



Co-funded by the Criminal Justice  
Programme of the European Union

ME.D.I.C.S.



MEntally Disturbed Inmates  
Care and Support



Ministero della Giustizia  
Dipartimento Amministrazione Penitenziaria  
Nucleo Progetti FSE

## ME.D.I.C.S.

MENTALLY DISTURBED INMATES CARE AND SUPPORT – JUST/2013/ACTION GRANTS

## THE NATIONAL SURVEY

*By* **Alfredo De Risio**

*In collaboration with*

**Matteo Pio Ferrara**

**Annateresa Inglese**

**Roberta Sardella**

*Revision and validation*

**Giulio Starnini**

# ***INDEX***

|  |                |
|--|----------------|
| <i>Introduction</i>                      | <i>pag. 3</i>  |
| <i>Introductory remarks to the study</i> | <i>pag. 4</i>  |
| <i>Methodologies and tools</i>           | <i>pag. 5</i>  |
| <i>Research outcomes</i>                 | <i>pag. 7</i>  |
| • Survey on interviewed individuals      | <i>pag. 8</i>  |
| • Survey on mental distress              | <i>pag. 18</i> |
| • Survey on intervention strategies      | <i>pag. 33</i> |
| • Survey on real data                    | <i>pag. 54</i> |
| <i>Final considerations</i>              | <i>pag. 61</i> |

## ***INTRODUCTION***

The project, which is co-financed by the European Commission, stems from the need to create a clear and detailed set of information with regard to the *mentally disturbed inmates' situation in the Italian penitentiaries, to identify both the real and perceived figures on the diffusion of mental distress and to offer a shared pattern for providing specific care and rehabilitation*. This will be helpful to overcome the Judicial Psychiatric Hospitals (JPH), which still persists in our country, and the subsequent establishment of special departments for mentally disturbed people, which are still present in many Italian penitentiaries. The SIMSPeOnlus (The Medical and Penitentiary Healthcare Italian Society) will be referred to as scientific partner in order to achieve some study-related goals – the study focuses on perceived distress, training and technical-scientific relations with partner countries. Against this background, the national study, upon identification and adherence by the Regional Penitentiary Administration Directorates of Piedmont, Emilia-Romagna and Sicily, aims at detecting the perceived mental distress due to the detention of the inmates in the target penitentiary facilities.

## ***INTRODUCTORY REMARKS TO THE STUDY***

Psychopathological behaviours are particularly frequent in penitentiary facilities and can be considered as the continuation or the exacerbation of pre-existing psychological disorders or the structuring of a psychotic-type reaction due to psychologically traumatising events such as imprisonment, judgment pending, sentence anticipation and sentence itself.

If, on the one hand, the agreement between the Corporations Under Specific Legislation (Law societies) and the Human Sciences gave the possibility to better discuss the complex topics of the relationship between form and content; On the other hand, it shows how the implementation of a flexible and global tool for a qualitative

and quantitative analysis of the phenomenon, which includes effective strategies for an adequate care of patient/inmate, is still too fragile.

Furthermore, 7 years after the DPCM, which was held on the 1<sup>st</sup> April 2008, it cannot be denied that the difficulty in harmonising planning and actions represented food for thought, which gave impulse for a renewed and ameliorated management of the main conceptual issues related to the link between prison and mental health, by detecting the real and perceived figures of mental disorders in the penitentiary sector.

The main purpose is to implement both quantitative and qualitative significant interventions as well as effective pathways for a therapeutic custodial rehabilitation and pathways for an intra-professional training and to subsequently optimise human resources. This study must be carried out with the awareness that detecting the “perceived” figures is not only an abstract intention, but a concrete and possible challenge.

## ***METHODOLOGY AND TOOLS***

A mixed methodology was chosen for the wide field of investigation, namely a ***psychometric prospective***, with the purpose of showing the unseen figures of “perceived” mental distress related to detention. Such methodology guarantees a quantitative approach to the phenomenon to be studied, through well-structured surveys which will be given to the various professionals; a ***clinical perspective*** within the framework of medical practices, which include medical history interviews and collection of objective data.

As far as the anatomic study of the difficult correlation between mental health and prison is concerned, a well-studied tool, which has been diversified for the different professional profiles – Ministries, Security staff for Penitentiary Administration and National healthcare staff - who, although being equally involved, have different roles and perspectives based upon the knowing of single episodes and cases.

With the purpose of achieving specific knowing, *surveys* are considered to be the best tool in order to detect and evaluate information, which takes into consideration the correlation among *individual-environment-lifestyle*, for the following goals:

- a) Collecting necessary information to elaborate intervention plans;
- b) Providing an analysis of the officers' attitudes and opinions also considering their different cultures and professional roles;
- c) Identifying the most suitable strategies elaborated by individuals and groups with different backgrounds but operating in the same context, so as to detect the environmental and relational conditions, which either favour or hinder professional interventions in the penitentiary field.

Thus, the surveys are elaborated to collect some *personal data of the respondents* such as: age, gender, professional qualification, role, years of service, knowledge of the study-related topics, given the added value that such elements represent for a correct quantitative and qualitative interpretation of data.

In our view, the methodological approach adopted as well as the evident complexity of the tools included in the survey worksheets enabled us to create useful assets for further research, equally based on the theoretical knowledge and the specific professional experience of the respondents.

## ***STUDY OUTCOMES***

The following paragraphs and charts summarise the statistical processing resulting from the survey worksheets used for the study.

Each chart will be presented as a whole before deducing from each chart those parts which emphasise the items with a higher correlation level, evaluated on the basis of the different worksheets included in the survey for each professional profile and with respect to the three target Penitentiary Institutions. This choice hinges on the study goals, which were previously mentioned in the introductory remarks to the study, but will not hinder further considerations which can be made by analyzing the data as a whole.

Therefore, the following charts must be considered as a source for other possible remarks, which are not taken into account in the present study.

After the initial analytical phase, in the final considerations, our interpretation will be given by combining figures of different charts, which will be presented so as to answer the questions of the study.

For the sake of simplifying, the charts are classified in four macro-areas:

- 1. Survey on interviewed individuals;***
- 2. Survey on mental distress;***
- 3. Survey on intervention strategies;***
- 4. Survey on real data.***

## ***1.SURVEY ON INTERVIEWED INDIVIDUALS***

The sample for the survey encompasses **368** subjects from the target institutions, of whom:

**235** from custodial staff

**34** from rehabilitation and managerial staff

**99** from the healthcare staff

More specifically, the nursing staff sample consists of **68** subjects:

*Palermo*: 28;

*Bologna*: 18;

*Turin*: 22.

The healthcare personnel sample consists of **31** subjects:

*Palermo*: 21;

*Bologna*: 3;

*Turin*: 7.

The rehabilitation officer sample consists of **34** subjects:

*Palermo*: 12;

*Bologna*: 5;

*Turin*: 17.

The penitentiary police staff sample consists of **235** subjects:

*Palermo*: 64;

*Bologna*: 82;

*Turin*: 89.

Survey-related information from respondents such as gender, age, knowledge of main topics of the study is summarised in this first part.

## GENDER

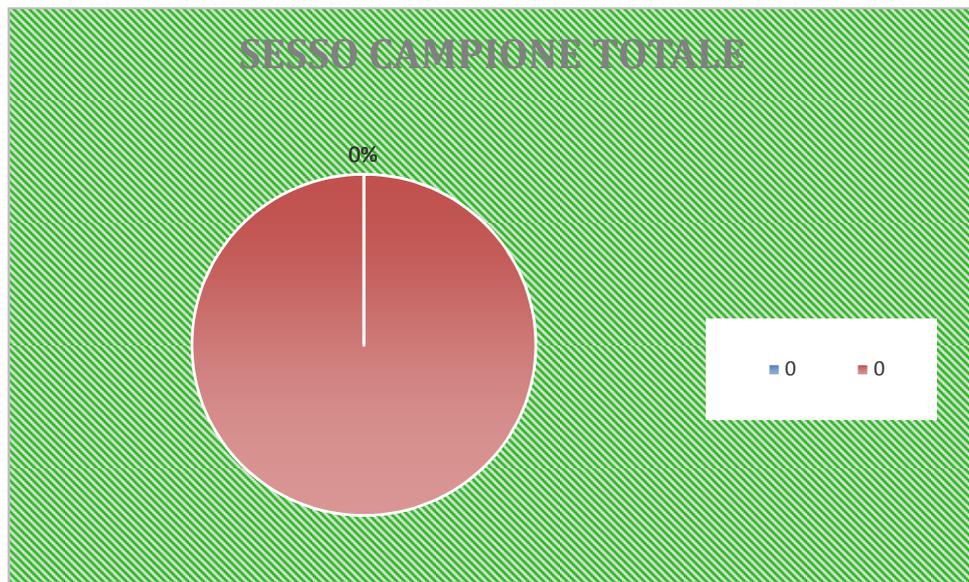
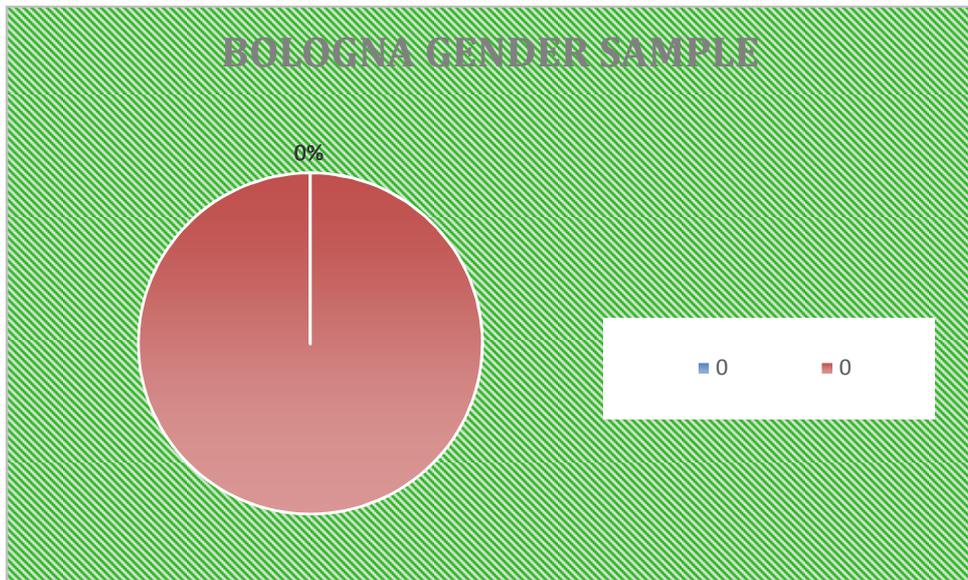


Chart. 1.1

[TOTAL GENDER SAMPLE]

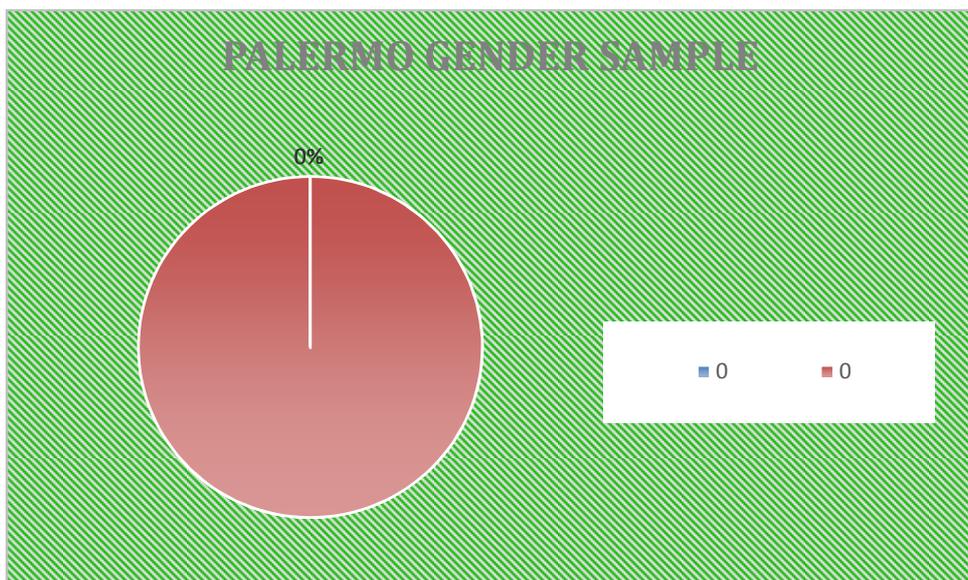
As shown in chart 1.1, the respondents are mostly male: **237** males and **102** females. Such gender difference can explain the diverging responses as for the topic in question.

