final sentence. The turnover in our establishment is of 700/800 prisoners per year. 50 % of those who arrive here will stay for about three months.

For instance, a specific work is carried out about domestic violence: empathy, emotional control, jealousy, male role, sense of responsibility.





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There is of course a problem of communication with foreigners. All of our inmates speak Spanish – more or less – but in order to speak about the inner self it is necessary to have a good command of the language...

We also accommodate sex offenders, who follow the same programme which is offered to adults. Only, it is called in a different way, in order to avoid labelling these young prisoners as sex offenders...

The modules system was once based on inmates' progressive development, that is on their response to the treatment offers. Module 4 was for those ones who had the worst adaptation. Module 1 was for the best ones... Modules 2 and 3 were intermediate positions. In Module 4 the offer included the minimum standards set forth by the law. In module 1 it was possible to get every benefit provided for by the law. It was also possible to regress through the modules. But that system implied a number of problems: when it is scrupulously applied, there can be too many movements from one module to another, and even the award to a better situation can bring a maladjustment, for the high number of "adjustments" to a new condition which an inmate had to face, even if positive. And also, in Module 4 it was almost impossible to carry out any activity, due to very frequent risk situations: in 2009, when the current prison governor took his duty, there was 1 fire a day!

The current prison governor changed that system and included treatment programmes in each module. Even work is offered to inmates in every module. On the other hand, there are rigorous sanctions for those who do not respect authority.

Given the strong presence of gangs, a balance was sought also from that point of view.

As for the situation of mental health, the prison healthcare service director informs the delegation that currently there are only 24 inmates under psychiatric care for the following pathologies: 16 anxiety, 11 personality disorders, 6 depression.

They ascertained that there is no connection between number of self-harm deeds and number of suicides.

A medical examination is carried out within 24 hours from the inmate's entry into the establishment. The medical file is computerized and include data from the inmate's free life. His mood is assessed through a form which asks a set of specifically aimed questions. Psychological assistance to the inmate is provided upon the subject's request or upon a worker's warning. The family doctor can prescribe a treatment or send the inmate to a specialist's examination. The latter, on his turn, can send a subject to the hospital in serious cases.

The psychologist is always in touch with workers of justice and of healthcare.

VIST TO THE STRUCTURE

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First day of Workshop – Center for Juridical Studies in Barcelona

Persons presents: **ME.D.I.C.S. Project delegation: Palmisano, Starnini, De Risio, De Tiberiis, Dionisi, Beccarini, Russo, Raguz, Humet Matilla, Martin Barberan**

Mrs. Palmisano opens the 2nd Workshop of the ME.D.I.C.S. project thanking for the visit carried out in the morning, which resulted far beyond participants' expectations. She finds that the project made meaningful progresses, which can be seen also in the way of cooperation among the project partners, which clearly appeared since the visit of this morning.

In the first meeting, held in Rome one year ago, some operational guidelines were set. We clarified which was the field of our survey, we set our common aims. Mrs. Palmisano reminds that the object of our survey is that part of prison population who does not need healthcare intervention, who does not have a psychiatric pathology but who still shows a psychological maladjustment during imprisonment. The penitentiary workers were involved in our survey, representing all the professionals present in our prisons. Today we can compare the different partner systems, since the same questionnaires were administered also to Croatia and Catalonia.

The first aim of this phase of our project is to determine the size of the phenomenon of mental disturb in prisons. The second aim is to identify which is the most adequate modality of managing and caring that disturb, in order to propose a model.

The visit which we carried out this morning enabled us to make a step forward in our fruitful cooperation. The model which was presented to us is extremely interesting for our aims and shows – once again! – the great utility of exchanges among different countries. For example, in Italy there is an on-going phase of change in prisons management, which started in 2102 and was accelerated by two judgments of the European Court of Human Rights, which pushed our Country to make important reforms and modifications in the approach to detention.

The meeting of today is a crucial moment because we can listen to our partners, Croatia and Catalonia, which will directly tell us about their experience, while England and Wales contribution will be presented by Mr. Starnini. A part of the Italian survey is still missing, and professor Santoro will talk about that on Friday morning.

In this workshop we will also decide what will be our next steps and the relevant timetable, since the end of the project is approaching: indeed, after the extension granted by the European Commission, our initiative will end on the 31st May 2016.

In the next months, in Italy, three integrated training courses will be provided to some staff members both from the penitentiary Administration and from the healthcare service.

