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ME.D.I.C.S.



MEntally Disturbed Inmates
Care and Support



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MEDICS - Mentally disturbed Inmates' Care and Support

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Generalitat de Catalunya
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National Offender
Management Service

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First day at the Criminological Museum

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The Head Italian Prison Service, Mr Santi Consolo. At his left, prof. Santoro



From left to right: Buffa, Flick, Cascini, The Head Italian Prison Service, Mr Santi Consolo, Palmisano (project co-ordinator)



From left to right: Caputo, de Tiberiis, Starnini, Di Fiandra, De Risio, Bonfiglioli



So much help from the interpretation service

1. Introduction, Giovanni Francesco de Tiberiis, psychiatrist from the National Healthcare Service – Italy – project consultant

I have given the honour of summarizing some of the relevant aspects of MEDICS experience, and of identifying practical and conceptual perspectives to share with you.

MEDICS experience saw the participation of hundreds of operators working within the penitentiaries involved. A great bottom-up participation to give a clearer and stronger contribution from those who work every day in this field. We also met colleagues from other countries and understood that we have the same purposes.

We should not forget the great experience of visiting other countries and we want to thank UK for its theoretical contribution.

To move on the substance during our visits we noticed that in all the countries involved there is a distinction between pathologies in line with the penitentiary setting and pathologies that are not in line with it (such as psychosis and mental deficiencies).

If the pathologies are not in line with the penitentiary setting the NHS completely cares for these inmates, if they are, instead, we have those individuals who need both the attention of the penitentiary administration and of the healthcare system that has to ensure them a treatment and a rehabilitation.

This ability to differentiate and screen should not be considered as an accepted fact; it needs a constant re-assessment and monitoring of its own assessment tools. Reducing the focus on this assessment work by the integrated system Healthcare-Justice can contribute, as in the US, in transforming penitentiaries into JHPs guesthouses. This would lead us years back in a state of chaos both from a healthcare perspective and from a penitentiary one.

There are a lot of different psychic conditions within prison, e.g. serious and constant insomnias, unpredictable changes in mood, violent actions, psycho-drugs addictions, self-harm and so on..

This kind of scenario can be seen in all the countries involved.

We have, on the one hand an increase of kind and amount of drugs, and on the other hand a conflict between the medical and the penitentiary field. Too often the NHS is asked to take completely care of detainees psychic healthcare; usually the most used response to this request on behalf of the NHS is administering, too easily, psycho-drugs, since they are the fastest tools to get an immediate outcome. This process results in a “delegation vicious circle” between the NHS and the penitentiary.

Since the fundamental question is “who must take care of this inmate-patient?” the two systems delegate themselves and give each other high responsibility.

The thing we need to start taking into account is prevention at an early stage.

In order to overcome the cultural misbelief that we can focus on a problem only after it comes out, instead of reducing the relevant risk factors for a specific pathology, it is important that the institutional representatives involved work on the prevention at an early stage. To solve the problem of “who has to do what” we must ask ourselves to make a step back and act on primary prevention.

In this regard Catalonia helped us understanding and provided us with an interesting scenario. If we focus on Catalonia we see that, although the problems they face with those individuals suffering from a serious condition, there is a great internal consistency within their organisational-penitentiary system and their organisational-psychosocial system, and that they are able to intervene in terms of primary prevention and reduce risk factors. This element contributes in reducing their drug expense for each inmate.

As examples of this primary prevention we can list: mobile prepays card distributed to inmates to call their family, affectivity rooms, both for families and for couples; the chance for two inmates, male and female, of defining themselves as a couple, after a period of analysis and supervision of their relationship made by the psychological staff.

This merge of the two fields (healthcare and penitentiary) primary prevention-oriented, can be seen in the way rooms, times, and rules are structured within an interpersonal dimension or a “community group”, instead of interventions that consider an inmate both subject and object.

This is very important since the community organisation of inmates entails great changes in interpersonal and hierarchical relationships within the penitentiary.

Inmates belonging to a group or community are mostly involved in protecting their group, since it becomes, on the small scale, their social, relational framework that most resembles “normal” relational life conditions.

Within the group/community there are tasks, responsibility, times to share and there is the chance of thinking and debating on plans and activities to do. Within this community group there is life.

In this way the inmate can communicate, find people around him and not just the penitentiary staff and the penitentiary system. In this way the inmate is no more alone.

All the precedent aspects greatly reduce treatments since the pathologies have a different level of gravity and intensity. Sometimes the group acts as a support and reports problems and alarming issues; so the groups acts as a filter and mediate between the individual needs and the hard life within the penitentiary.

We learned a lot from the Catalan experience, and we really recognized the centrality of their pragmatic and sensitive approach.

Just to make an example of their ability of creating community groups within the penitentiary I would like to quote the words of doc. Josè Manuel Nunez Hortas, Juvenile prison director. We have asked him how he coped with inmates belonging to specific south American gangs within this

community penitentiary framework; we asked him if he preferred spreading the members of these gangs in different sections or if he succeeded in integrating them in a community group. He immediately answered that if the leader of the group was a positive leader (rules, activities, behaviour) he could keep his community group, if he was negative he would spread the subjects in different groups.

The pragmatic approach embedded in this vision, with a great social experience all over the years, are the proof of the director expertise both in the legal and cultural framework in which operators work.

Dott. Nunez Hortas is, in fact a psychologist!

Another relevant aspect to underline in the Catalan situation is the strong presence of a psycho-social staff seen as a unique treatment body. This structure is made of educators and therapists and it works as a reference point for both the director and the penitentiary staff. The doctor is involved only when is strictly necessary, and this factor helps reducing the link between psychic distress and psycho-drugs abuse.

Now I would like to talk about some relevant figures about the need of involving the detainee before he enters the facility, when the judgement is made. As an example, in UK and Croatia, the detainees are provided with rehabilitative treatments when the judgement is made. In Croatia the judge advises the convicted person on specific paths of "treatment", by taking into account his/her crime, seriousness and circumstances. Such an example: alcohol addiction, drug addiction, paedophilia, violence, PTSD (mostly in Croatia due to war).

In addition to this there is the strong demand of the Italian penitentiary police of being involved in participating in inmates treatments and therapies. We should not forget the role and the importance of these professionals in this framework.

As far as patients with serious disturbs of personality concern, special reference should be made.

We know that UK has committed itself for several years in treating these individuals. Spain too, particularly Catalonia, are looking for the appropriate tools to treat and diagnose these patients. Medics project underlined the relevance of this issue.

We should analyse personality disorders in depth in order to define the condition of every single inmate and decide how to intervene. We found in Catalonia the best approach and ability to cope with this issue. It is probably connected to the social prison environment structured in community groups as previously mentioned. This kind of community and group life is able to reduce the consolidation of a personality disorder. This is nothing new if we take into account what the great psychiatrist Wilfred R. Bion stated during the 40s; he said, in fact, that there is a direct relationship between the tendency to have personality disorders and the lack of a group or a social framework, such as the community group set out in Catalonia and Spain in general.

In a nutshell, the directions that MEDICS project wants to give in order to reduce psychic distress among inmates are, in order of importance.

- 1) Studying and promoting a structure based on primary motivational prevention, in line with the Catalan model;
- 2) studying and developing norms to bridge the gap between the judgement and the beginning of the detention. This clearly occurs in UK.
- 3) promoting an European study on serious personality disorders within penitentiaries, so as to find shared ideas in the common debate to use as a starting point for developing new approaches, methods and effective treatments.

I would like to conclude by a reflection on a crucial information given by Doc. Jaime Martin Barberan and Doc. Victoria Humet Matilla.

They told us that the first rule enforced by the Spanish Parliament after dictatorship was the reform of the Criminal Code, the Code of Criminal procedure and the penitentiary regulations and norms. Our colleague also told us that their Legislator was inspired by the Italian laws in making those amendments.

Beyond the anecdote, this is the proof of the fact that punishments and rights systems are fundamental in assessing the human and democratic spirit of a society.

I. Contributions from speakers

Session 1: The problem of psychic troubles in prison before and beyond the abandoning of Judicial Psychiatric Hospitals (OPG): the ME.D.I.C.S. project in search of solutions, good practices and pilot experiences

EMILIO SANTORO - *Professor of Philosophy of Law - University of Florence – Research contributor - Project ME.DICS*

The lack of electronic medical record prevents tracing the stories of the inmates so to understand if they had previous mental disorders. Important data come from the research carried out at the Bologna Dozza prison; they tell us that the existence of conditions of hardship is not identified by the first entry interview in prison, but after about a year and a half. The early detection of latent disorders is crucial to explain the data. Another important finding coming out from the Bologna data is that the tendency to self-harm in the prison population with and without psychiatric disorders is the same. It seems that psychiatric disorders do not favour self-harm. There is a problem of having data and communicate across several administrations. Mental disorders which are not related to drug addiction are mainly present in nationals. Thus we need to know: this situation is due to the fact that the phenomenon is related to our lack of language skills and comprehension? In addition, the MEDICS great outcome has been the approval given by the Bologna healthcare service on the research protocol that facilitated our project results.