The measures of the sample for each single institute are shown in the following charts:

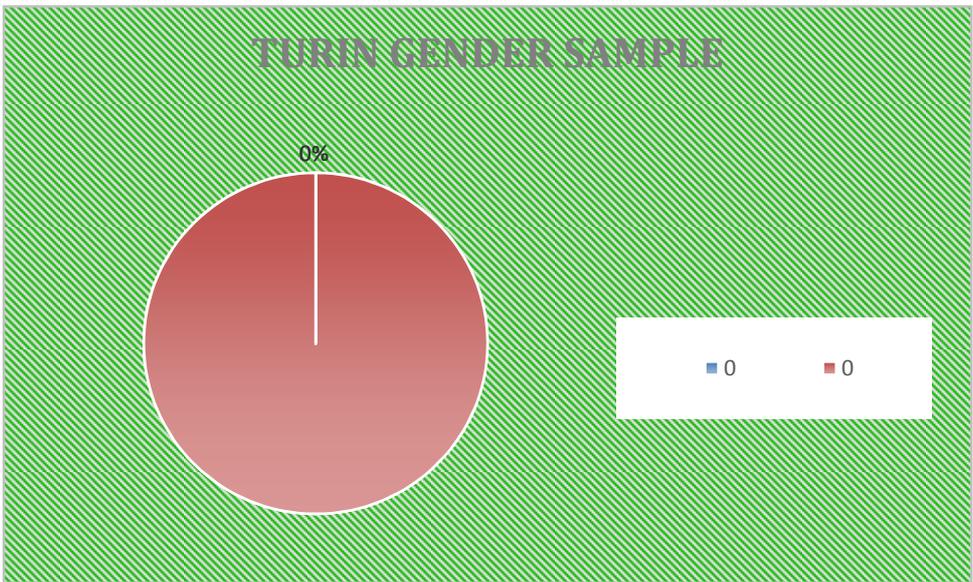


**Chart. 1.2**

[BOLOGNA GENDER SAMPLE]



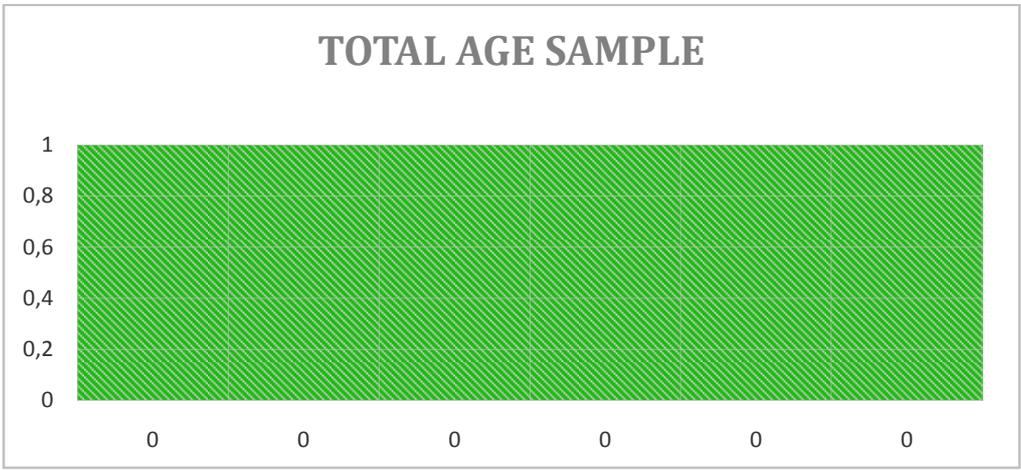
**Chart. 1.3**



**Chart. 1.4**

**AGE**

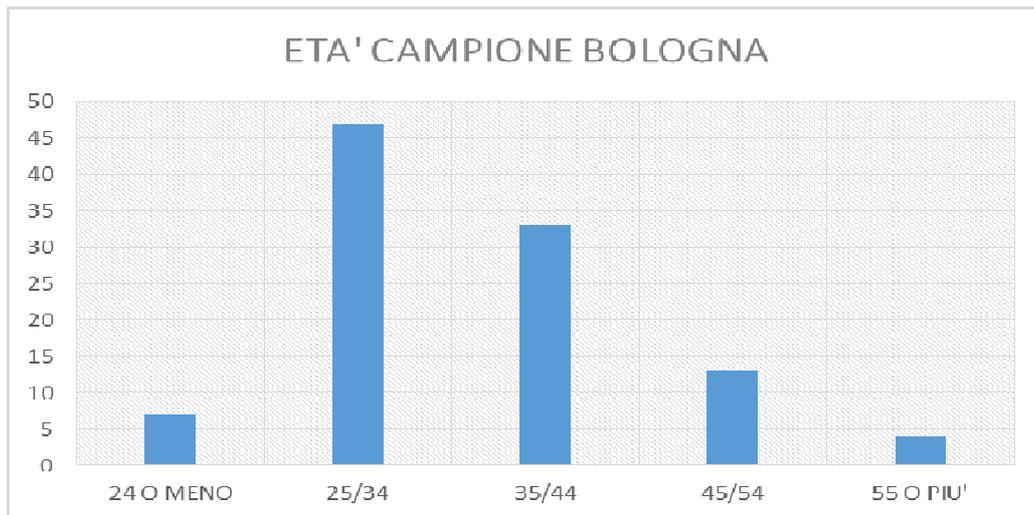
Data shows that respondents' age mostly ranges from 35-44 years (young adults chart 1.5)



**Chart. 1.5**

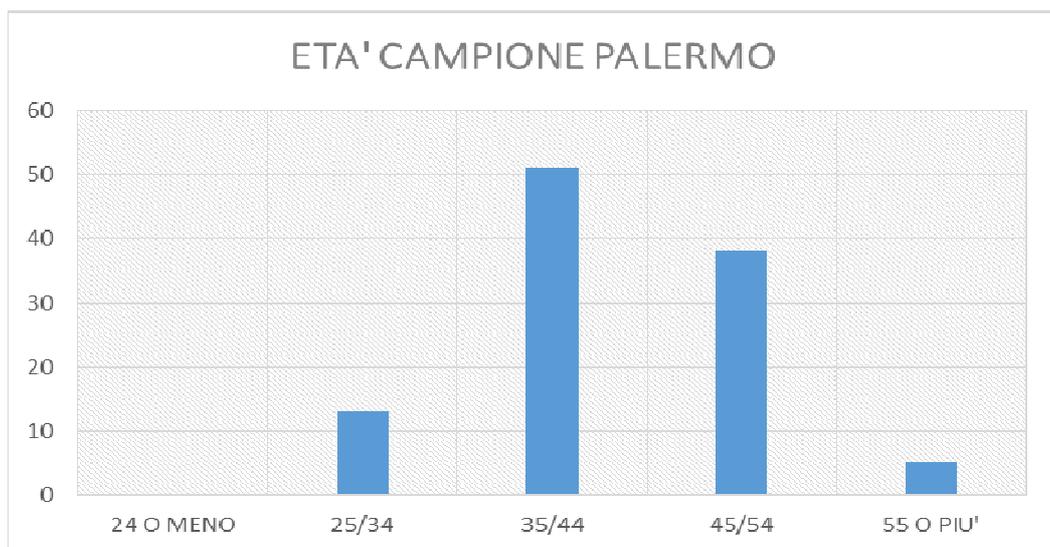
[TOTAL AGE SAMPLE]

Age-based distribution for each single institute is shown in charts 1.6;1.7;1.8



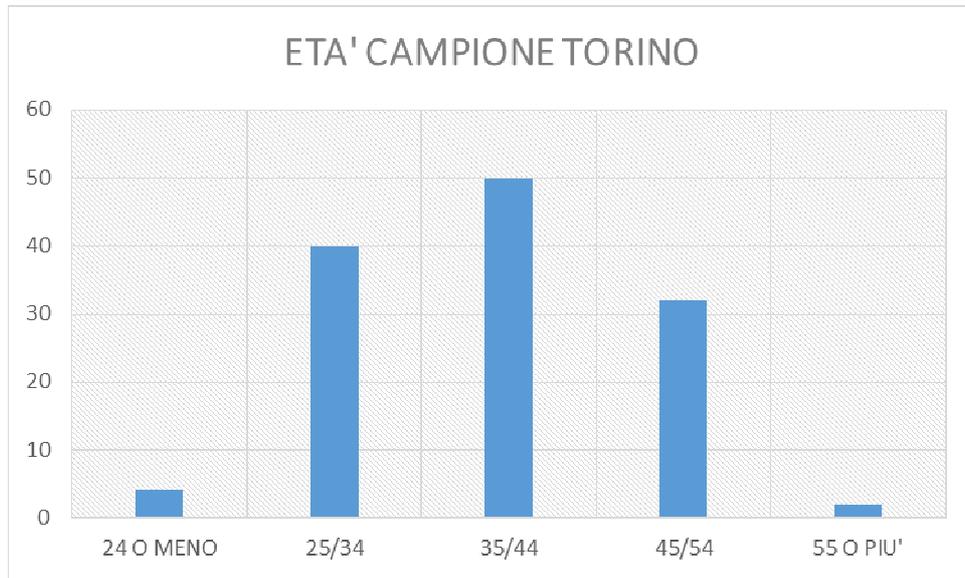
**Chart.1.6**

BOLOGNA AGE SAMPLE



**Chart. 1.7**

## PALERMO AGE SAMPLE



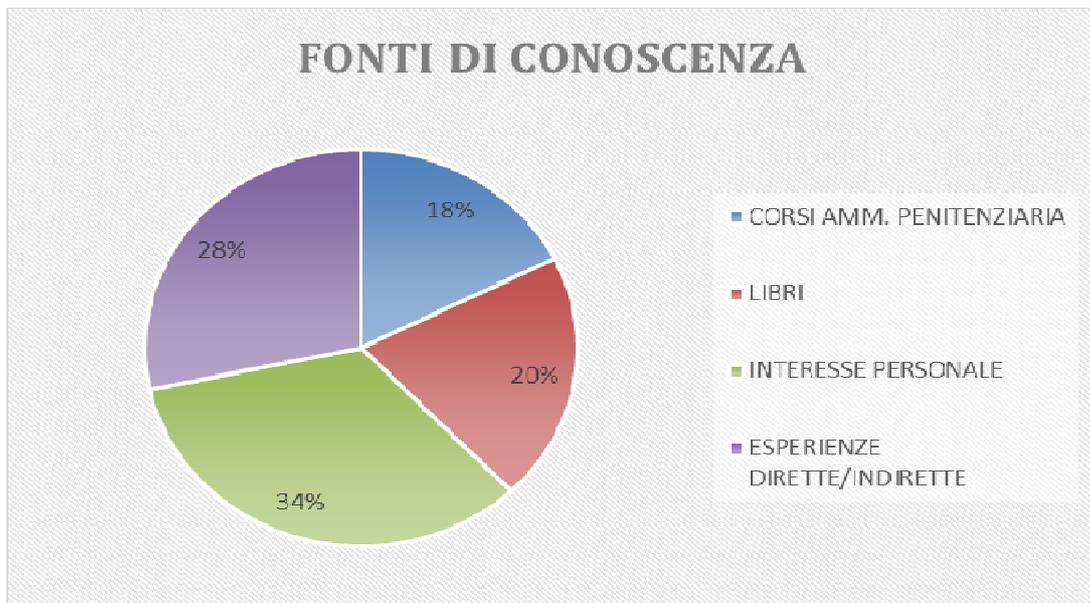
**Chart. 1.8**

## TORINO AGE SAMPLE

## ***SOURCES OF KNOWLEDGE***

Every respondent was interviewed as for the sources of knowledge related to the study at issue.