Our ambition is also to address to the European Parliament a recommendation for the care and management of mentally disturbed inmates in EU prisons, and we will see whether that objective can be achieved or not.

Mr. Starnini praises the cooperation established with the Office for Studies and Researches of the Department of Penitentiary Administration (DAP) of Italy, since it is very stimulating thanks to the active spur of Mrs. Palmisano.





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Our English partner (the NOMS) attended the first Project workshop in Rome, but had then some problems and changes of mind, thus they sent written documents concerning studies and researches already carried out about mental health in prisons. In England and Wales too, there was a reform – like it occurred in Italy – of the penitentiary healthcare which shifted from the Justice system responsibility to the umbrella of the National Healthcare System. That change started in 2003 and ended in 2012. A cooperation is established among the various agencies involved in that field (NOMS, NHS, PHE), and the quality control is entrusted to external agencies, even NGOs.

The scientific research for which NOMS provided the outcomes is different from the ME.D.I.C.S. survey, because the English interviewed inmates, while we addressed the staff.

As for the situation in Italy, article 11 of the Italian Penitentiary Act (1975) makes reference to mental healthcare in prisons, establishing that a psychiatrist has to be present in penal establishment. Also in the Regulations of enforcement of the Penitentiary Act of 2000 an explicit reference is made to mental discomfort (in the articles concerning the subjects' entry into the prison).

Mr. DE RISIO: The research carried out by the MEDICS Project in cooperation between SIMSPE onlus and the DAP surveyed on the one hand the real datum, that is the number of specialist services provided by psychiatrists and of medicines administering, and on the other hand the perceived datum, since the psychic discomfort is often hidden by the inmate, in order to avoid his further isolation from co-inmates.

In Italy, the number of valid replies to the questionnaires was 363.

(see Mr. de Risio's slides)

Mr. DE TIBERIIS: The results of our research (at least in Italy) can be read from two different points of view:

1) How the penitentiary system replied, how it reacted (that is the three big prisons involved) to our requests. It is not usual to ask questions to staff about psychic or emotional problems of prisoners. We have noticed a good sincerity of answers, there was neither a research of "politically correct" answers, nor any predictability aimed at "making a good impression". We had replies from 2/3 of the persons interviewed, with prevalence of some professionals on others.

All the replies in general show the staff's openness to possible and desirable changes.

2) A request appears of "less healthcare and psychiatry" as well as a demand of a greater attention to the prison "climate". The need arises of a prison "community" rather than of a "psychiatrized" prisoner. One could say, as a sort of slogan, "*more pedagogy and less psychiatry*". For instance, we could ask ourselves about the inmates' family links, about the topic of (the inmate's) hope with respect to the time going by, about the quality of relationships established during detention; about the look that the outside world has got on prisons and prisoners (we may fear that some initiatives in favour of prisoners are considered as excess by the public). Moreover, there's no common thread linking the different interventions carried out by various workers for one prisoner.

Thus, the demand arising from the replies to our questionnaires is the need of a "not too medical" approach.



SIMSPE





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The purpose should be to go towards an organization similar to the structure which we observed this morning, based on prisoners' motivation to participate in the prison life.

Mrs. HUMET MATILLA

(see the slides)

The participation in the questionnaires was of 23% out of a total number of 744 potential participants. The staff category with the lowest participation was the volunteers, mostly for practical reasons.

As for years of service, 43% of participants has at least 6 years of service. The staff category with the longest length of service are medical doctors and nurses.

A striking factor is the education level of participants, including surveillance and security staff: 70% of participants have a University degree.

Mrs. RUSSO

(see slides)

THURSDAY 29 OCTOBER 2015

Visit to the BRIANS 1 prison – men, women, psychiatric hospital (St. Joan de Deu)

Participants: ME.D.I.C.S. Project delegation (Palmisano, Starnini, De Risio, De Tiberiis, Dionisi, Beccarini, Russo, Raguz, Humet Matilla, Martin Barberan), Prison Governor and deputy Governor (in charge of female prison), prison healthcare service director

This prison was built about 25 years ago; in origin it was made of 4 module to accommodate about 700 persons. Afterwards, it was enlarged and the women establishment was added, then an "open centre" and the psychiatric centre.