SANTI CONSOLO - *Head of the Department of Prison Administration – Italy*

The MEDICS project is in line with what I call the “warning” of the Minister of Justice. Warning received in a positive way because we have to renew the focus on this issue. Mental disorder in prison is an intolerable phenomenon. We must commit ourselves, but we must not take triumphant tones. Although statistics are in favour of a decrease in 2015 and they are still dropping in early 2016, the attention shall not be less: we do not feel satisfied by statistics that, although reduced, still underlie a human tragedy, and by no means should they let us engage less. Commitment must always be steady and deep. In 2015, we had alarming peaks of temperatures in Summer time (2015 saw the hottest Summer ever had since 150 years). So it is clear that a situation of physical discomfort facilitates risks. Therefore, psychiatric care alone is not enough. We need counteractions aimed at creating well-being.

The most evident effect of discomfort is given by the higher incidence of suicides among those who are placed in solitary confinement. Therefore: how many prisoners are put in solitary confinement? What is the rate of suicides occurring in people submitted in solitary confinement? If we rate them, you will see that percentages come very high. Out of 39 suicides happened in 2015, just 12 were committed by inmates not living in solitary confinement. And in revising the so called open regime, which allows inmates to go back to their cells any time, we should acknowledge that by giving this possibility to the inmate, we consequently give him the opportunity to isolate himself and be at risk of suicide. All these considerations make us understand that isolation is to be avoided and a strong partnership with the healthcare staff shall be put in

place. Health care must be assured to all. At national level, outside prison, the healthcare service is unequal for nationals; this inequality is reflected in prison, too. This entails many problems: one for all is that at the moment of his reception it is almost impossible to know his former health condition. We should strongly think of it. Thus, first step to strengthen partnerships with the health service; second step the electronic health file. The individual's reception in prison shall be on the basis of the subject's former health conditions. When we talk of "discomfort", at the time of entering prison the discomfort is total. Detention should be reserved as a last resort when there are no alternative measures. We intervene on a person who has presumably committed a crime because he might be in a state of discomfort. Discomfort is all individuals arriving in prison and we are called to handle it; per gestirlo bene è necessaria la conoscenza. and to manage it well, we need to know it well.

Getting to know the inmate at reception and during induction is the very first necessary action. To avoid risky situation at the gate, we need to be supported by the healthcare staff. It is with this support that an efficient reception processing can be put in place in terms of prevention and good reception which is lately up to us to improve. This means to me "prevention". We can work on peer support of inmates to cellmates. We can work on staff training on mental disorder in prison. The current situation is just 13 protocols have been enacted on partnerships with local healthcare services. The protocols should be the start of a project in which all assume a commitment. Much has still to be done. Sharing information among practitioners is of utmost importance because in many cases difficulties are coming out from a lack of understanding. Who has a mental discomfort should be treated, not punished. We must go all in the same direction. Critical events are events that often seem strange that the inmate is using to attract attention to himself because he feels neglected or not treated in a dignified manner. I think we took the right path, but we must continue. We must monitor the results that we can achieve with joint commitments. If we are able to move in the right direction all together, I believe that with the potential of humanity of all of you, we can improve the situation.

FRANCESCO CASCINI - Head of the Department of juvenile justice and community - Italy

I have followed the project from its beginning. Roberta Palmisano identified this funding opportunity. Our first thought was common to identify the overall need for analysis of the penitentiary institution's climate. According to WHO, everyone is at risk because the detention environment pushes frustration especially when there is overcrowding and poor hygiene. We hypothesized a comparative work to understand how to reduce risk. An important issue: the relationship with the local healthcare services. At the time, the analysis was not comforting: perhaps today is rather the same. For some factors, the management of the discomfort is undertaken mainly in the so called smooth cells (cells with any device usable by the inmate to self-harm or commit suicide, ndr), in solitary confinement, with deprivation of personal belongings. This is conceivable in an initial phase. Until a few years ago we could still find straitjackets in prisons. There is a containment method that can be hypothesized in an acute phase but is likely to become a management method. It serves balance between therapeutic and pharmacological interventions. Living conditions in the prison that can mitigate the tendency to frustration are most wanted. Catalonia is a model to take for example - not by chance the inmates there can cultivate their affections. Not being able to cultivate the relations with the loved ones is among the many causes of aggressiveness. And self-harm is not always resulting from the presence of mental disorders.

It is important to debate on the state of play on regional and local protocols. In compulsive conditions even healthy people may experience pathological behaviour. When we confront mental illness, there is no need for specific expertise. My study prepared in January 2012 concerns the analysis of the content of the 13 regional protocols and other 33 local protocols. They are heterogeneous materials. The survey sought to understand what kind of correspondence existed between the guidelines of the WHO on the prevention of suicidal in prison (very important) and protocols. My analysis looked at three indicators: the degree of innovation of the Protocol; the propensity of the Protocol to push for cooperation between the various operators; understand the real possibility of turning into real actions what was written in the protocols. Regional protocols are affecting 16,000 prisoners; the rest of the prison population is not covered. But if we see the effectiveness of the protocols, only 7,300 persons (13%) have guarantee of an effective protocol; other 30,000 (56%) are in a medium-low effectiveness situation. All regional protocols provide for the exchange of information among professionals on cases at risk. These professionals are healthcare and prison workers who have always worked together. Another proposed action in the protocols is staff training (12 protocols of the 13 are foreseeing training activities); 11 of 13 protocols provide fostering collaboration between social health agencies and prisons. Most difficult aspects: only 2 protocols – out of 13 - provide for the possibility of address to the protocols in case of an emergency (in case of a suicide attempt, there is no protocol that specifies how to behave. At regional level there is no need to write down what staff have to do in those circumstances. 4 of 13 involving the use of detention mates (peer supporters) - is an ordinary pattern in many other countries, like the United Kingdom. Basically, an individual commits suicide when he is materially and physically alone. The definition of clinical intervention protocols are present only in 4 protocols out of 13. Only in 4 for protocols the need for a local security program in prisons is addressed.

Another part of the WHO guidelines regards the treatment of people with suicidal behaviours. They list 10 behaviours. All protocols address the need for screening at reception. 12 – out of 13 - provide for the observation of the detainee throughout custody because custody may entail suicidal behaviours. The most serious is that at regional level there are no specific protocols that provide emergency protocols. If we compare regional and local ones you can see that priorities are changing. For instance, if at regional level there is a need to pay attention on listening and relations, through integrated actions involving all professionals in prison, locally this approach is lessened by the fact that they is a greater awareness of the impossibility of that said approach. At local level, the use of peer supporters is in the second last position, while at regional level is seen as a higher priority. Conclusion: at the time of the analysis, only 16% of the inmates was in prisons with protocols defined according to the WHO's guidelines. The reform in question put the focus on 4 fundamental questions: organizational fragmentation (the various organizations are still following to their own logic); skills and spaces commonly shared in practical/technical and organizational grounds; responsibility; resources. These are all elements that have highlighted our problems. Many prisoners are not even formally supported by useful protocols. More positive data: increased awareness of interprofessionality and integration of actions; we understand the need for training. The protocols have been refined over time. Among the less developed actions, there are protocols in cases of emergency, the use of peer supporters and so on. We must do more and we need a revival of regional and local protocols.