The sources of knowledge for the different professions are shown in charts 1.9;1.10;1.11;1.12 , while data from healthcare personnel (from each institute) indicating professional qualification is shown in charts 1.13;1.14;1.15



[Sources of knowledge]

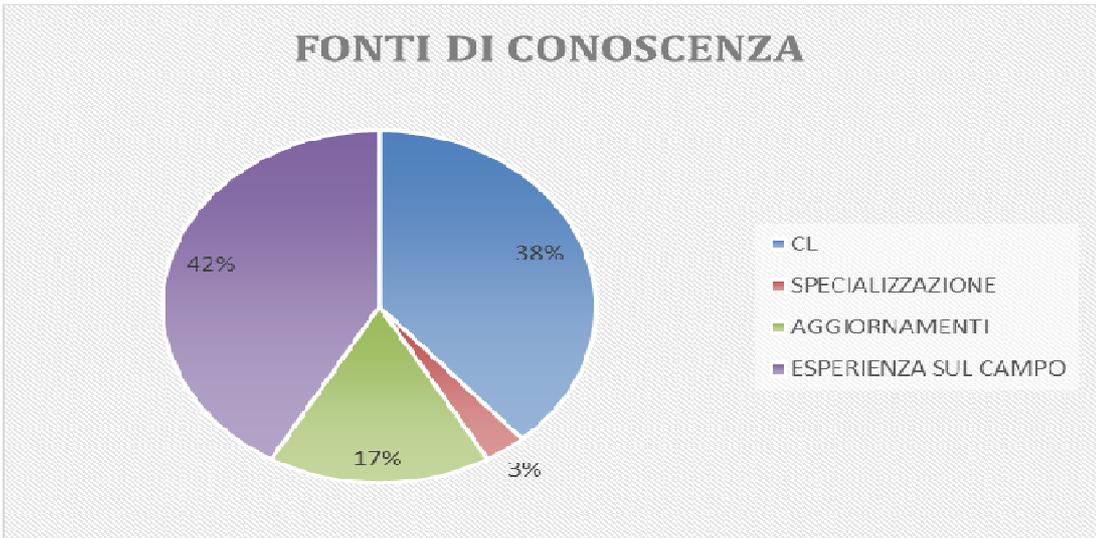
PENITENTIARY ADM. TRAINING COURSES

BOOKS

PERSONAL INTEREST

DIRECT AND INDIRECT EXPERIENCES

**Chart. 1.9 Rehabilitation officers**



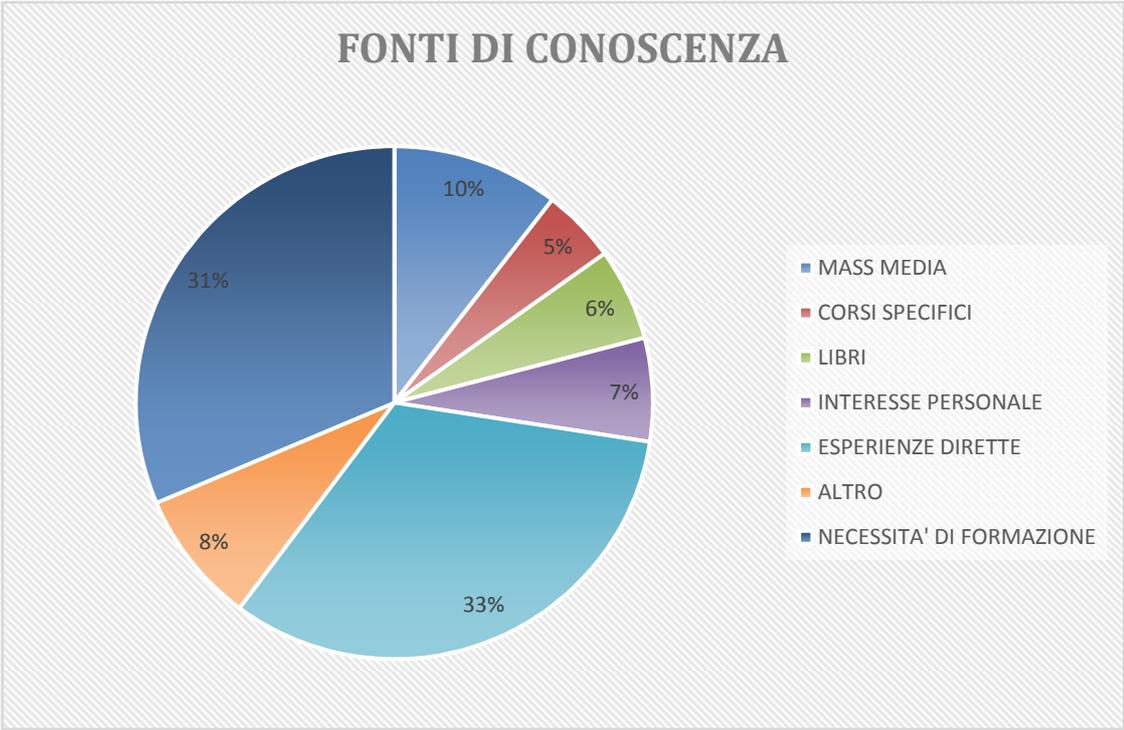
**Tab. 1.10 Nurses**

**CL**

**SPECIALISATION**

**PROFESSIONAL UPDATE**

**ON-THE-JOB EXPERIENCE**



MASS MEDIA

SPECIFIC COURSES

BOOKS

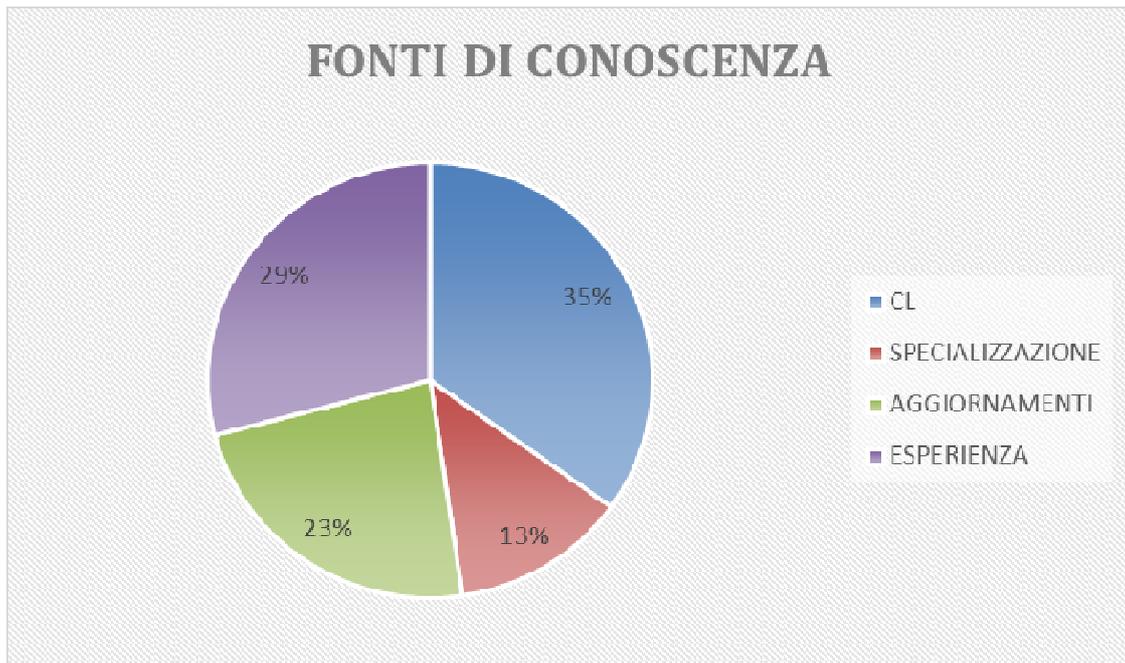
PERSONAL INTEREST

DIRECT EXPERIENCE

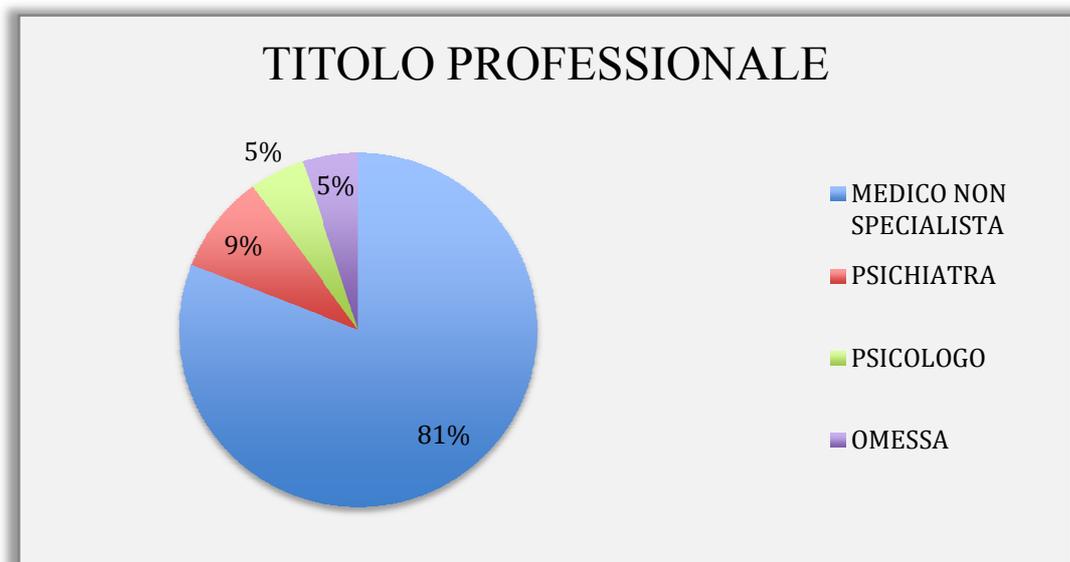
OTHER

TRAINING NEEDS

**Chart. 1.11 Penitentiary police staff**

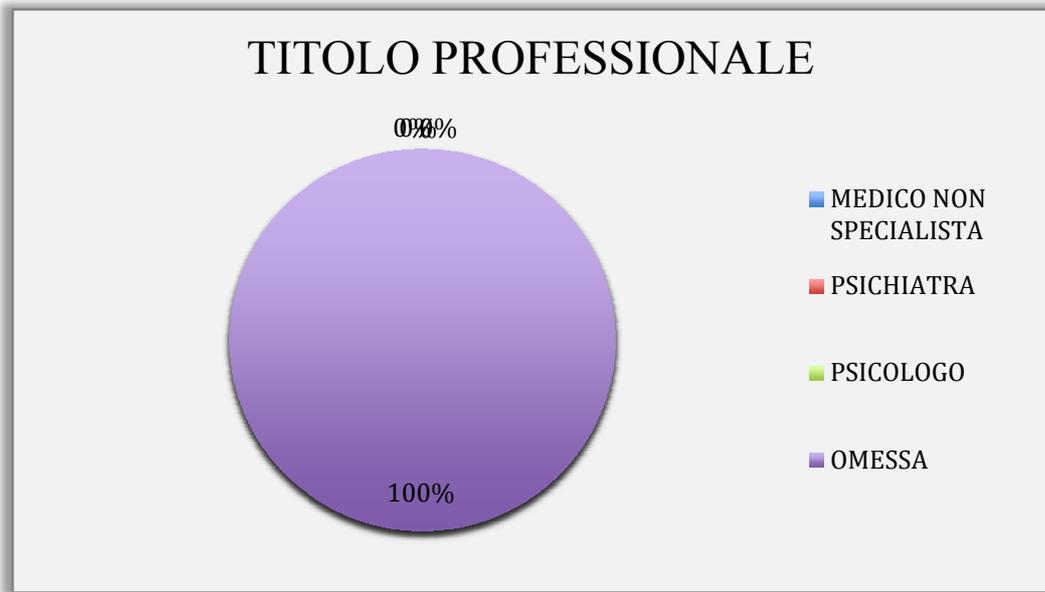


**Chart 1.12 Healthcare personnel**



[professional qualification]