Today, it accommodates 1300 inmates and it is structured as a "system". There we find: the "standard" regime, the open centre, the closed regime (for a maximum number of 28 prisoners), the psychiatric centre where psychiatric services are provided. Most of prisoners are finally sentenced offenders, with a small number of 50 to 100 remand prisoners.

The standard regime foresees the daily permanence outside the cells (for the whole day) except for two hours at lunchtime and in the weekends, when activities are reduced.

The treatment staff intervene immediately upon the subject's entry into the prison: the inmate is assessed by the multi-disciplinary team and he/she is assigned to the most adequate wing. The offer of treatment is based on the reasons for the inmates' crimes.

As for bonus leaves and benefits, which can be granted – as a general rule – after having served ¼ of the sentence, in case of short leaves, not exceeding 3 days, the decision is made by the Governor; if the benefit duration is longer than 3 days, the decision is made by the treatment team and is approved by the penitentiary judge.





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Different treatment programmes are proposed to prisoners: for sex offenders, for gender violence crimes perpetrators, for violence in general, for addictions, for psychiatric problems arisen during imprisonment, for self-control, for impulse management ...

Treatment staff today include 30 psychologists, 30 educators, 15 social workers, 18 vocational trainers, 13 jurists and also the healthcare staff (doctors and nurses).

Prisoners' work is remunerated with about 200 € per month against 4 working hours a day. There are about 700 prisoners who work inside the prison.

Meeting with the Director of the Psychiatric Centre of Brains 1 (UHPP: Hospital Wing of Penitentiary Psychiatry)

In smaller prisons, with a number of inmates under 1000, there is a psychiatry service where the specialists providing some hours of service. When in these prisons a serious case arises, the subject is sent to this centre, which is a true hospital and is a branch of the San Joan de Deu hospital in Barcelona.

In prisons accommodating between 1000 and 2000 inmates, there are wings like this one. In Catalonia, this is the only existing penitentiary psychiatric hospital, providing assistance to all the prisons in our Autonomous Community. Thus, all physicians and psychiatrists working in Catalonia prisons are sending to our centre their patients with various pathologies: schizophrenia, bipolar disease, suicide attempts...

The healthcare service is ensured by the public healthcare system, while security is a matter of the Justice system. We ensure a psychiatric service 24 hours a day.

There is an "acute" wing, a "sub-acute" wing and a rehabilitation wing, for a total number of 62 beds. Once the patients are stabilized, they are discharged and sent back to the wings they come from. If necessary, they are followed under an out-patient modality.

Those who undergo security measures, that is who are not criminally liable, cannot stay with other inmates. The assistance of a family doctor is ensured, besides the care of a psychiatrist. In the rest of Spain there are only two psychiatric centres, one in Alicante and one in Sevilla, therefore it can happen that one person who needs intensive psychiatric care has to be hospitalised in a centre very far from his/her house and family. Here in Catalonia, on the contrary, we can easily work with families and local communities, given that distances are shorter, since all our patients come from within the same Region. A Judge decides where a security measure has to be enforced and judges often make their decisions in consultation with the same psychiatric centre.

We have a special programme on mental retardation, in particular the so-called "functional" retardation, that is relevant to persons who cannot write, or to the foreign migrants who do not speak at all the language of the country where they are living. In those cases we have a big problem in administering the DSM IV tests, since the patients do not speak any Spanish (nor Catalan). In Catalonia there is also the possibility of internment in Special Educational Centres.

Within the penitentiary system, there is a community for mental retardation in the prison of Quatro Caminos (for a total number of 50 beds).





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Staff at the Psychiatric Centre in Brians I is composed of 7 psychiatrists, 2 psychologists, 3 educators, 2 social workers, 2 trainers and 70 nurses, all of them working on 3 shifts per day.

As of today, we have about 60 patients and there is always one free room for urgencies.

Here we take care of very serious personality disorders, while the less serious troubles are followed while subjects stay in their modules, otherwise it should be necessary to hospitalize 80% of the current prison population.....

The inmates' medical file is computerized and includes also data relevant to basic healthcare assistance. It is shared with other penal establishments, but not with all the civil hospitals. It is true that (so far) the prison doctor can see what the family doctor writes in the patient's file, but the contrary is not true (yet).

In prison, the doctor undersigns by a number and not by his/her true name. This is a controversial issue: the current trend is to give priority to physicians' safety, but this can challenge the patient's right to know the name of his/her treating doctor.