I will give you a very general testimony. I would like to tell the fault line that is created between the attention addressed to discomfort in prison and the almost total insensitivity of public opinion and even of political opinion. I will tell you of an extremely stimulating and interesting experience: the one of the panels that were held at the Rome Rebibbia prison. While the President of the Republic was present in prison, there has been an almost total absence of the media. This absence has left baffled a man like me who has addressed the prison issue with before as a political man and later as a constitutional judge. I feel very positive towards the growing attention at European level on this problem, and you surely know more than me. It seems to me extremely disturbing the contrast between this trend and the opposite generalized indifference of the public opinion and the politics to prison issues and to his separateness. And I believe that this should be denounced, because the analysis that you are detailing that of humanization, of dignity in prison, the attempt to overcome his exclusion and expulsion capacity and to enhance rehabilitation and re-education is the testimony of a more attention to the prison setting that is able to respond to the fundamental constitutional values: the individual and his dignity, that are central to any institutional action. These two aspects have recently emerging as cornerstones of overcrowding and the reaction to this phenomenon: a structural phenomenon, not just an emergency. I am convinced that the objective of the prison abolition is utopian, we all know and it is useless to talk about it. But the goal that we can and must pose to ourselves is to consider custody as a last resort. Beccaria, 250 years ago, had foreseen two types of battles: the death penalty - and after 250 years later we are about to win that battle; the other was a bit underestimated: the balance to be achieved between security and freedom. The underlying philosophy of Beccaria, of the philosophers during the Enlightenment, of Rousseau, was the exchange between security and freedom. The citizen gives freedom to the state and receives in exchange security. Today, this second challenge not only is still open, but has dramatically changed, because now dignity has taken the place of freedom in the relationship between the individual and the State. It has done a lot in this regard. Especially in the declination art. 27 Constitutional Charter, with its double meaning of tendency to re-education, on one hand, and the need of humanisation in the other. But I have a feeling that prison, and its problems, are seen from different perspectives and these perspectives are separated each one from the other. It is a bit reflected in what we see in the justice system: we passed from a retributive justice - you have done evil and evil receive in return - to a rehabilitative justice, and we have chosen the tendency to re-education as the main aspect of the enforcement of sentences. We now have before us a challenge that is also important for the problem of discomfort in prison setting and for the design of the prison as a last resort: it is restorative justice, justice of mediation and reconciliation. Other countries are in this process - I am thinking of Rwanda and South Africa. In Europe, we are following this pathway just now, after post terrorist attacks. With us it is beginning laboriously during the terrorist post events to address this type of problem. But we should take into account not only article 27 of the Constitutional charter, but also article 13, paragraph IV, moral violence on inmates, and article 32, on the right to health assistance – and this is the single time that the Constitution speaks of fundamental rights. Health is defined as it is in the WHO guidelines, not only as an absence of disease, but as a physical and psychological well-being. We all know its definition. Article 3 of the Constitutional charter on equality, which in terms of health has a greater meaning: equality of treatments inside and outside the prison setting. In the light of my experience, even the Constitutional Court has done enough to promote dignity, to affirm the respect of fundamental rights, also for people deprived of their liberties. I believe that perhaps one of the messages that the Constitutional Court has tried to give - encountering great difficulty - is that of the need to ban any kind of stronger affliction on inmates, notwithstanding what is strictly functional to the deprivation of personal freedom. It is not just a question of rehabilitation, or of the multi-functionality of the sentence. Not only is

it a problem of prohibition of inhuman treatments. I remind everyone that Article 27 of the Constitutional charter uses two different expressions: a positive one – punishment shall aim at rehabilitating convicts, and a negative - punishment cannot consist in treatment contrary to human dignity. Those treatments are not further punishments, they are not even tortures, but we are not very far from those considerations. But the most important thing is this attention, this assessment, to the risk that a harsher affliction might be aggravating the deprivation of liberty and the inevitable conditions of that deprivation.

Today, I opened my heart to hearing about discomfort previous to custody and discomfort in prison. Thus, Discomfort or is caused by the impact with prison – then you have to consider if it is compatible with custody - or discomfort may be a result of the individual's permanence in custody, then the offender shall be freed before his discomfort might be translated in a violation of the right to healthcare, because this right is prevailing on any need of security.

Prison is an extremely complex reality because he has lived and is still living totally different situations and seasons. Different in typology of inmates, in policies addressing prison management, and the resources to it dedicated. All these factors are constantly changing. Prison cannot fail to have a percentage of depersonalization. I fear a rate of depersonalization is inevitable. I was joking when I was saying that the real mental disorder is the one which has affected individuals, who – while entering in prison – do not feel the discomfort. But this is a joke. The central point is another one for me: prison can still be regarded as a container for an audience of very different prison situations? Think of the 30% rate of foreign nationals in prison. I was thinking of the Antolisei's example: the savage who does not know what laws are and he eats it. The savage was given as an example of someone unable to understand and act. Think of the diversity of cultures that are in prison, and I am referring not only to the cultural differences of immigrants: there are also the cultures of the criminal groups that seek to preserve their structures while in prison. It seems to me that it is time to start thinking of prison as the very last resort. To stop thinking of prison as a social container, a social landfill, where you enter those dangerous and toxic waste in a community. All talks about mental disorder, I think, become a strong warning bell, to make sure that those who are suffering for a mental disorder which has caused his custody, are to be differently sanctioned. A different type of measure, correction and re-education. On the other hand, those who – while in prison – are boosting disorders or start feeling the discomfort, they shall find the way out.

MAURO PALMA - National Guarantor of the rights of people deprived of personal freedom or in prison

I would like to start with some suggestions. I am very much waiting for this change towards what Mr. Flick was calling restorative justice and to that hypothesis that considers crime as a damage that somehow must be remedied not only in a context of an offender-victim but in a broader context which also questions the overall social bonds. I look from this with great concern when I see the elements of backwardness and very often I wonder how much backwardness there is still among us. We talk about restorative justice, we talk about it very often now and then we are not able to hold a debate at the school of the judiciary on restorative justice, because some are offended by the relationship with offenders and between offenders and victims. And today I have heard one word - very often evoked, and I do the same by naming it very often: it is that of mental and physical wellbeing of the person, the wellbeing of a person who has conscience of his own self and his feeling good with his self. Then I realize that in fact when we start talking about mental and physical integrity of a person, of which sexuality is a part, when we start talking of the totality of this aspect of wellness, we consider it as an element to be negotiated with the trade unions. We

have to consider how some staff is looking at this aspect, if it is taking it positively or negatively. There are some issues on which we shall be very clear: the psycho-physical integrity of the person is something that need to be precise and clear. Then you can find the forms through which you guarantee it. But that is a second point of the matter. But on the first point that integrity must be protected and it shall always be present in any action taken. For example, while thinking of the architecture of the prison facilities. We think at the protection of the right to healthcare, but we shall also discuss on building wings for prisoners with mental diseases to be hosted. This holding together the rights of people and the setting up of structures shall never lose become out of sight. I come to the issue of the protection of wellbeing in prison: you know we usually have a number of parameters in recommendations and international regulations, and in our standards. For years, as you know, I chaired the European Committee for the Prevention of Torture whose job was to verify these aspects. The first is that of the equality of care. For a system in which individuals do not have the same opportunity to access the health cares, equality becomes a problem that raises questions: how do we protect equality in situations, territories, hospitals which are different in different aspects and are not all present in the same territory and ask for a transfer of the inmate in another territory? How do we face the problem of the continuity of care? Mr. Consolo was saying on the need of starting with the personal digital medical file: what's the use if then files opened in one region do not use the same system of another? Then, there is the need of the system of independence. In Italy, for instance, we have the prison doctor who is part of the disciplinary board. This is no more acceptable in European context, not even by giving as reason the fact that he may play a role in preventing solitary confinement. In all jurisdiction the prison doctor is not in the disciplinary board otherwise the doctor-patient relationship can be in some way deteriorated. And there is the last parameter that we need to be quite careful of: is that of a medical intervention that has a connotation of proactivity and not only as a response to a medical need. Too often I find myself talking to directors in prisons who, on the question of health care, answer by taking action when medical need is manifested. I often answer that there is a need to be somewhat proactive and not reactive. These parameters, in my opinion, we should bear them in mind. And I add a few words on the question of psychiatry and how we confronted it. And what I would say basically two things: the first is that the psychiatric units are such called if they exist as such. I very often visit prisons in which these psychiatric units do not look like a regular psychiatric unit. Returning to the issue of detention, we need to reflect on how we deal with situations of acute care within prisons. They must be addressed keeping in mind the three parameters: the first is the location which is not the prison wing; the time which must be immediate, the forms there cannot regress to forms of restraint either chemical or physical. So we have a problem of reflection and wide enough in the context of a reform that I see going in the good that starts from a principle: the psychological problems should not be treated differently from that which is the somatic disease. This was the principle that we wanted to say. But around these measures we still have a lot to think and much to redefine.

CLAUDIO SARZOTTI - University of Turin and coordinator of table n. 17 on the Process of territorial rehabilitation and care – about the enforcement of the sentence