**Chart 1.13 Palermo healthcare personnel**



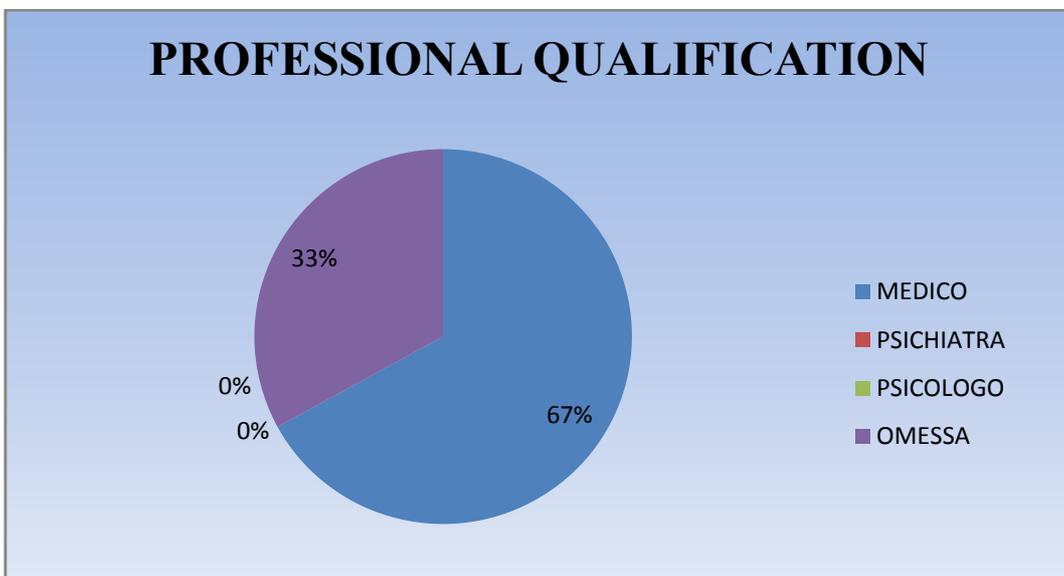
**General practitioner**

**Psychiatrist**

**Psychologist**

**Omitted**

**Chart. 1.14 Torino Healthcare personnel**



medical practitioner

psychiatrist

psychologist

omitted

**Tab. 1.15 Bologna Healthcare**

The analytical description in this section aims at taking into account the purpose of such study, intended to provide data as fully as possible, also pending the forthcoming training proposal, a fully integrated part of Me.D.I.C.S., which will be developed within specified Penitentiary facilities representing the national study.

The qualitative features emerging from observations made on sources of knowledge among the target population, although the roles taken into account are extremely different, contribute to develop the awaited “narrative lens” which, furthermore, refers to the framework of the training project as an extension of such paper and as a possible feedback of the training expectations specified in Chart 1.11. This request may be seen in its dual dimension: on the one hand, a greater and efficient involvement into treatment activities and activities with a community relevance; on the other hand, the establishment of a working group comprising officers who speak different languages.

In order to enhance the readability of data based on gender, it is important to stress that the significant difference in percentage among male and female population in the Penitentiary Police Staff can be explained by the ban on working in custodial sections for the opposite sex. This equally applies to male employees even though the male population in the penitentiary staff consists of 96%.

## **1. *SURVEY ON MENTAL DISTRESS***

In this second part the purpose was to emphasise the epidemiology of mental disorders caused by imprisonment.

It was possible to establish those items attributed to detention syndromes which, as resulting from recorded data, cause distressed and oppressive sensations in the subjects, phobic disorders, fear for physical safety, insomnia, loss of appetite, inability to manage emotions, serious anxiety state, call for pharmacological help, self-harming behaviours that may define the detention experience as a psycho-neuro endocrine stress.

The charts obtained from the analysis of the surveys administered to the different professionals involved in the study are specified below.

## *PENITENTIARY POLICE STAFF*

### *“IMPAIRMENT OF PSYCHOLOGICAL STABILITY”*

Subjects were asked to give their views on what they believe could be the cause of this extreme distress of inmates that may lead to desperate behaviours such as self-harming gestures, hunger strikes or suicide attempts. The tool provides a series of items (potential situations of extreme distress) and subjects had to give their opinion on the basis of a Likert scale. The penitentiary police staff sample answered homogeneously identifying key factors for the impairment of psychological stability such as:

- 1) **depression**
- 2) **detention-related stress;**
- 3) **simulation for judicial purposes;**
- 4) **drugs use;**
- 5) **psychosis;**
- 6) **psychotropic drugs abuse;**

**Homosexual panic** and **sense of guilt for a crime** can be added, although at lowest percentage.

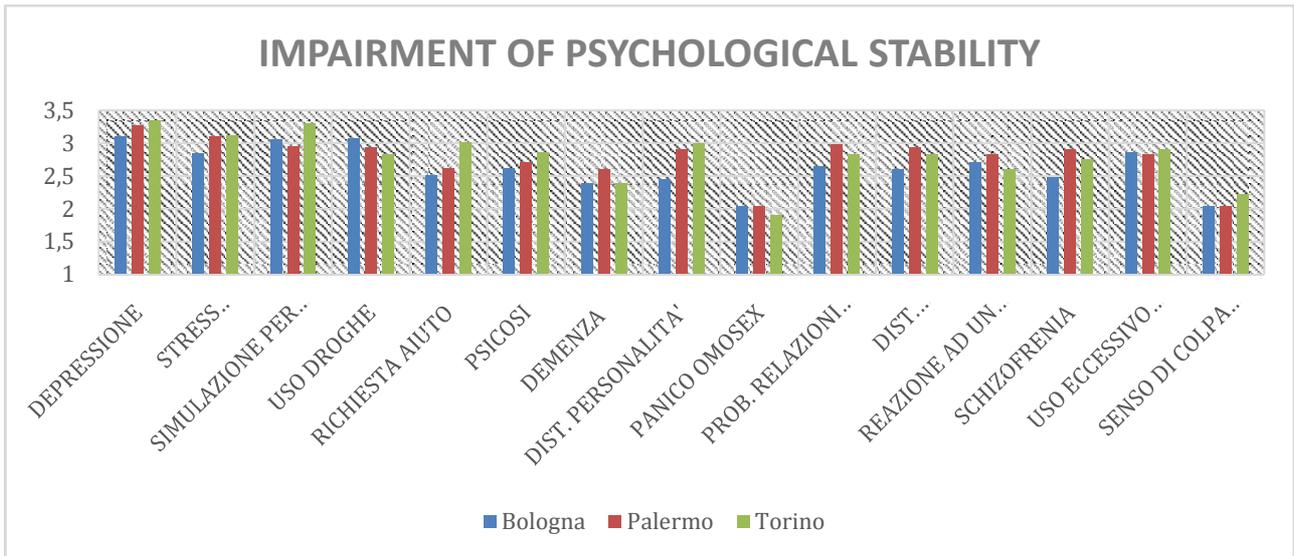
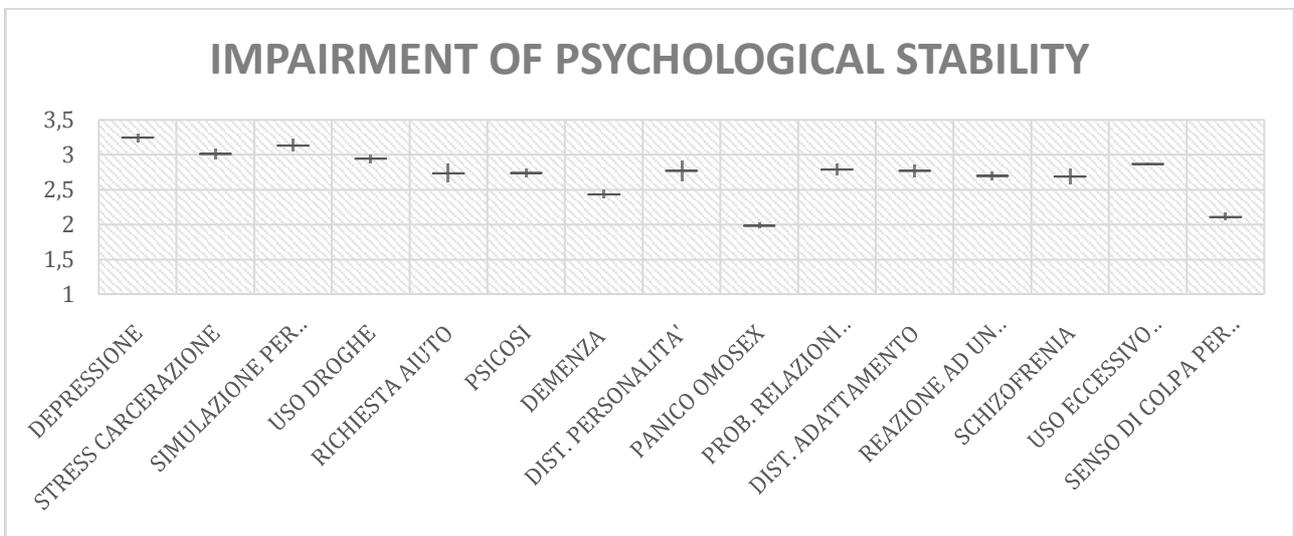


Chart 2.1

Y(abcissa): Likert's scale measures

X(ordinate): Item

**DEPRESSION – STRESS – SIMULATION FOR JUDICIAL PURPOSES – DRUGS USE – CALL FOR HELP – PSYCHOSIS- DEMENTIA – PERSONALITY DISORDER – HOMOSEXUAL PANIC – RELATIONSHIP-RELATED ISSUES – DISORDER – REACTION TO... - SCHIZOPHRENIA- PSYCHOTROPIC ABUSE- SENSE OF GUILT FOR A CRIME.**