Second day of Workshop – Center for Juridical Studies in Barcelona

Persons presents: **ME.D.I.C.S. Project delegation: Starnini, De Risio, De Tiberiis, Dionisi, Beccarini, Russo, Raguz, Humet Matilla, Martin Barberan, Santoro**

Doctor De Risio points out that the DSM IV, although it is a tool, that physicians are using at international level, it has been updated with the DSM V. This last foresees other types of classification. Anyway, there is a variety of factors that are to be taken into consideration when operational choices are taken when talking of inmates with personality disorders. One for all might be staff stress, given that personality disorders are very demanding in terms of staff attention; another factor might be all consequences on public budgets.

Doctor Starnini affirms that in Catalonia individuals affected by personality disorders are treated by staff from the ministry of health and from the ministry of justice. In Italy, the lack in human resources is having consequences on the number of subjects to be treated by the public service.

Doctor De Risio specifies that, from what he has learnt during the visits to the prison establishments in Catalonia, the prison governor's function is sometimes overlapping that of the Italian *magistrato di sorveglianza* [a judge who supervises sentences enforcement both in prison and in the community, *n. d. T.*]. For instance, home leaves lasting less than 3 days are granted by the prison governor. And it is not a coincidence that the two governors we have met during the visit to Brians 1 prison are both psychologists. And again, psychologists are in the rehabilitation experts group. The idea I was given is that in Catalonia prisons are considered as diurnal centres that provide help for the inmate in his building a pathway to social dignity.





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Prof. Santoro asks his Catalan workmates if in prison equality of treatment is granted to prisoners as to the community. Are healthcare treatments known to prisoners? Do they have easy access to treatments. Undoubtedly, rehabilitation in prison settings helps in avoiding the risk of psychiatrization.

Mr. Barberan replies that in Catalonia all prisoners know about their personal rehabilitation scheme. Information is given through the rehabilitation experts group. Custody staff, working in detention blocks, is also delivering information to inmates. Besides, in Catalonia, another tool is at the staff's disposal and it is a mandatory tool to deliver information to prisoners: it is the programme called SAM, Motivational Assistance System. It is updated each three months and through it the judge is informed of the personal improvements of the inmate so that he/she can have access to benefits such as early release.

Doctor de Tiberiis opens a dissertation on the topic. The Italian survey shows a situation that might be defined as an "institutional countertransfer" towards the inmate. For instance, if we build up with the inmate a trustworthy relationship, we experience the patient's transfer towards the specialist and a countertransfer from the specialist towards the patient.

The institution can also act the countertransfer towards the patient. With the project MEDICS, we have asked the system how staff feel towards prisoners with mental uneasiness. The countertransfer can also foresee some unbalanced results, that we divide in three categories. They all work well in detention, where both actors in the relationship are in a closed setting (the prison itself):

1. The subject to which the countertransfer is to be addressed is broken;
2. The subject to which the countertransfer is to be addressed is a child and has never received enough;
3. The subject to which the countertransfer is to be addressed is not broken nor even is a child that is not satisfied in attentions; instead, s/he is a dangerous individual.

In prison, we generally move within these three categories. This type of dysfunctional countertransfer develops more and more and it develops solutions that are punitive and infantilising. In our survey, we have inserted our replies in this only punitive-infantilising category. In Catalonia, it seemed to me that the community dimension, In Catalogna, it seems to me that the community dimension, is very much present. It is the dimension where the institution is developing a new relationship, which is moving from a *us-him* modality towards a common responsibility assumption. And, this is happening especially in the dimension of broadening the community space.

Mr. Barberan replies saying that in the Catalonian new prison facilities, space has been reconsidered as in a village: it has at its centre the community of men and women.

Doctor De Risio opens on a broader social reflection. The prisoner and the institution, punishment and custody, are all vaguely recalling Foucault. During the visit to the penal facilities in Catalonia, doctor De Risio has noticed that the tool adopted by the prison service is a social tool that do not hinder human dignity. What he is bitterly acknowledging is the predominance of prejudice related to the care of the social dimension, inside and outside the prison setting. For instance, by comparing the inmate's easier access to healthcare services in prison, to the difficulties in gaining access to the same services faced in the community by free individuals. The inmate rehabilitation, true to say, is fully delivered only for convicts, while remand prisoners are definitely parked in cells, not receiving any kind of assessment.





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Mr. Barberan replies saying that the SAM system is applied to both convicts and remand prisoners.