I believe you have invited me here since I am the coordinator of table 17 about the territorial participation and the enforcement of the sentence. We started monitoring the Italian situation, in order to understand to what extent the territory feels involved in the enforcement of the sentence that involves many actors and not just those who are primarily touched by it. This monitoring has been quite discouraging, in particular for the role of local authorities. My understanding here, is that we have a reform that also entails penitentiary healthcare and that highlights the need of civil society to care for the enforcement of criminal penalties and for the mental and physic state of the convicted person. The fact that civil society must care

for these elements emerges from the premise, as the Constitutional Court has underlined in recent years, that a convicted person maintains his rights of citizenship. So the convicted citizen is still a citizen with all those rights who are in line with his condition of deprivation of liberty. The root principle of the penitentiary healthcare reform lies in the fact that the convicted citizen and the free one should be treated in the same way. Anyway there are always obstacles when considering rights of citizenship for the detainee and for the free citizen, for this reason the relationship between the detainees and their “keepers” is of paramount importance. For the penitentiary staff a person in prison is more a detainee than a citizen. It is no coincidence that we have mentioned the WHO recommendations for preventing suicide attempts, which are general recommendations for all kinds of people and not only for detainees. I want to quote another important statement made by the WHO that defines “health” not as a merely lack of pathologies but as a mental and physic wellbeing state. Here we have another question without answer. During a conference on penitentiary healthcare in Turin I have asked to the audience, and there were many penitentiary doctors: “how can we ensure a mental and physic wellbeing if we don’t ensure, in the meantime, the detainees’ rights to affectivity and sexuality?” Nobody answered. During his speech, doc. Buffa emphasized that many other WHO’s recommendations on suicide prevention conflict with the prevailing subculture of the penitentiary. As an example, the strategy of peer support, of letting detainees help each other and communicate with the penitentiary staff in case of need, is completely in contrast with the stereotype in which every form of solidarity among detainees puts the penitentiary management at stake. Anytime detainees have mutual solidarity and understanding, the penitentiary police staff sees a potential threat for the prison security. One example more, the need to avoid humiliating and childlike situations. We all know that these situations generate from life in prison naturally, and not from the behaviour of penitentiary staff. One of the negative aspects we recorded is the lack of data on penitentiary healthcare, we had more data before the reform was enacted, namely when the Penitentiary Administration cared for penitentiary healthcare – e.g. on HIV. Now we don’t have data so we cannot intervene in any specific way. Another issue is the risk of making all behaviours psychiatric: you don’t need to be a psychiatrist to notice a risky behaviour of an individual who is going to attempt suicide or self-harming actions. Anyway, these are not elements to determine a mental illness, they are, instead, very natural to occur within the prison life. I think that sharing experiences on this field with other European facilities will be very useful since they have already witnessed the shift of penitentiary healthcare to NHS: in France this shift took place 10 years ago. According to a research conducted by Millet one of the most important elements for the effectiveness of this reform lies in changing the professional culture of the penitentiary staff as well as the professional culture of the penitentiary doctors who usually saw their job as less professional and less eminent compared to the job of their colleagues outside the prison. Changing this kind of culture improved the situation in France as well. I would like to make a comparison between the French and the Italian situation concerning the surveillance court. This profession is seen as less eminent compared to the other kind of judges. So, in my opinion, the cultural aspect plays a very important role, since it is a network aspect that leads to a stronger coordination among the staff involved in the enforcement of the sentence. This is one of the main aspects to enact a reform of principles.

LUCIANO LUCANIA – *President of SIMSPE Onlus, member of table n.10 on mental Health and distress – States General on the enforcement of the sentence*

After all these speeches is for me difficult to add new ideas, but I would like to talk on behalf of the operators. Through MEDICS project we don’t want to talk about mentally disturbed inmates care and

support on a multinational level. We can face all the issues without transparency. We must take our responsibility, this is what President Consolo said. We should share this responsibility with all the healthcare staff and the penitentiary staff. Maybe it could be useful for every facility to have a room with video-surveillance for emergencies, so as to avoid the well-known sight-surveillance that has its criticalities. In the society in which we are living detention is seen as a form of violence and a detainee has more difficulties to adapt than he had ten years ago. I am sorry to say that there is no great attention to life in prison and health and mental wellbeing of detainees. I want to quote the Italian handbook on public healthcare to which I gave my contribution writing two chapters on healthcare protection and inmates safeguarding, cured by the Catholic University. In these chapters I highlighted the importance of intervening on life in prison, on the time spent by detainees in order to reduce the burden of detention. And I am talking about leisure time and education to legality. So as to take into account all the dimensions of personal suffering. Under the structural profile we talked about mental distress. The one that led once, to JPH hospitalization, that should overcome art. 111 c.p. and art. 112 c.p. concerning observation and art. 114 for the state of illness. It should instead be considered as a temporary reclusion for those who really suffer from a mental disease and really need a medical treatment and measures to re-integrate the detainees in concert with territorial mental healthcare centres. My point of view is that of operators, that maybe conflicts with other visions but it is an everyday life concern. I have been a member of table 10, coordinated by president Maisto who is an example of balance, and we discussed about the current demand for a national observatory within the Higher Institute for Health and about the mismatch of JPH in 1975 and about 2000 regulation, with the formal consequences of the shift of penitentiary healthcare into the NHS. This issue needs a whole re-assessment both in formal and practical aspects. The healthcare systems are no more penitentiary-friendly, but they need to be user-friendly. This is the added asset of this project, trying to look forward toward a dynamic rebuilding of a solution for constant problems connected to the prison.

ANTONIA TARANTINO – director of the planning area for vulnerable individuals (mental healthcare, prisons – region Lazio)

Even if we started late, since we were not involved in the monitoring of protocols, region Lazio established guidelines for the care of drug addict detainees with operational programmes that are going to begin, same thing for detainees suffering from mental distresses. Risk prevention has already been enacted in 3 facilities. Within the region, RPAAAs and healthcare facilities have been set up for overcoming the old JPHs. We defined the penitentiaries in which we had to build new structures and provide new beds. We worked with regional healthcare centres to care for those patients who were within the 6 Italian JPHs. The problem of temporary security of the 106 is really serious. The region has a protocol agreement with the court of surveillance and with CPSs, so we are setting up guidelines for the common management of patients within REMS. Working with magistrates and courts is of paramount importance. Region Lazio has identified 5 facilities distributed in 2 areas of the territory: Frosinone ASL (Local Healthcare Centre) and ASL Roma 5. Currently, 4 out of 5 facilities have been opened. The fifth will open in the next few days. We work in concert with RPAAAs, LHCs and courts. We had the approval of the Ministry and we have been assigned funds. It still seems like we don't have enough places since always new inmates both from prisons and from outside arrive in REMS. Aversa's JPH should close the last month but we could not close it due to the presence of some detainees.

Session 2: “From the transnational project to the operational proposals for managing mental troubles in prisons”

TERESA DI FIANDRA - *Executive Psychologist - General Directorate for Prevention, Ministry of Health*

Since 15 years, I am representing Italy at the WHO, whose instruments are taken to be part of the Italian agreements, and are the result of work done on these documents. In light of this, I want to give fast response to the analyzes made by other speakers; first our NHS is based on the framework laws on the guarantee of basic levels of care (quality levels) and you have to deal with the regions that are autonomous in the administration of services. This is a fundamental element because the organizational responsibilities are assigned to the Regions and the panels are used to level up the quality of the responses. The Ministry of health has powers other than that of justice, it cannot make orders but must share in the joint conference (with local entities) agreements. Despite the many agreements, joint works are not known although decided between the Ministry of health, justice and finance. Among the things said before: first, the prevention and the ability to handle suicidal issues were addressed to a technical working group and we now attempt to implement a tighter monitoring of the actual implementation of these shared choices. A basic problem has been and will be the digital medical file: all criteria for a national health information system with the ability to put the data in the network had been developed, but the problem is that health data are covered by privacy. It was then decided which data could appear in the file (especially infectious diseases to take appropriate preventive measures), due to the fact that you cannot provide all information, for the risk of being sanctioned by the Privacy authority. All agreements signed so far include joint training: the basic point of integrated training is to learn health and penitentiary language to interact in improving the quality of care and the environment. Importance of the environment: the person's mental well-being may be at risk in prison and favoring the environment for the detainee is a must. How to contact WHO: I knew of an international project focused on creating a climate of cooperation and mutual respect, using peers to improve the climate and enable to provide welfare to all detainees. I have coordinated a study with six Italian regions, led by Tuscany (docs are available online), which profiled the health needs of 16,000 prisoners (1/3 prison population) and provided a glimpse of the real needs, especially that the highest health problem for more than 40% of prisoners is a mental health problem, followed by gastrointestinal diseases and other pathologies. Another new project in the Emilia Romagna region on suicide, mental health, which will develop training courses on cultural mediation and offering vaccinations also to migrants in prisons of the five regions involved. Another sub-project on the management of pain in prison to get to prisons without pain, high consumption of drugs and often inappropriate from a health point of view, as a personal commitment will send the report to all to act as a sounding board. By law (Law 81, 2014), we have received synthesis rehabilitative therapeutic pathways for of all those present in the OPGs. After a first profiling of the characteristics of psychiatric problems of OPG'S detainees, we are building a database for all those that pass and are in REMS (residences for the execution of security measures) which accommodate inmates transferred from the psychiatric hospitals (OPG) - facilities with maximum 20 beds. After an analysis of the initial diagnosis and the individual paths proposed for these people in the residences, an overall report will be drafted. There are many elements, dialogue exists, but you can communicate better.

MASSIMO DE PASCALIS - *Deputy Head of the Department of Penitentiary Administration*

I feel compatible to the needs of the penitentiary system and the needs of the health system. The protection of inmates' health is a priority. The health of the prisoner shall be provided outside the prison facilities and not replicating services inside the prison establishment. Concerning the privacy issue, we do not invade privacy, but the question remains that throughout the prison system, the treatment requirements, the protection of human rights, the treatment program and the security revolve around the knowledge of the person. To know the individual is a fundamental element that also affects his health. One goal is to develop a balance between the parties in full awareness of treatment needs of the prisoner, to avoid different behavior in each prison that lead to dispute in the workplace.