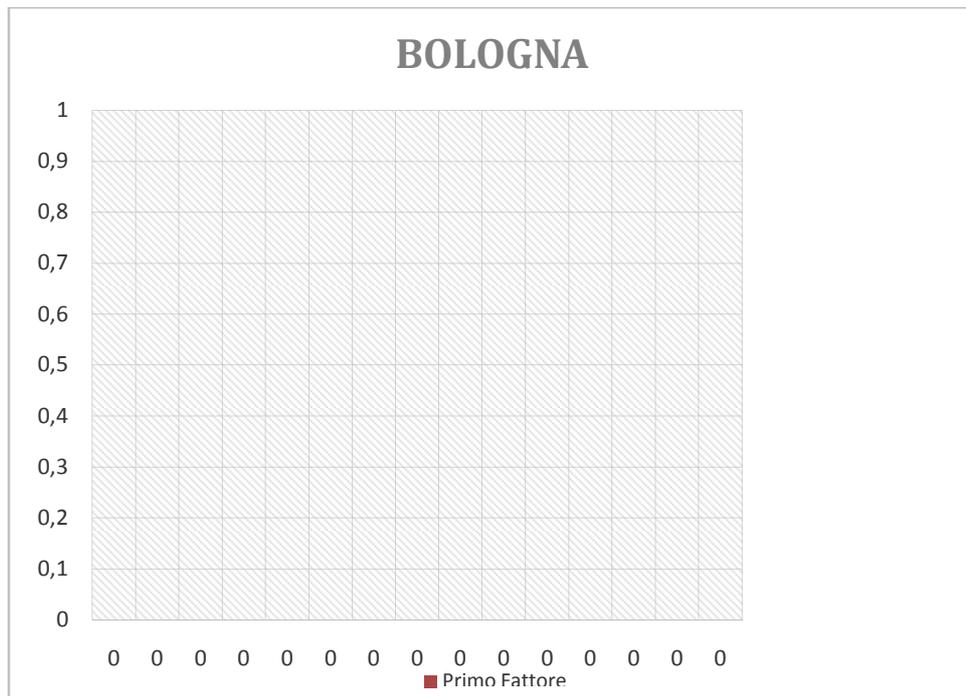
**Chart. 2.2**

Y(abcissa): Likert's scale measures

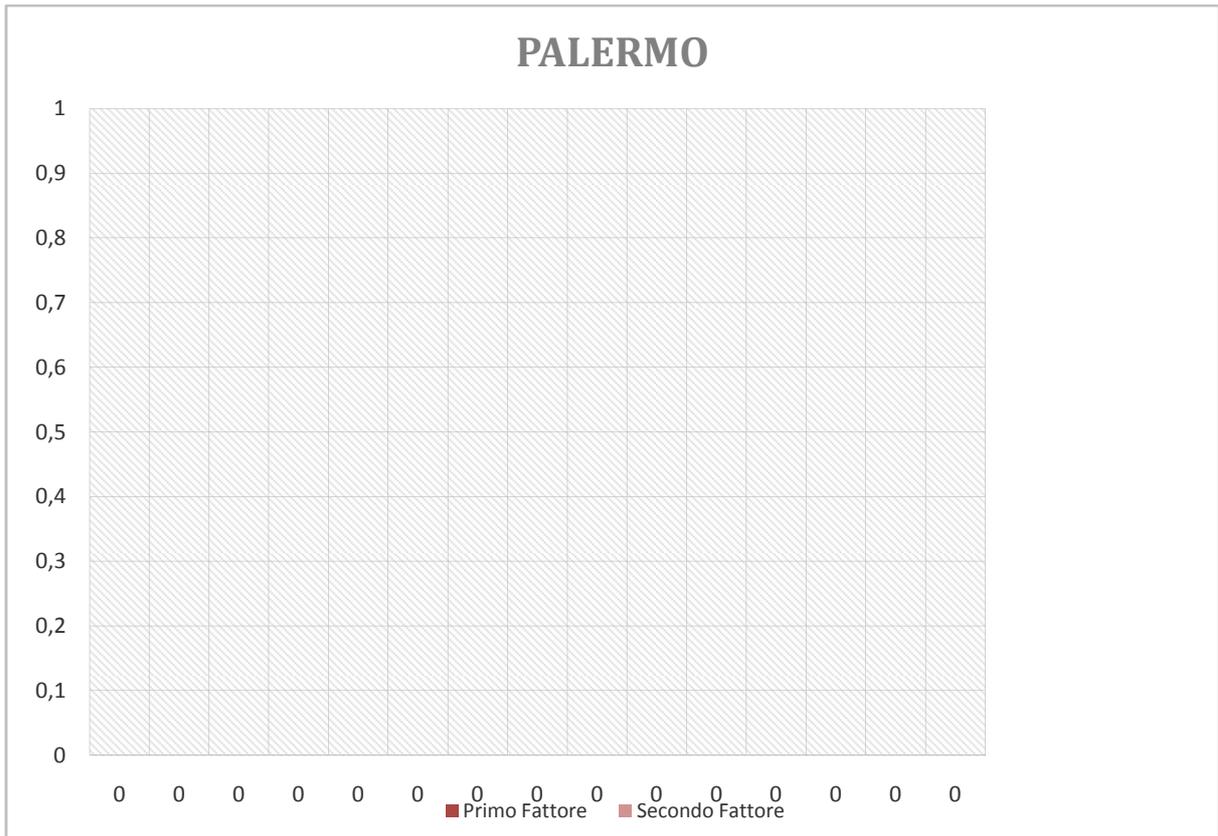
X(ordinate): Item

**DEPRESSION – STRESS – SIMULATION FOR JUDICIAL PURPOSES – DRUGS USE  
– CALL FOR HELP – PSYCHOSIS- DEMENTIA – PERSONALITY DISORDER –  
HOMOSEXUAL PANIC – RELATIONSHIP-RELATED ISSUES – DISORDER –  
REACTION TO... - SCHIZOPHRENIA- PSYCHOTROPIC ABUSE- SENSE OF  
GUILT FOR A CRIME.**

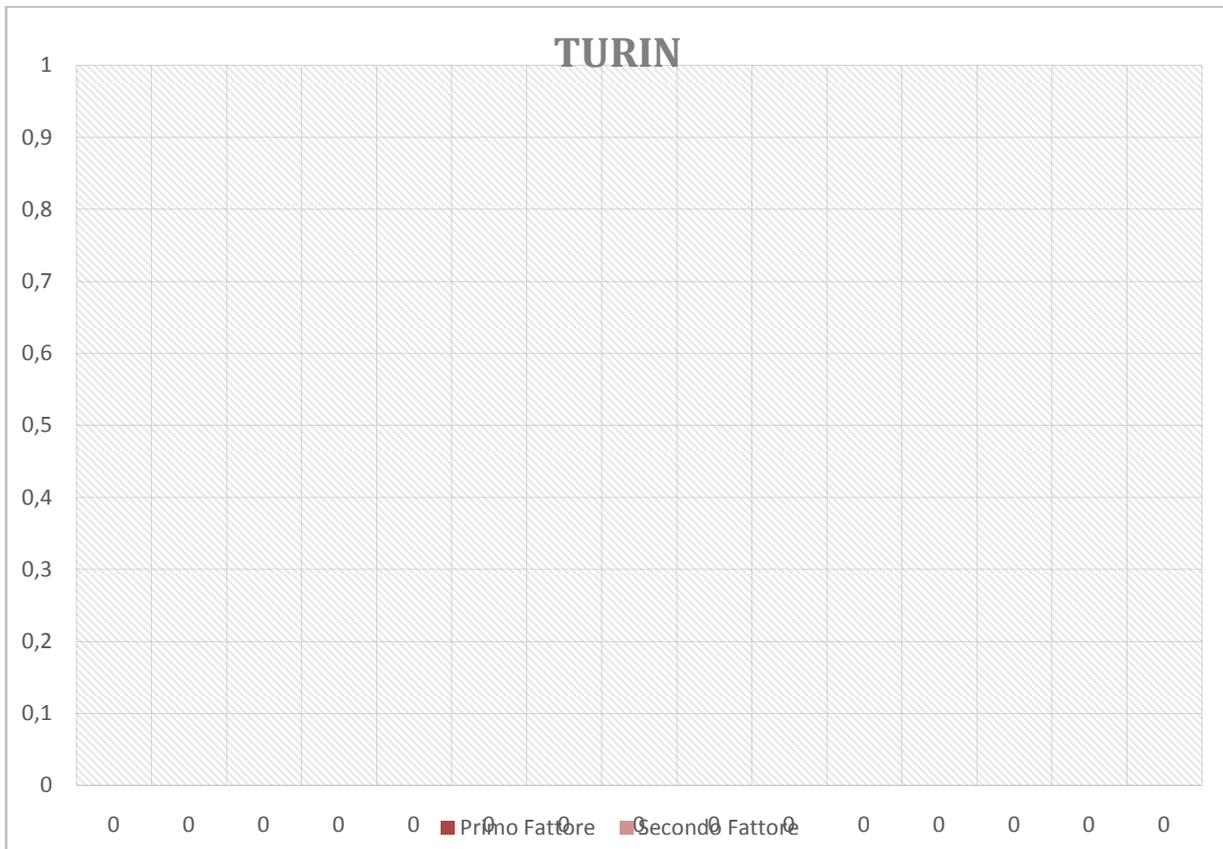
The following charts provide the first and second item identified as expression of extreme distress.



**Chart. 2.3**



**Chart. 2.4**



**Chart 2.5**

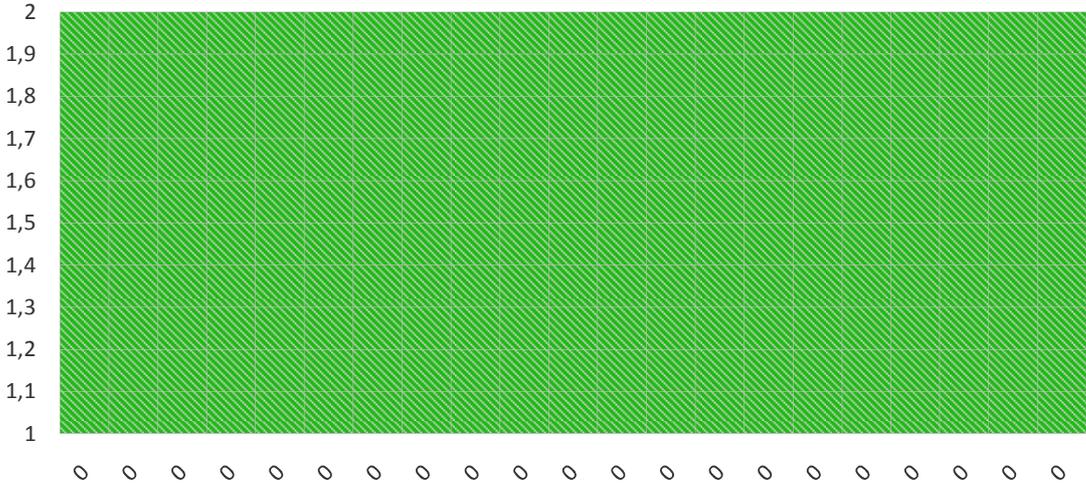
## ***PENITENTIARY POLICE STAFF***

### ***“CONTRIBUTORY CAUSES IMPLYING DISTRESS”***

Subjects were asked to give their views on what they believe could be the contributory cause of distress. The tool provided a series of items (potential factors of distress) and subjects had to give their opinion on the basis of a Likert scale. The penitentiary police staff sample answered homogeneously identifying key items for distress such as:

- 1) absence of aid from others;***
- 2) growing up in a dysfunctional family;***
- 3) vulnerable personality;***
- 4) drugs use;***
- 5) have suffered sexual harassment;***
- 6) unemployment.***