Doctor Starnini poses some questions. Can we declare that the sharing of data and info between prison/healthcare practitioners and inmates, at the basis of the SAM system, which therefore has become an assessment tool for prison staff, is necessary in our national system, too? Is it a tool that can change our system?

According to doctor De Risio, yes, it can change our system. It will also be useful in avoiding lack of information that may encourage the inmate to saying "I did not know".

"Narrative has taught that the institutional countertransfer and the bipolar relationship are both important", affirms doctor de Tiberiis. He continues: "When this model is transferred from the psychiatric setting to the prison environment, we can understand that it is possible to act the process; nevertheless, we cannot close a prison [as Italy has done with its judicial psychiatric hospitals, which have been substituted with other facilities]. Therefore, the improvement of communication and the relationship between staff and the inmate is necessary process when dealing with this typology of inmates".

Mr. Barberan outlines some aspects of the prison policy adopted insofar in Catalonia. All in all, the history of Catalonia has had the advantage to start from scratch: in 1984, Catalonia has been the first, and only one, Spanish region to get the autonomy in penitentiary matters. In few words, it has inherited the Franco's system, but with some advantages. The penitentiary law has been the first law promulgated after the Franco's death and the first one after the constitutional paper of 1979. The penitentiary law has been created by many ex-prisoners of the Francoist regime. According to Mr. Barberan, it is far more advanced than the European Prison Rules. Since 1984, Catalonia has very much pushed forward its constitutional charter to set the ground floor of its penitentiary service and the rehabilitation of inmates. It has turned to the rehabilitation goal of punishment and not to its security objective, namely fully adopted by the Spanish penitentiary system (in counter terrorism, for instance).

Doctor Humet Matilla underscores that many penal institutions are not far from the prison administration headquarters. Thus, it has become much easier to interact with prison managers.

Doctor Starnini explains that in UK, as we could understand from the British MEDICS report, the control on prisons and on healthcare in prison has been transferred to bodies outside the prison administration.

Prof. Santoro replies, saying that a supervision from the outside might be an advantage, but also a disadvantage if we think to all bureaucratic difficulties it can produce. For example, such a broad control acted by Healthwatch can be destabilizing to the extent that nobody is taking responsibilities and decisions are bumping from one side to another. A centralized supervision might be a more efficient solution. In Italy, for instance, the regional ombudsman is appointed by the regional executive board. Its tasks are to supervise and report on the enforcement of sentences in prison. It is a regional body and should perform within the regional boundaries, just like the healthcare service, and it should also be heard by those public service entities. In reality, it is not like that. In a nutshell, each supervision body, including the judge in charge of the execution of non-custodial sentences, shall have a decisional power.





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Otherwise, they become useless and their decisions are not fulfilled. The great issue is not the supervision power, but how much supervision bodies are empowered and their cooperation with the prison system.

Doctor Starnini asks to the delegates, if they deem necessary a general supervision.

Doctor Humet Matilla replies that what is needed is not a general control, but a general assessment, like the one performed in Catalonia through the SAM system. If the inmate with mental disorders is kept all the time in custody, he will never meet the judge in charge of his case and, by no means, he will have the possibility to improve his condition. In Catalonia, through the SAM system, he has the opportunity to revise his position each three months.

Doctor Starnini underpins the great opportunity the Catalanian system is given and its important step towards a responsibility process. It should be taken into account when developing the project's European recommendation as one final outcome.

Prof. Santoro affirms that the Italian set of rules on the enforcement of sentences, set in 2000, the problem has been the rehabilitation plan. Our Penitentiary act is definitely following the 1987 European Prison Rules, but it is a bit out of track if compared to the 2006 edition of the same Rules. Therefore, our prison system should go through an innovative process that is transforming the rehabilitation of the inmate in a updated rehabilitative scheme: the prisoner's intake, the implementation of the personal healthcare file, the knowledge of the inmate and of his personal history are all factors and information to be taken into account before building upon a rehabilitation programme. And, this will be interesting to be proposed to the European bodies.

ⁱ Note added by Mrs Victoria Humet Matilla, Penitentiary Healthcare Service of Catalonia: In our new clinical reports (from the health department), the name and surnames of each professional appears together with his/her field of work (family doctor, nurse, traumatology....). So, in Catalonia, doctors now share (inside and outside prison) the clinical reports. The same goes for 80% of our hospitals.