GIUSEPPE CAPUTO - *University of Florence - National Research - Survey life pre-prison project ME.DICS*

First of all some methodological premises: the project aims is to "analyze the frequency and distribution in the prison population of psychological distress and psychological problems linked to the consumption of drugs and alcohol in relation to the major legal changes and social and personal", trying to join the health to the legal part.

The distribution reflects the study of 2015 of the Health Ministry, 65% inmates without diagnosis and 35% with psychological diagnosis, 20% bound to drugs, 9% real psychological problems. The sample of 250 prisoners. The double diagnosis of mental distress and substance use affects only 7/256 detainees. 40.5% stress-related and somatoform disorders, obvious discomfort. On diagnoses related to drug use and alcohol it is to be noted the prevalence of disorders related to opioids. One of the most interesting data is the time of diagnosis: 60% at reception, the rest of the percentages below 10% or a little above 10% (after one month, two, etc., etc.) are lower, but if we decompose the data into psychic diagnosis and psychological diagnoses related to substance use, we see that the first entry is diagnosed in 17% of cases. Maybe due to the type of cause, often stress reactions or pathologies that emerge in the course of detention. Faced with such a disorder linked to diagnoses substances instead carry out the entrance of the prison. Distribution Unlike disorders among Italian and foreign, the latter 45% of the total sample of patients with mental disorder, 83% mental disorders without substances composed of Italians. First idea: Italians are more prone to disorders in prison? The Italian inmate has a better and easier relationship with the medical staff? The percentage back in balance for disorders related to alcohol and drugs. Between males and females, there are many differences, December 31 to 8% of the institute consists of women, the percentage of women with mental disorders is 3 times higher than the internal proportion to the institute. Analysis of the number of previous incarcerations of individuals with mental health problems and drug addicts and even time in jail both current and previously findings: addicted prisoners (for the most part foreigners) at least 4 PRIOR imprisonment with lower residence times, inmates Mentally ill veritable had fewer incarcerations PRIOR with an attendance time in the longest prison. Among women with mental disorders, the average age is higher than men, have a lower rate of external relations, there are many factors to consider. You can joint the health care and legal and I think that should be our starting point, I appreciate the ministry study of 2015 I think he filled a large knowledge gap. The bioethical committee of Bologna approved there on behalf of the DAP this research protocol that we hope will have further developments in the future.

ALFREDO DE RISIO - *psychologist - SIMSPE Onlus National -Search - Life Project survey custodial ME.DICS*

Thanks to the table of the Presidency and to the guests. The SIMSPE that I represent was instrumental in research and training, thanks to Mr Ferrara, Inglese and Ms. Ramirez for training in prisons. A greeting to the European partners who have worked with us. Rome is in the slide because it tells us from the baroque to the Fascist period, but there is also, behind the "altar of the fatherland", the Mamertine prison, recognized among the most ancient of our history. What prison? Prison is society, a normed society. On this idea we started with the study MEDICS, as recalled by the project co-ordinator Palmisano, we wanted to look in the three Italian regions and in people's voices, impressions of the relationship between the individual and the way of life in prisons that can be traced in the questionnaires distributed in prisons. The sample is divided between sectors Ministry, security and the regional health service. Figures that were missing but that have been reported (volunteers, often not mentioned why not professionals but not for this non-professional). The goal was to investigate attitudes and investigate possible intervention strategies to promote or hinder the project of mental health in prison. The Italian research is divided into four areas: sample surveys, surveys on mental illness, intervention strategy and reliefs on real data. At the request answered 368 professional sub-divided as I said before. What we want to highlight is not the real data because it is not difficult to trace with clinical interviews, the use of medications, specialist visits, but the data to bring out is that of psychopathology by imprisonment, which has more fluctuating aspects that characterize paintings clinical equally important because they lead to a state of deep psychological distress. In foreign experiences with professionals of San Giovanni di Dio hospital intervention that they were working for a psychopathology, they were those from Axis 1, but those disorders telling us about other forms of disability were supported by psychological interventions in the group. Reflection on the use and abuse of the drug compared to forms of discomfort that can be addressed in different ways. Therefore the prison disturbances include types of disorders that are important to be called when a national health service enters in penitentiary institutions. Those from incarceration syndromes are translated into everyday language. Painting in the slide, encounter between Jesus and Caiaphas, judgment and prejudice, but especially the injury to nursing offers to be included in the "mental health project in prison," the canvas was attributed to Giotto, we have a medics perspective, a size depth, we look beyond appearances. The prison according to the constitution and its educational function collides with the theme traced in the cards, the theme of idleness: even meeting the realities penitentiary partners of the project we have seen that the rehabilitation activities must begin with an action of the subject. The leisurely exacerbates the malaise of psychopathology from prison. Theme of the complexity of the report, carried out by research and training activities in the target institutions that is traceable in independent and interdependent models who still after eight years still find it difficult to be implemented. All this recalls the promotion of the welfare of the individual strategies. Important question: is it possible to cure? Fundamental human rights are read as exotic human rights or even rights that do not wear out, and that instead, if not fed, are likely to fall by the wayside.

ALESSANDRA ORETTI- *Psychiatrist - Mental Health Department ASUITs Trieste*

I am bringing testimony of practical experience of the work of the Mental Health Department of Trieste in the City prison, the prison seen from the perspective of territory of interest for the department. I speak of an experience done in an area with small dimensions and in which after the Basaglia law has developed a network of deeply rooted services in urban areas and that today meet the 17 % of the city's residents. Mental health centers are substitute the hospital, open 24 hours a day and are 94% of the investment in spending compared with 6% for the psychiatric service for diagnosis and treatment. The Trieste Experience has shown

that cities can live without mental hospital and you can give help maintaining the highest degree of freedom possible on limited local areas. We have a very low number of TSO, in 1 year only 1 inhabitants every 10,000, abolished forms of violent treatment (shock and restraint) and mental health services operate to avoid prison security measures and sending patients in REMS. In the last two decades, we created network health services on the principle of community medicine and the start of new health services in 1965. We work with other health agencies and our services are carried out in collaboration with the medical staff. In 2015, we carried out a training course on suicide risk for 2/3 of prison officers and health professionals and which will now be repeated for volunteers working in prison. We observed that activities have had good results, including to the stigma of detainees patients, and helped the social reintegration of these. The collaboration with prison administration and judicial was possible and staff awareness of mental health issues was crucial. One must start with strong psychiatric services willing to maintain contact and continuity of care. Here we come to the problem of resources, in our health healthcare business takes 4% of total healthcare spending, the numbers are lower than in other regions, some rich outside the institution mental health can ensure better managed to mental health ' internal. Services must be good already starting.

SESSION 3: The problem of psychic troubles in prison in the European context: experiences comparison

RICCARDO TURRINI VITA - *Director General - Directorate General for Education and Training; Department of Penitentiary Administration*

At the beginning of the second day of the conference, the moderator, Dr. Starnini, gave the floor to Mr. Turrini, who addresses the question of the theoretical psychological distress, a problem that is in the most acute forms and in those less acute, has asked for more than two centuries the execution subject of the sentence. The assistance system to psychological problems of prisoners is now invested for ten years by important changes. Changes in institutional position, responsibility, allocation of funds, although it is still early to pass judgment on these changes. Before giving the floor to the other speakers, Dr. Turrini notes that these have focused on the needs of the person and the community. It is hoped that by this comparison and from these experiences which were then collected you can come to have a consolidated to spread Italian administration and the prison administration can make their own.

GIULIO STARNINI – *Responsible of scientific survey*

Dr. Starnini takes the floor and put a focus on the differences that emerged in taking charge of the patient between Italy, Catalonia and Croatia. The aspect of training is one of those aspects that in the last two years of work has emerged strongly in the Italian context, in research of dr. De Risio at meetings in Catalonia and Croatia. The commitment to the training of Italy but also in other European partners must have priority. In Catalonia the positions of the Ministry of Health and the Justice Department have been clarified for years. The charge of the patient socket takes place safely for Catalan citizens, while respecting the right to health. In Croatia, the health care is still at the Ministry of Justice. This allows a different approach from Catalan, with less resources compared to Catalonia, but effective nonetheless. In Italy, joint training is the first obstacle: the difficulty of dialogue between the health institution and the prison administration, the two institutions that should interact to deal with the problem of mental distress in prison. In Catalonia and in Croatia there is cooperation between justice and health and that is why the system works. In Italy, work is needed so that this spirit of cooperation also involves the health care system.