# DISTRESS ITEMS



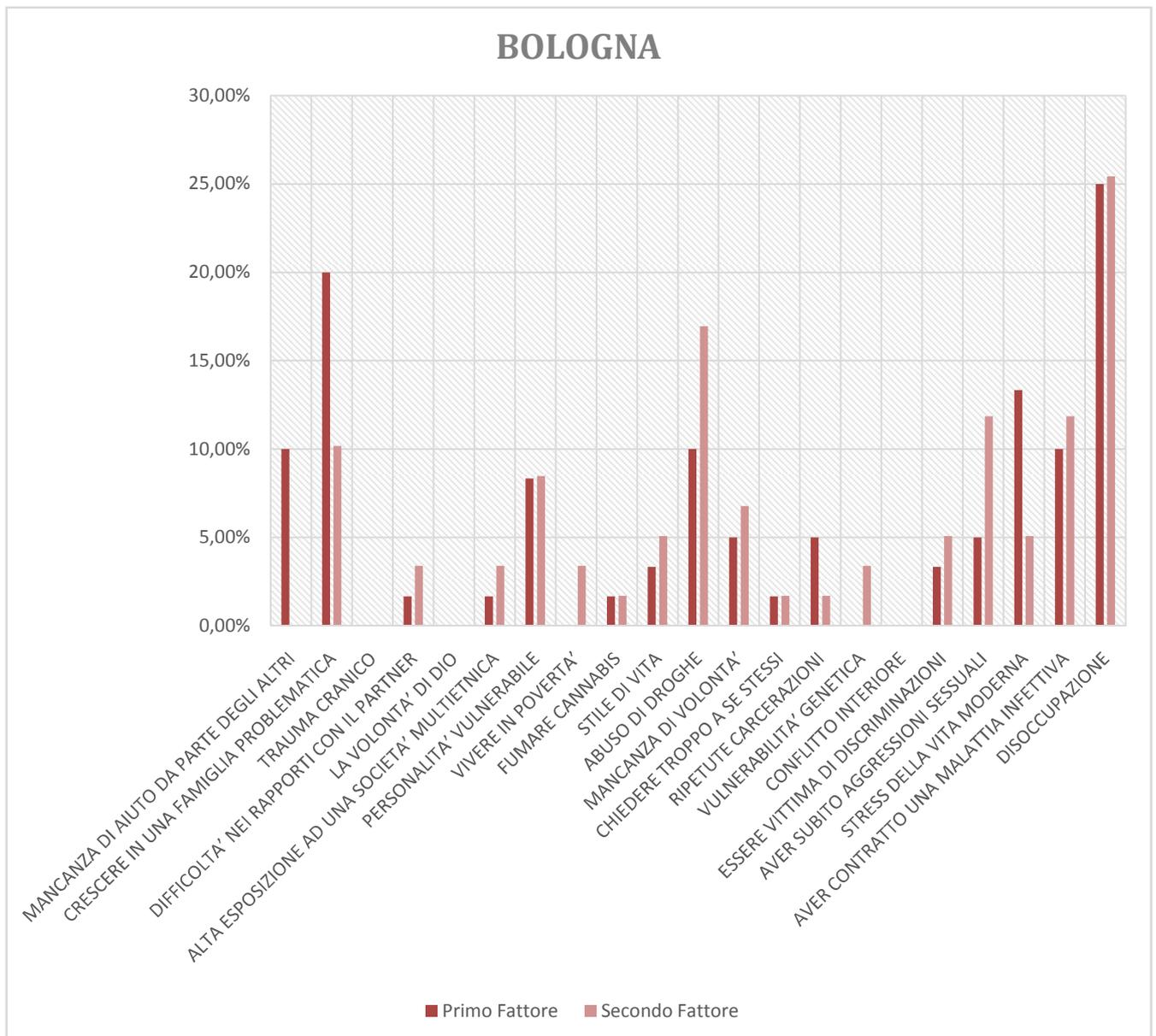
■ Bologna ■ Palermo ■ Torino

**Chart. 2.6**

**Y(abcissa): Likert's scale measures**

**X(ordinate): Item**

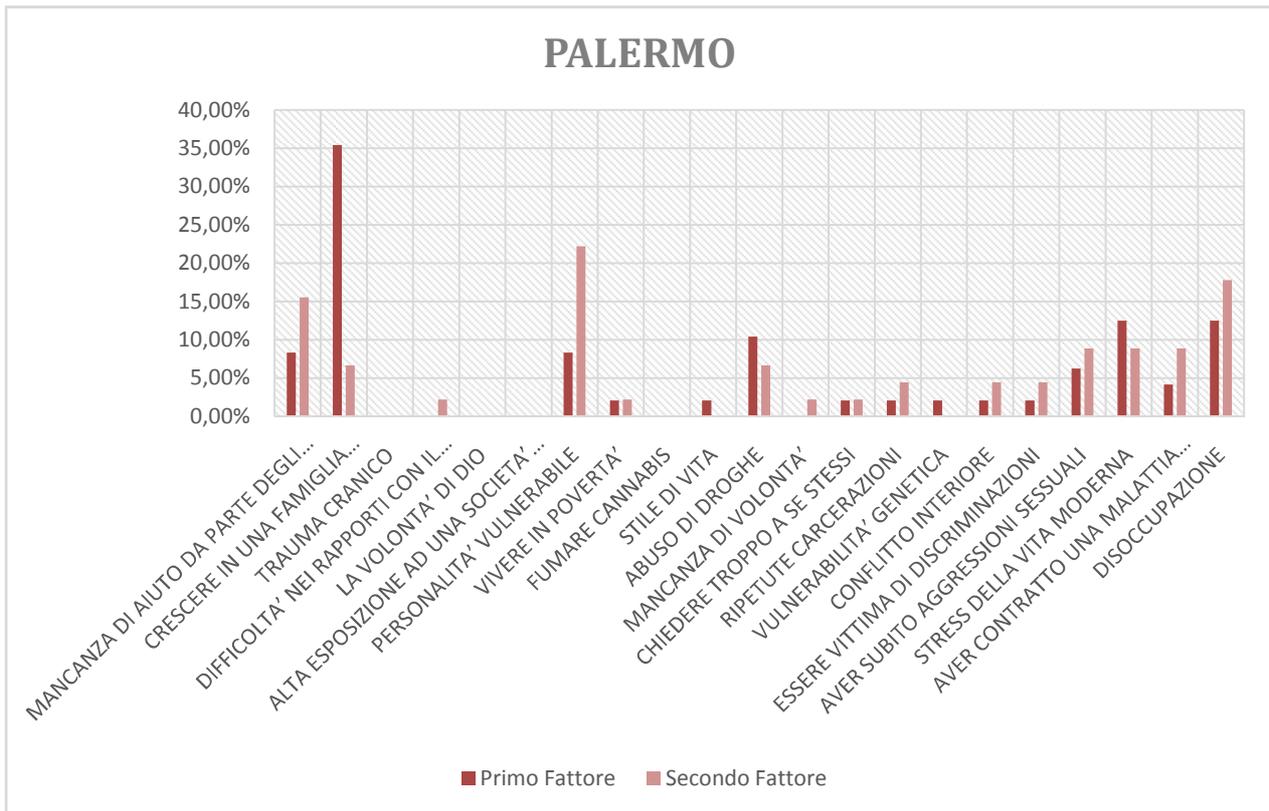
The following charts provide the first and second item identified as contributory cause implying psychopathological distress.



**Chart 2.7**

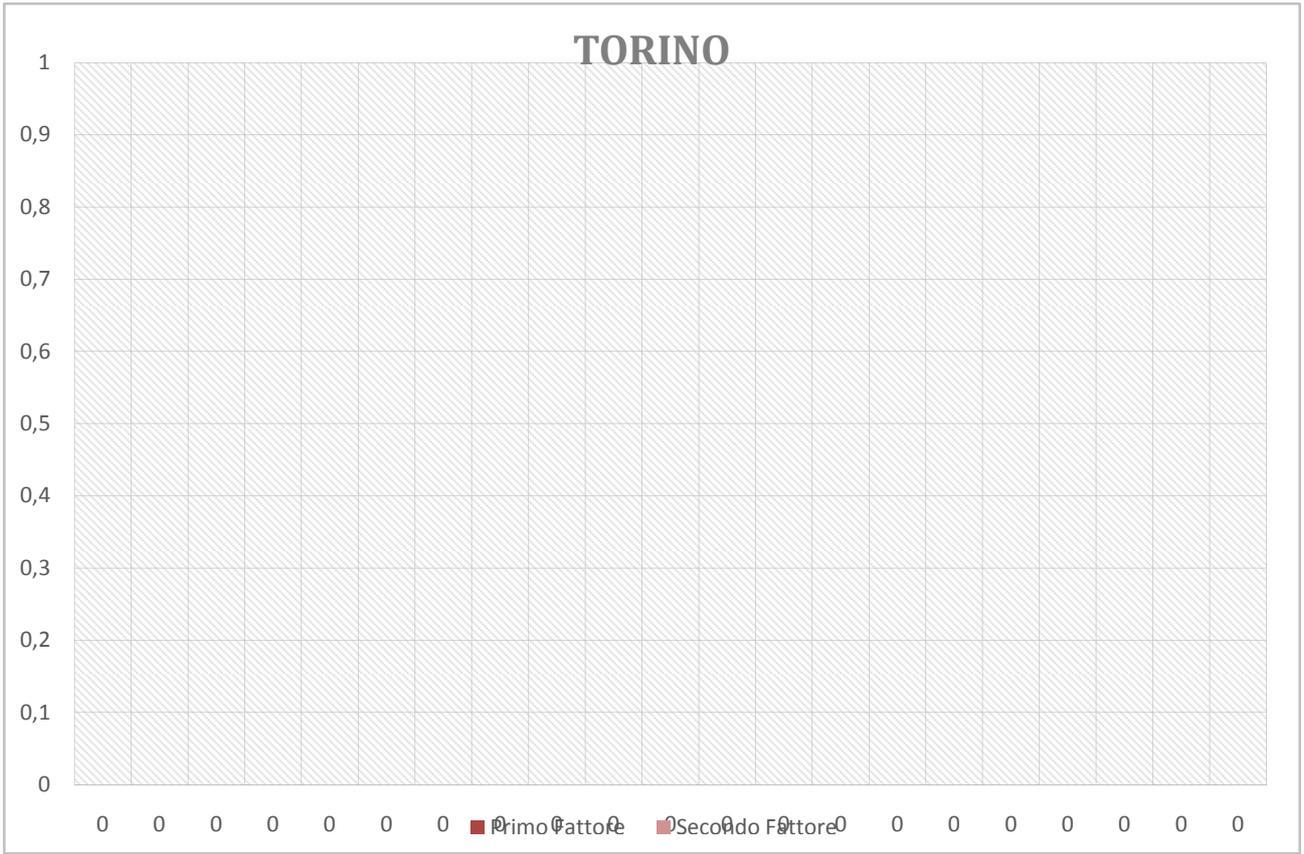
ABSENCE OF AID FROM OTHERS – GROWING UP IN A DYSFUNCTIONAL FAMILY-  
 TRAUMATIC BRAIN INJURY- DIFFICULTIES IN THE RELATION WITH PARTNERS- GOD’S WILL  
 – HIGH-EXPOSURE TO MULTI-ETHNIC SOCIETY- VULNERABLE PERSONALITY- LIVING IN  
 POVERTY - SMOKING CANNABIS- LIFESTYLE- DRUGS ABUSE- UNWILLINGNESS-

DEMANDING TOO MUCH FROM ONESELF – REPEATED INPRISONMENTS- GENETIC VULNERABILITY- INNER CONFLICT- BEING A VICTIM OF DISCRIMINATION- HAVING SUFFERED SEXUAL HARASSMENT – MODERN LIFE-RELATED STRESS- CONTRACTING AN INFECTIOUS DISEASE- UNEMPLOYMENT.



**Chart 2.8**

ABSENCE OF AID FROM OTHERS – GROWING UP IN A DYSFUNCTIONAL FAMILY- TRAUMATIC BRAIN INJURY- DIFFICULTIES IN THE RELATION WITH PARTNERS- GOD’S WILL – HIGH-EXPOSURE TO MULTI-ETHNIC SOCIETY- VULNERABLE PERSONALITY- LIVING IN POVERTY - SMOKING CANNABIS- LIFESTYLE- DRUGS ABUSE- UNWILLINGNESS- DEMANDING TOO MUCH FROM ONESELF – REPEATED INPRISONMENTS- GENETIC VULNERABILITY- INNER CONFLICT- BEING A VICTIM OF DISCRIMINATION- HAVING SUFFERED SEXUAL HARASSMENT – MODERN LIFE-RELATED STRESS- CONTRACTING AN INFECTIOUS DISEASE- UNEMPLOYMENT.

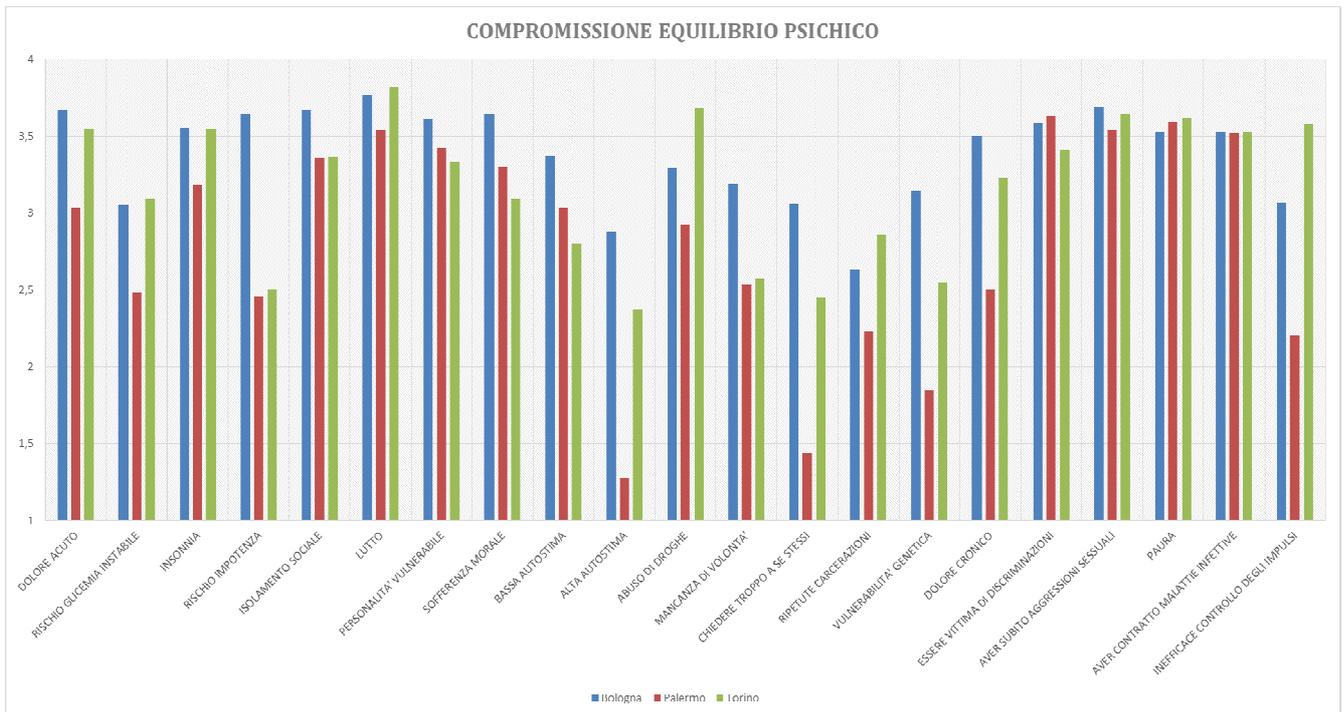


**Chart 2.9**

## ***NURSES***

### ***“IMPAIRMENT OF PSYCHOLOGICAL STABILITY”***

Subjects were asked to give their views on what they believe could be the cause of the impairment of psychological stability of individuals in detention. The tool provides a series of items (potential factors of distress) and subjects had to give their opinion on the basis of a Likert scale.



**Chart 2.10 Nurses**

**Y(abcissa):** Likert's scale measures

**X(ordinate):** Item

SEVERE PAIN- RISK OF UNSTABLE GLYCAEMIA- INSOMNIA- RISK OF IMPOTENCE- SOCIAL ISOLATION- GRIEF- VULNERABLE PERSONALITY- MORAL SUFFERING- LOW SELF-ESTEEM - HIGH SELF-ESTEEM – DRUGS ABUSE – UNWILLINGNESS- DEMANDING TOO MUCH FROM ONESELF- REPEATED INPRISONMENTS- GENETIC VULNERABILITY- CHRONIC PAIN- BEING A VICTIM OF DISCRIMINATION- HAVING SUFFERED SEXUAL HARASSMENT- FEAR- CONTRACTING AN INFECTIOUS DISEASE- INEFFICIENT IMPULSE CONTROL.



Chart 2.11 Nurses

Y(abcissa): Likert's scale measures

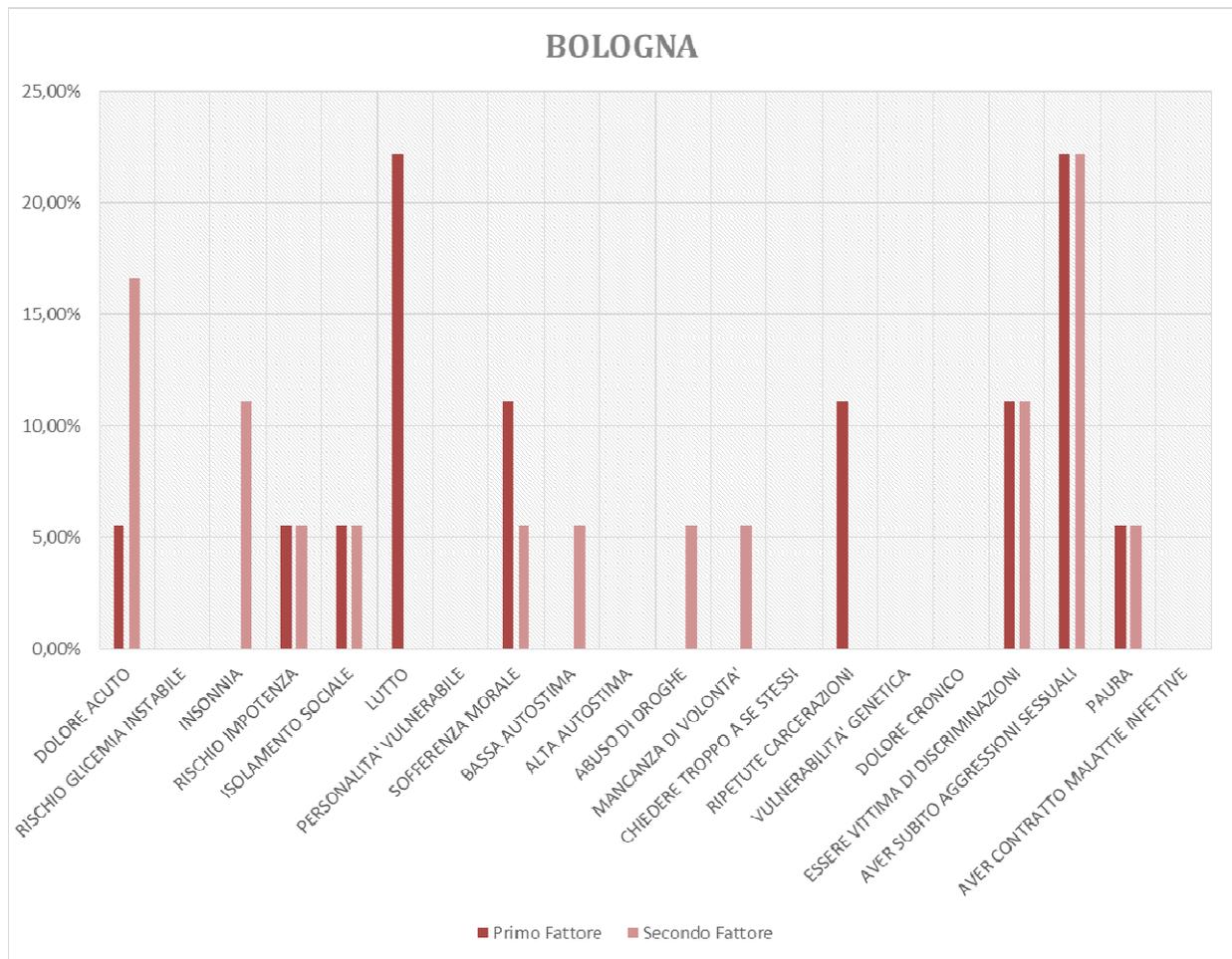
X(ordinate): Item

SEVERE PAIN- RISK OF UNSTABLE GLYCAEMIA- INSOMNIA- RISK OF IMPOTENCE- SOCIAL ISOLATION- GRIEF- VULNERABLE PERSONALITY- MORAL SUFFERING- LOW SELF-ESTEEM - HIGH SELF-ESTEEM – DRUGS ABUSE – UNWILLINGNESS- DEMANDING TOO MUCH FROM ONESELF- REPEATED INPRISONMENTS- GENETIC VULNERABILITY- CHRONIC PAIN- BEING A VICTIM OF DISCRIMINATION- HAVING SUFFERED SEXUAL HARASSMENT- FEAR- CONTRACTING AN INFECTIOUS DISEASE- INEFFICIENT IMPULSE CONTROL.

The three institutions answered homogeneously identifying as key items:

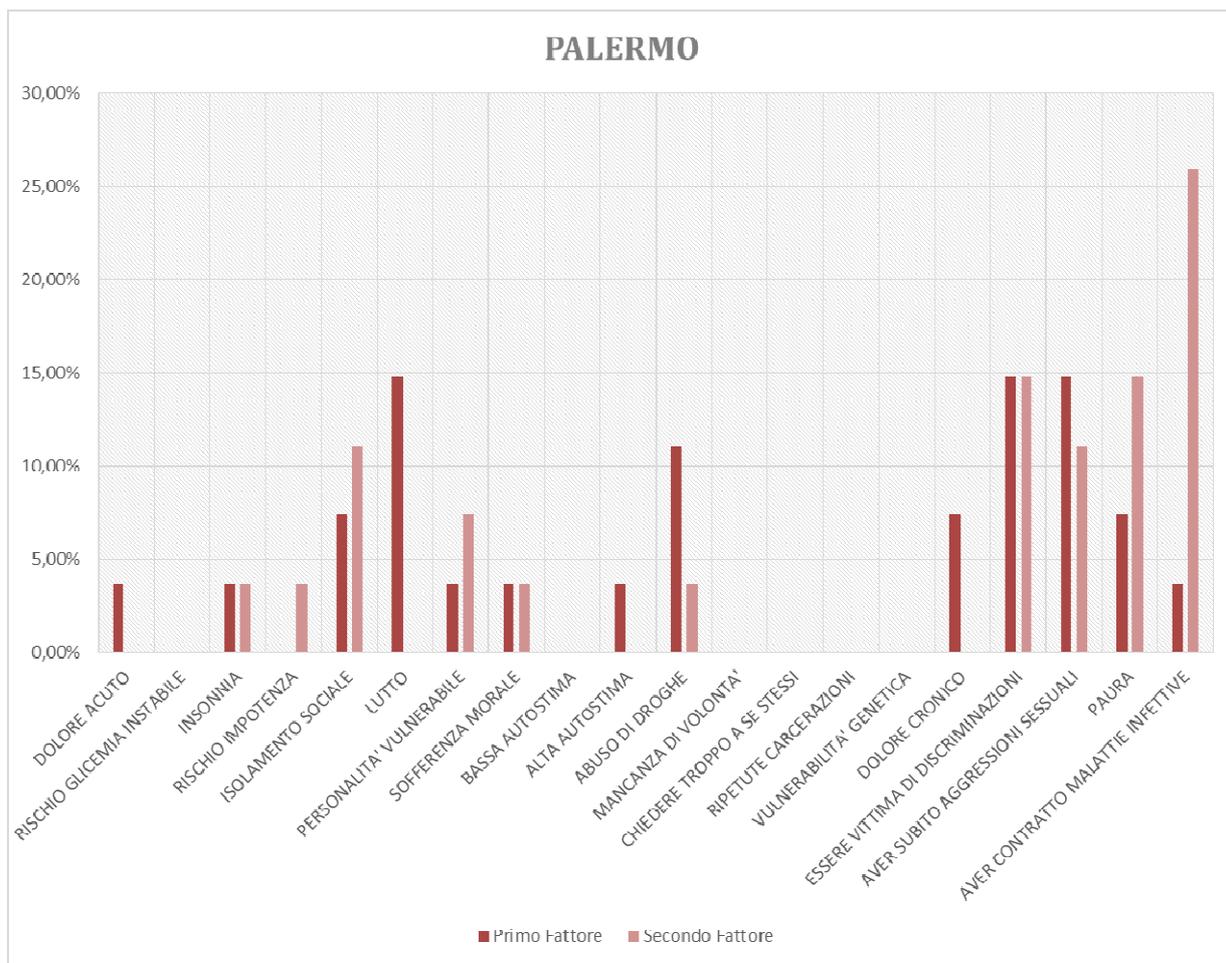
- 1) **grief;**
- 2) **contracting infectious diseases;**
- 3) **fear;**
- 4) **having suffered sexual harassment;**
- 5) **being a victim of discrimination.**

The following tables provide the first and second item causing impairment of psychological stability.