GRAZIA DE CARLI, *Prison Governor - Department of Penitentiary Administration*

Dr De Carli takes the floor and soon underlines what has been the project major difficulty: to put together prison administration, healthcare services and regions. It took a year to get a common dialogue between these three institutions. After three years of working together, and this problem occurs again before the training offer made by the prison administration to the regions, with ongoing projects and programs they replied that they do not mind training because it is not their responsibility. The doctor, however, stresses that the joint training is required. De Carli has dealt specifically the closing process of judicial psychiatric hospitals and then the prison security measures. In 2008 he was issued a Prime Ministerial Decree tracing the lines to go because you arrive at the final closing of the judicial psychiatric hospitals and custody of these persons to national health and regions. The Prime Minister's Decree was organized in phases: the first phase was returned to the community, to civilian life, people being treated in psychiatric hospitals for

extensions, after a hazard review. However, it was impossible to discharge patients due to lack of health facilities that they could take charge, so by the judiciary was again extended the security measure. This was the first joint action by health regions and to discharge patients from psychiatric hospitals (300/400 people). The second phase was to bring in prisons people who were not in the status of internship, but held, and that proceedings were initiated in judicial psychiatric hospitals for psychiatric or psychological infirmity observation. This resulted in the establishment of the joints, which are not psychiatric wards or prison sections, but a transitional moment must be assured observation or care and a prison life. According to De Carli there is no need to establish new institutions in the joints because they are small numbers (about 200 people). It has addressed the issue of the 148 of the penal code under which prisoners should go in the REMS, but according to Dr. is not the solution. He worked from a distinction between status and detention status of internship. There are more people that are held under observation in OPG because these are closing. Three are left to close, one is in Campania, in Aversa, with only seven inmates, one is in Montelupo Fiorentino and one in Barcelona. Were closed psychiatric hospitals Castiglione, of Reggio Emilia and a nursing home section and custody in Florence Sollicciano. The doctor then makes reference to a question posed in the first day of work, about which disease were to have a prisoner to go to a REMS. The start of a prisoner in a REMS is given by the dangerousness of the subject, that the currency magistrate on the basis of technical expertise. The doctor concluded her speech with an evaluation of the work, a difficult and that has not yet come to a path, but it is giving positive results.

PAOLA MONTESANTI, Prison Governor - Director of the Office for Health Services at the Department of Penitentiary Administration

Speaker Dr. Paola Montesanti, office health services director - DAP, which answers the question of Dr. Starnini how can intervene the prison administration to address the problem of prisoners with mental health problems in prison. The doctor confirms the difficulty of the comparison between the two institutions, health care and prison administration, which must take care of patients with mental health problems. The National Health Service is a great technique and cultural resource. The difficulty lies in defining its role and the interaction between the two institutions. The system at the national, regional and local level must be able to communicate: this is the greatest difficulty encountered because the health administration does not want to be involved that much. Much has been made in terms of agreements with the National Health Service to organize the prison health care uniform throughout the country. The latest agreement of 2015 is aimed precisely at this: homogeneity assistance, definition of the roles, tasks of the Medical Institute, which acts as a spokesman for the national health system, spokesman for the local health authorities in dealing with the prison administration. Montesanti then highlights the concept of networking, dialogue and joint reflection on the topics covered.

JAUME BARBERAN, Head of the Directorate General of prison services and rehabilitation - (Catalonia)

Dr. Starnini gives the floor to dr. Jaume Barberan, head of the Directorate General of prison services and rehabilitation, whose intervention is aimed at informing those present on the prison system in Catalonia, on the administrative environment and to explain what are the powers of the Directorate-General in the penitentiary system. First of all Barberan he makes a brief reference to Catalonia, made up of four provinces with seven and a half million inhabitants. 75% of this population is concentrated in the province of Barcelona. In 1984, the prison administration have

been transferred in Catalonia. In Spain there are two prison administrations: one in Spain and one in Catalonia. Catalonia is the only community with skills for the juvenile prison and probation and the police. The penal code is unique for the whole territory and was approved in 1979. This was an important event because the politicians who approved it had been in prison during the Franco dictatorship. The Spanish code is much more progressive than the one approved by the European Council: for example, in Spain in some detainees institutions can meet to make decisions on what to do. The Department of Justice in Catalonia has two general directions, one for prisons and probation and juvenile delinquency. The Department of Justice performs various tasks, for example as regards the enforcement of judgments, the technical advice of the judiciary and the mediation program between the guilty and the injured persons. At the beginning of the transfer of powers in Catalonia the prison population was 3,000 units, but increased greatly between 2000 and 2010. Today there are 15 prisons, 11 of which in the normal regime in Catalonia and 4 prisons open regime. The appearance is surprising is the percentage of the female prison population, which is close to 8%, twice that of Europe. Another important aspect is given by the institution of the open system which is part of the 21% of prisoners who, according to this kind of scheme, must return to prison just for sleeping. Finally Barberan finds that the crimes committed by the majority of inmates are against property and drug trafficking. Prison staff consists of 5400 units; 8% work in surveillance and the rest in administration. He asked Dr. Barberan if there is independence of the judiciary with respect to certain aspects or whether there is a single judicial national system. Dr. Barberan replied that the judicial system is centralized.

HUMET MATILLA, expert from the Ministry of Health - Catalonia

Mrs HUMET, part of the health program management for studies Catalan prisons, thanked the scientific coordinator, MEDICS project and the prison service Italian. He says that the project has been able to count on great professionals in the control of prisoners with mental disorders of the presentation concerns of staff opinions, which he believes offers a series of programs to identify possible discomfort of detainees including: informational protocols shared with experts psychotherapists, trainings, psychotherapy treatment, outdoor tours, activities gruppo. Le conclusions and proposals of Dr. HUMET says that we need more motivation and incentive policies. training courses with online materials that represent a saving for the administration, and to work with multidisciplinary teams. It reiterates the need for organization among the various parts and teams that sometimes are not able to cooperate. Psychopathological problems for the computerized report should be shared by the entire medical staff. We must pursue the idea of personalized programs providing incentive policies. Start programs in community buildings under special surveillance without the need to open new centers but to reach agreements with institutions to carry out these programs supported in existing buildings, supported by a multidisciplinary medical team. Dr. affirms the need for better diagnosis by judges who sometimes do not assign inmates / patients for lack of adequate information that could be provided by specialist doctors.

ANDREA RUSSO, Healthy Cities – Zdravi Grad – project partner

Mrs. Russo speaks about the Croatian experience and began his speech by thanking the MEDICS project and focuses on the need for concrete action to improve the conditions of detainees in prisons, giving more importance to substance over

form, for example, relations inmate / staff. MEDICS has provided new horizons and perspectives showing the need for collaboration between the various prison administrations, thereby exceeding the cultural and language barriers.

NUÑEZ HORTAZ - Director of the penitentiary center for young people in Granollers (Catalonia)

I would like to thank the organization for inviting me. For me it is an opportunity to learn from my European colleagues. Yesterday I found that the problems we have in Italy are the same as we do: self-mutilation, standardization, skills between health and safety conflict. It is a common reality, but maybe the tools that we are a bit 'different. It is right diagnosis, it is not a health problem but of organization. I will try to explain our system to offer a different vision of how to solve the problem in the system. I bring the example of a youth prison of Catalonia inaugurated in December 2008, before the prisoners were in a very old prison and standardized, 5-6 persons per cell, then the property has been renovated with new equipment, but all ' beginning there were management problems, both with the staff who were not accustomed to using tools like the touch screen to open and close the doors of the cells, both with inmates who despite everything had a new space and worthy is badly behaved because the 'previous building was less controlled, he had no surveillance camera; whereas here there are 270 security cameras in all common places and this is powerful intrusion in the privacy of persons and thus generated numerous resistance. When this prison began to function there was a chronic conflict, a lot of violence, organized groups of different identities that were fighting each other, so many fires in the cells. So big was the problem that the Minister of Justice of Catalonia called me almost every week, and asked me what was going on in the prison, because he could not work and what we could do to improve it. A prison culture is a process that you do not create a day to the other. We have a swimming pool in the prison and this generates controversy in the region. People say that it is as if the people in prison were on holiday, in the hotel. But in my opinion the pool in prison is a luxury not a necessity. I'm an engineer, not a politician so I have to use all means to achieve the goals we have in charge. The pool is not playful but is a premium, it is bound to a motivational system. Our structure is composed of four modules: input department, infirmary, maximum security, a building for specialized care, an education building, a sports area, all the logistics service area and the area of productive activities (workshops). The maximum theoretical capacity of 467 inmates but in fact in 2008 resided 380-400 detainees. In Spanish law the responsibility up to 13 years of the family, 14 to 17 years in force the child's criminal law, minors are not allocated to the penitentiary system, but to educational centers, for more than 18 years applies the criminal law for adults but at the penitentiary level there is a difference: 18 to 21 years shall be allocated to the prisons of young adults, although occasionally may reach up to 25 years in cases of immaturity, however, in general it was found that up to 23 years they remain in the prison of young adults. 70% are convicted, 30 budgets, we have a 57.3 to foreigners, but if we consider the origin is 80%. This greatly affects the reality of the prison: Maghreb 41%, South America 34%, and mainly relate to crimes against property (theft with violence). The drug you take is usually hashish, not heroin, nor cocaine. Our legal purpose in accordance with Article 25.2 of the Spanish Constitution is that the custodial sentences of freedom are intended to return the person to be competent and polite. Then there is an aim of management that create a climate of low conflict and engage in treatment activities. In Catalonia, the treatment is very developed. I realized that there is an important difference with the Italian system: the psychologist does not come from us but from the penitentiary scope health, depends on the department. This greatly reduces the working range of the prison health because it certainly deals with the physical and mental health of the prisoner, for example, cases of schizophrenia, but their work is focused, rather than from the health point, as part of the reintegration of person. Self-harm may not always be diagnosed, but maybe impulsivity yes and there does not need to

work, but a pharmacological treatment or a psychological one. In our treatment activities affect the climate of unrest in the prison. We know that a person lounging time and has nothing to do creates problems, while those who work do not. The interaction between staff and inmates lowers the conflict. The environmental organization of the prison, paid work, together with the penitentiary benefits and expectations of exit permits are very important. A system that does not handle the hope of prisoners is not going to work well. We have the advantage of having a penal law very flexible and generous, our system is very motivational. This flexibility is also in Italian law. All this creates an expectation on the part of prisoners to improve their condition. It's like a game. In my prison, I saw that there was a need to create incentives for the behavior, we can not take away the rights under the Spanish law such as the ability to contact a family member twice a week, instead we can play on the number of rewards. If the behavior of an inmate is perfect we give a benefit: activities pool, video games, televisions loans. This works in all the prisons in my pear tree is more immediate because young people need more immediate answers. Our population is divided into 4 levels ABCD according to two factors: support and motivation in the treatment and disciplinary behavior activities. For example if a detainee is at level A means that his behavior is good. If it is at the lowest level it has benefits. The Telefonica computer system (like a large telephone company Vodafone in Italy) gives us free calling minutes and we play well on this. A prisoner can make two calls a week but we can also give extra calls. Communications are powerful instruments of motivation. The family is very important as well as the intimate calls are their right and we can not deny them. As for family gatherings, we also have joint meetings or more prisoners with their families in the same room; and this is something that even enhance molto. Adesso will implement an internet connection (strictly controlled) that the inmate is eligible if it is at the level A. Another very important thing is the internal organization of the prison. When I arrived there as a director in 2008 I found a progressive band system, or a system that distributes the detainees in the various departments according to the disciplinary behavior. Those who misbehave are combined into a module and those who are doing well in another, then there are intermediate forms. The benefits are distributed in a different manner according to the module based on a psychological motivation. For example if a person is in the department of those who behave badly you will have the least we can give him the law and then will be pushed by a stronger motivation to improve their condition and then get to the module A, where has all the benefits. If he misbehaves, it recedes into the system. And this reinforces the behavior and learning because everyone sees what happens to others. It is a system that seems well structured but in practice it does not work well because it creates unfair situations and does not consider the personal circumstances of the detainees. If a person is in the most difficult form, then it is promoted to the next module, but knows neither educators nor the fellow must make an adaptive effort and this causes stress. This system generated many problems, so much so that I had the highest full security system. Then I changed the system initially do an evaluation of the person at the time of the institution (from the health point of view, psychological and educational), becomes a penitentiary profile (number of times in prison, toxicological history, l ' attitude toward the professional, psychiatric diagnosis) then you decide the department. The intention is not put together wolves and sheep because we know that's not good. We must balance the profiles inside the units. Another thing we have changed is the system of rewards, because if on the one hand in the form at all was perfect, everyone was covered in module D (the lowest) was hell, there was a lot of violence. The process of the modules travel to its treatment program to break out of prison was too long. Then we changed the system and now the treatment is done in all modules. The benefits are distributed in the same form in all modules as well as motivation. The movements are very restrictive, only in cases of serious incompatibility or conflicts between groups. The result was a behavioral balance throughout the prison and I as Director dispose of the most competent professionals. We have a large

number of detainees who are treatment activities: the school moves 2/3 of the prison population, then even sports activities, workshops. Then we also have psychological treatments to reduce risk of suicide or self-harm. In conclusion, I think it's very important to have a system of motivation in institutions. The disciplinary system is not working alone, it works so well to establish the limits but after our authorities must intervene. In my institute an inmate who assaults a teacher is sanctioned by the maximum punishment because we must never lose our authority. When we respect the detainees work well and can do everything, because our mission is legal, but the prison you have to govern. There is always resistance to change, our security officials did not understand well what was happening. People are afraid to change reality but our officials have realized that they live better, that with this new system the conflict and aggression decreased. Now my security professionals are the first who worry that kids go to school. Why is it worth to them, there is no difference between managing five or 50 guys. Why even their behavior towards detainees has changed a lot. Defending the treatment system is beneficial to all. The problem of suicides in France for example is not only the detainees but also of officials who bear a very difficult reality. Our system is milder and this also allows the working conditions of our employees are the best. It needs a political momentum because we are technical and not political. There are two sides of the coin: on one side the politicians are concerned that it not leave anything in the papers, on the other do not raise a finger, do not do anything. The politician must be aware that there is no need of politics, need to invest in this sector. A superficial help is useless. We will never stop: reality is in constant motion. For example, we are now working on another program to prevent jihadist radicalism. We are working on a preventive program.

Session 4: The penitentiary administration confronted with the psychic troubles of prisoners

FABRIZIO SCALICI, *Healthcare service director at Palermo prison*

Mr. Scalici, manager at the regional healthcare service in Sicily, underlines that the prisoner should be considered a national. He exposes the current situation in Sicily, where a psychiatric prison hospital (so called OPG) is still present, and where detainees, who are not hosted in the modern REMS, are assigned to prisons like “Pagliarelli” and subjected to more restrictive regimes. What he has so far listened and presented by other professionals and experts, the focus is on the need to consider the prisoner as a national, and do the best to host him/her in a prison facility where s/he can receive the support of a psychiatrist. The nature of the issue is coordination, with justices, who sometimes fail to assign mentally ill prisoners in the buildings where they can be better monitored.

ARMANDO REHO, *Responsible for the detainees and treatment office at the Regional Prison Superintendency of Emilia-Romagna and Marche*

Undoubtedly, when psychological and mental disorders in prison are the main concern, prison staff is always involved, we that are daily dealing with this discomfort. We often realise the discomfort of a detained person not only from the psychological point of view but also in relation to the detention conditions: discomfort may be generally reflected in self-care. So the first thing to detect is the inmate’s loss of self-care and this is the first sign that is likely to increase his/her discomfort. So we have to find in the current legislation and in the modus operandi of the prison workers an answer in order to do our best to reduce the effects of the loss of self-care and allow a decrease in psychological distress. So we have to talk mainly about the quality of the relationship and interaction with the subject. The Italian system is underpinned by a solid set of rules but the prison environment is constantly changing. The healthcare service in prison has passed from the Ministry of justice to the Ministry of Health under the NHS, but this change shall not be translated in a loss of values in quality and relationship approaches with inmates. This new working conditions should help us revising our relationship with the inmate and improving communication among professionals, sharing procedures and methodologies that may affect the quality of relations with the inmates. In a nutshell, we shall create opportunities of discussion and the scope for joint initiatives among all front liners. We shall also reverse our perspective: not only work on problem solving, not only ask ourselves “why discomfort?” and immediately solve it; we have to look at the problem in a more enlarged, and problem setting perspective which is aiming at defining how to carry out human relationships. Mutual observation leads us to a particularly strengthening the network of operators who leads us towards integration, to perform unit operations. From a practical and concrete perspective all this we have already dealt in the past with joint programs, and today there are many protocols on the prevention of suicidal behaviour and self-harm, and in these national frames and also at local level, we can continue this path.

CLAUDIA CLEMENTI - *Director of the Bologna Prison*

We work together with healthcare professionals every day, we have a very present health service because we have a duty doctor who works 24 hours a day, we have many specialists, we have a psychiatric ward that is open on all days except weekend and we daily analyse individual cases. There are many multidisciplinary teams that include healthcare staff participation, the rehabilitation unit for drug addicts, the new arrival unit. There is participation and discussion moments with healthcare providers. However, when work is skipping from the practical daily activities and we confront on ideas and opinions, the right pathway is fading away. In Bologna, we have protocols signed with the local healthcare services: there is a regional protocol, a protocol of a general nature, a protocol on suicide prevention, and it seems that all devices and instruments are at disposal. The problem is that we have difficulty in moving from the deductive to the inductive process. In fact, this mechanism is sometimes stopped and we acknowledged some problems. Not long ago a prisoner committed suicide: at that point we realised that there was a lack of communication between the rehabilitation service in prison and the healthcare units. Roles and responsibilities of professionals should be clarified. The experience of everyday life is still fruitful. The MEDICS project has made some proposals: joint training, the possibility of dedicating European funds to these subjects, the monitoring of professionals. These are all needs coming out from front liners. Another project is ongoing at the Bologna prison: it is called "Creatively". In this prison, we are experiencing many artistic expressions and we have realised that the structure is well oriented. For this reason, we have decided to work on one side with men to the facility renovation. Actually, the premises are very well maintained, but we decided to make it more "attractive" to the public. On the other hand, the women prison population decided to work on the production of jewelries. And they worked closely with the tailoring atelier present in the Bologna prison.

ROBERTO DI CATERINO, *Chief prison officer at the Bologna prison*

Mental distress is an important aspect of everyday life. The lack of resource is very much evident at week-ends when we particularly suffer the lack of healthcare staff. We all have to realise that the prison environment is not a parking area where you can even park mental illness and then leave for two days. Life continues with its distinct rhythms also on weekends, we cannot stop. This is an important thing. The inconveniences, which are communicated to the operators, the psychiatrist, the doctor does not only happen every day but more than once a day. This is the difficulty and even the skill of the prison service, the ability to interpret an expression, to understand the prisoners. I'll tell you about an episode occurred in my prison: an inmate, who is about to lose a foot, returns to his cell and says to his companion that for him life has no more sense. It happened on a Saturday and there was no psychiatrist, so we had to put a strict surveillance on him: this was the only remedy to his extreme expression of despair and to help him walking the pathway to some hope.

GIOVANNI BATTISTA ALBEROTANZA, *Chief prison officer at the Turin prison*

At the Turin prison, we had a different approach and we launched a project on *peer support* in the management of mental illness in prison. How to face the issue and confrontation with justices, while tackling the subject of sharing of responsibilities with other professionals. Accountability and sharing of responsibilities are two topics that the project has taken into consideration. The importance of first impact with the prison setting at the reception unit. We worked on improving the approach to the new arrival and enhancing the service so to reduce discomfort at admission or during the

induction processing. From previous experience with very difficult inmates, we have acknowledged that a strict surveillance has proved to be useless. Prison officers tend to be more authoritarian, rather than authoritative. This is why we have developed a new method in the assignment of prisoners in the wings, based on the type of offense and level of risks, depending on the different types of care the inmate might be requesting. Therefore, healthcare staff have been very helpful in giving a diagnostic framework of all prison population for improving management, and develop new types of approach.

BONFIGLIOLI MARCO, *Director of the rehabilitation service at the Regional Superintendency Piedmont, Liguria and Valle d'Aosta*

Do you agree with the Head of the Italian Prison department on what he has expressed about maladjustment in prison, or that the psychological discomfort has to be cured and not punished? If you want to talk about psychological problems, you should start right from the prison facilities. Prison officers shall not feel to be abandoned: on the contrary they shall feel a sense of belonging to the prison administration and experience working in groups. Sharing is therefore essential. The dark side of professionalism is bureaucracy. And if you follow my consideration that mental distress is generated by the organisational system discomfort, than you will agree on the fact that suffering produces suffering! Therefore, if we look at the recent reform in custodial approaches in the Italian prison system, the so-called dynamic security, we will realise that we shall work hard to avoid an implosion of the distressed system. If we look at numbers, we will notice that the number of prisoners has decreased compared to 2010-2011, but with no sensible decrease of critical events, which in proportion appear to have increased. I found very important the considerations of Mr. Nunez Hortas, in particular when he underlined that a system not generating hope is ineffective. Other key elements in confronting discomfort in prison are the reception of the inmate, the creation of structures where discomfort can be alleviated, and finally the overcoming of the strict surveillance in custody. Of course, all these key elements should be underpinned by the utmost cooperation between the prison system and the healthcare system.

DOMENICO MINERVINI, *Director of the Turin prison*

When I first arrived at the Turin prison, I found the facility in rather a difficult situation: there had been a severe case, which involved two prison officers (a shooting) and the main need was to rebuild human relationships, especially those with the healthcare staff, suffering of prevarication attitudes by prison staff. During the conference, there has been much talk about cultural changes. At local level this change did not go through. What we need indeed is to define the role of healthcare in prison and most of all to understand that the Ministry of Health's approach is different from ours and therefore we need to find a common line of intervention. As a result, I started a dialogue with the local healthcare bodies, and I tried to give a different idea of the prison administration as an overall authority in prison. Bearing in mind that a partnership to be successful shall be equal and any cultural change must involve all the various prison administration levels.

PAOLA Montesanti, *Director of health services - DAP*

I'd like to focus on the healthcare reform in prison and on the fact that an inmate being received at the prison facility, on the basis of a mental pathology, by the healthcare staff shall be previously been profiled by prison staff (or already filed by the judiciary, on the basis of his/her offense) as non-dangerous. Therefore, all positive aspects of the reform are addressed to inmates, we call *media sicurezza* (medium security profile). Inmates with a high level of dangerousity (such as crime organisations leaders, A-level inmates and inmates cooperating in investigations, are not included or targeted by the reform and they are transferred to other prisons without any previous agreement with the local healthcare authority on the availability of resources at the in-taking prison. Thus, while for ordinary prisoners we could monitor transfers to other prison facilities or other mental health care structures, in the case of a high profiled inmate, we could not monitor any activity addressed to him.

GIUSEPPA IRRERA, *Director of the rehabilitation service at the Regional Superintendency Sicily*

The current situation in Sicily is a bit demanding and delicate. Healthcare in prison has recently passed from the Ministry of Justice to the Ministry of Health (February 2016) and we are losing consistency of approaches in the different provinces. Mental distress in regional prisons is increasing also because of changes in the inmate profile entering the facilities. To tackle the problem is mandatory the restoration of good relationships with the local healthcare services, because prison staff is feeling a sense of loss in approaching this issue.

GIUSEPPE RIZZO, *Chief prison officer at the Palermo prison*

The MEDICS project has enabled the Palermo prison to think about best practices, which prison and healthcare staff were already following, without being aware of. At the moment, transfers of competencies to the local healthcare services are still ongoing and they are supported by the past cooperation among staff. At this time the institute has facilitated the transition to the penitentiary medicine as it works with doctors who know for a lifetime, therefore cooperation is fruitful. In August 2011, 30 mentally ill inmates were transferred from the regional penitentiary psychiatric hospital Barcellona Pozzo di Gotto to the Palermo prison. We experienced a methodology in approaching mental disorders in prison, which was based on mutual cooperation and it also helped in determining future approaches in starting the new model of dynamic security in 2013. Moreover, what shall be boosted in our prison administration when tackling the issue of the inmates' mental health is the training of staff – healthcare and prison staff – aiming at the protection of the right of prisoners to receive healthcare during custody.

Session 5: The integrated training

MAGDALENA KRYSZYNA CHOJNACKA, *the European Penitentiary Training Academies Network - training academy in Poland*

My presentation is about the integrated training experience with psychologists, healthcare and prison staff. The topic is of utmost importance to the extent that, being the annual president of the EPTA network in 2016, the Polish academy has put in the annual conference agenda the issue of tackling mental and physical disorders in prison. As regards Poland, there are 74 units for inmates with mental disorders, 22 for prisoners with no psychic disturbances, 33 units for prisoners with alcohol dependency, 15 units for inmates with addiction to drugs and 7 units for inmates with sexual disorders. The MEDICS project outcomes could be of great use to other European countries. Although there are substantial differences between the penal systems in European countries, I believe that it will be vital to improve cooperation among Member States. In Spring 2017, we will hold a seminar during which experiences in the field of mental and physical disorders from different European countries will be shared; the focus will be on training and different approaches and methodologies. How to approach and how to train inmates with mental health problems is a common problem in all European countries, therefore they are open to sharing training experiences.

MARIA DI PALMA AND VERONICA TAGLIACARNE, *Bologna prison*

The Bologna Group has seized the opportunity to participate in the MEDICS project. Since a few days, the Parma prison has accepted some female inmates with mental illness coming from the Tuscany. The prison director has soon deemed necessary to build up a working group composed of prison staff belonging to different units so that each professional could contribute to this experience and acquired skills. Following this experience, the existing protocol was amended on the basis of the new approach and methodologies. Therefore, new proposals have been put on agenda, such as the need to invest in training, the introduction of a supervisor that can assist the work and, in particular, the codification of the operating modalities. Up until now, we have heard about the inmate wellbeing and not a word on the prison staff wellbeing. And if a system – in the word of Mr. Hortas – “must generate hope”, a system can generate hope if its prison staff work in healthy conditions. With regard to the Bologna prison, prison population raise up to 742 detainees: it has just 4,5 rehabilitation officers with a workload of 170 cases per officer. Definitely, above the average.

The training groups

Bologna



Palermo



Torino



The follow-up day. Rome, 24th May 2016



Working in groups