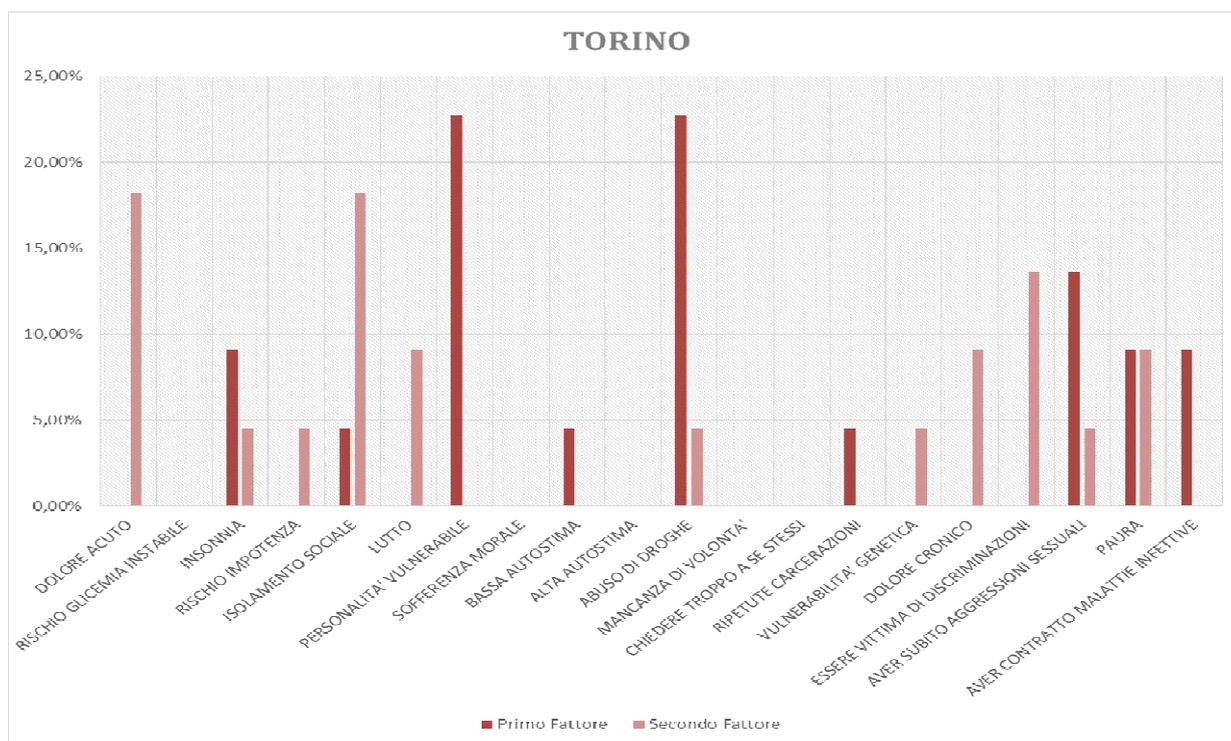


**Chart. 2.12**

SEVERE PAIN- RISK OF UNSTABLE GLYCAEMIA- INSOMNIA- RISK OF IMPOTENCE- SOCIAL ISOLATION- GRIEF- VULNERABLE PERSONALITY- MORAL SUFFERING- LOW SELF-ESTEEM - HIGH SELF-ESTEEM – DRUGS ABUSE – UNWILLINGNESS- DEMANDING TOO MUCH FROM ONESELF- REPEATED INPRISONMENTS- GENETIC VULNERABILITY- CHRONIC PAIN- BEING A VICTIM OF DISCRIMINATION- HAVING SUFFERED SEXUAL HARASSMENT- FEAR- CONTRACTING AN INFECTIOUS DISEASE-



**Tab. 2.13**



### Chart 2.14

SEVERE PAIN- RISK OF UNSTABLE GLYCAEMIA- INSOMNIA- RISK OF IMPOTENCE- SOCIAL ISOLATION- GRIEF- VULNERABLE PERSONALITY- MORAL SUFFERING- LOW SELF-ESTEEM - HIGH SELF-ESTEEM – DRUGS ABUSE – UNWILLINGNESS- DEMANDING TOO MUCH FROM ONESELF- REPEATED IMPRISONMENTS- GENETIC VULNERABILITY- CHRONIC PAIN- BEING A VICTIM OF DISCRIMINATION- HAVING SUFFERED SEXUAL HARASSMENT- FEAR- CONTRACTING AN INFECTIOUS DISEASE- INEFFICIENT IMPULSE CONTROL.

At the end of the quantitative analysis distinguishing this area, it may be possible to trace an organisational as well as a cultural analysis, in order to guide to a better interception and management of subjects suffering from psychological distress.

Not only should instrumental and organisational data be underlined, but also human and perceptive data, which appears transformed as a result of leaving certain strict schemes regarding the behaviour of respective roles and functions. Tracing psychological distress related to imprisonment and detention increasingly is becoming even more a collective expertise. Obviously, it must be reported to others in terms of specific and professional aspects, however its interception covers us all. Whilst, on the one hand, new and brilliant perspectives are opening up in interaction and integration activities between services and professions, in order to enhance the existing “internal” and “external” and therefore providing a better “diagnostic-prognostic” tool in support of difficult subjects. On the other hand, the strong sense of frustration of officers, due to the perception of a faulty work without any strategic value, cannot be avoided. Given the national counting of resources based on insufficient numbers, the psychological intervention for the “safety” of the patient/inmate is quite unlikely.

The area which analyses the “impairment of psychological stability” is particularly complex to deal with, since human inner mechanisms or psychic processes are difficult to evaluate and cannot be objectified. A thorough analysis allowed to

identify those items that, according to the Penitentiary Police Staff, lead to the impairment of psychological stability in detention.

At this point an introduction is necessary in order to outline the importance to address this specific question to a professional without training in this field, but able to examine it, since penitentiary police officers are closely in contact with inmates, sometimes even 24/24 h. The penitentiary police staff have the duty to guarantee safety, but this does not exclude their personal sensitivity which, therefore, allows them to perceive the distress experienced by inmates. Expectations, in fact, have been met and the examined penitentiary police sample enabled a thorough analysis, which confers a great value to the statistical data. Therefore, the entire distress field is made up of several interconnected items emerged from the analysis. More specifically, the “depression” (first item) emerged, is conceived as the psychological condition which also implies a stress condition (second item), arising from detention and which could turn into a defensive reaction that leads inmates to “simulation for judicial purposes” (third item).

In this sense, the data showing that “drugs use” is conceived as highly damaging for psychological stability, is therefore not surprising. The one item considered as discordant, if contemplated within detention distress, is “homosexual panic”. However, if contemplated within the most intimate and deep part of inmates, it is not difficult to see how inmates lose any liberty, therefore becoming vulnerable to any form of satisfaction of their sexual needs.

Finally, the last item “sense of guilt for the committed crime”, is also well connected with the other distress items.

Further confirmation of the abovementioned is provided by the “Contributory causes implying psychological distress” section. This section outlines the perception of mental distress perceived by the penitentiary police staff, and the emerging data could make the rehabilitative intervention more accurate, innovative and sustainable.

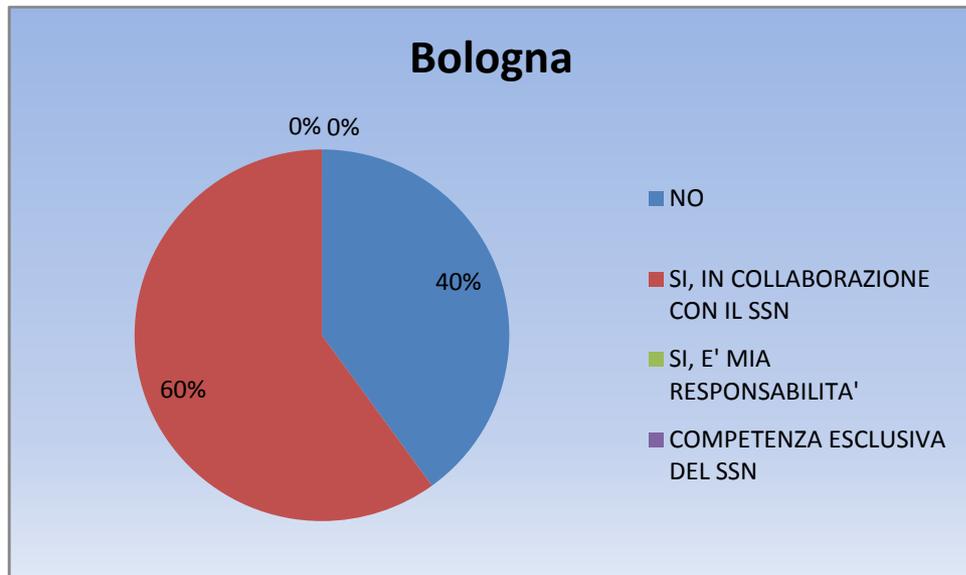
## ***2. SURVEY ON INTERVENTION STRATEGIES***

Obviously, this section of our study is very relevant, compared to the previous one that served as a framework for every reference and correlation.

It is important not only because it will allow us to understand, on the basis of the experience of the respondents, which are the main strengths and “best practices”, but also which are the reasons for conflict and weaknesses during the care of the mentally disturbed inmate, as it was highlighted in the previous section.

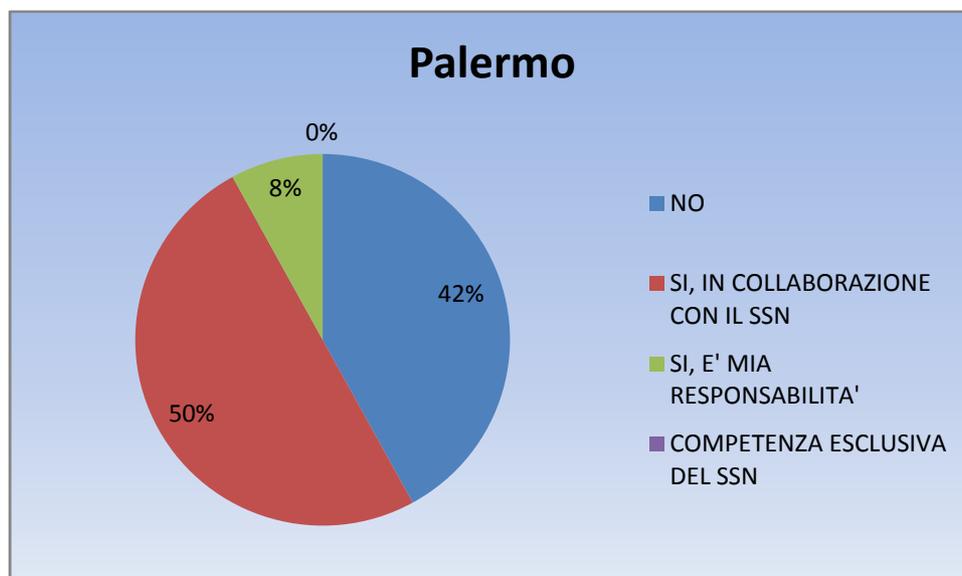
By evaluating relevant figures, it is possible to presume that a standard for a mental disorder treatment is still far from being reached in our penitentiary system, not only as for mental health-related needs but also in terms of providing with operational tools and guidance.

**REHABILITATION OFFICERS**  
**“INSTITUTION BEST CONDITIONS FOR THE MENTALLY DISTURBED**  
**INMATES’ CARE”**

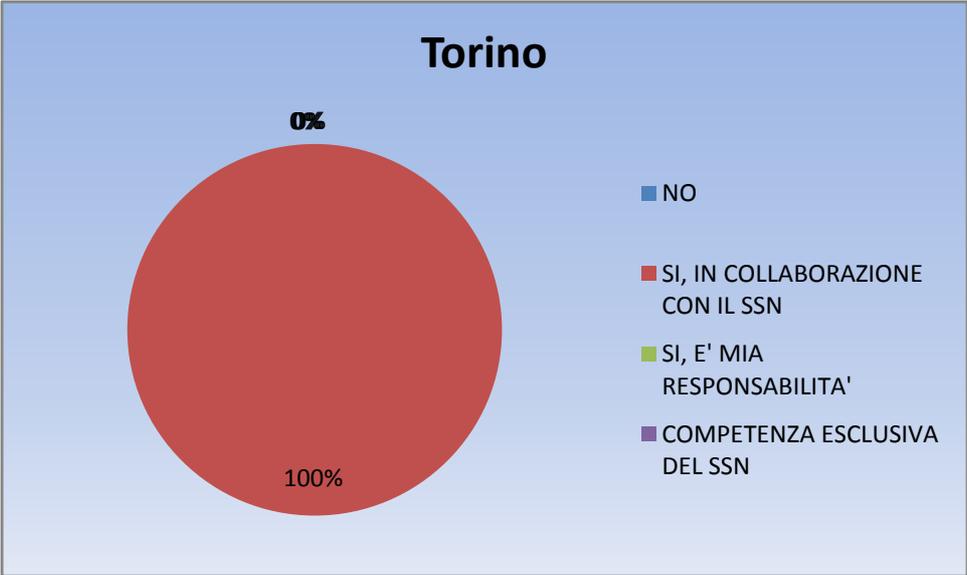


**Chart 3.1**

[NO- YES, IN COLLABORATION WITH NHS- YES, IT IS MY RESPONSIBILITY, IT IS ONLY NHS RESPONSIBILITY]

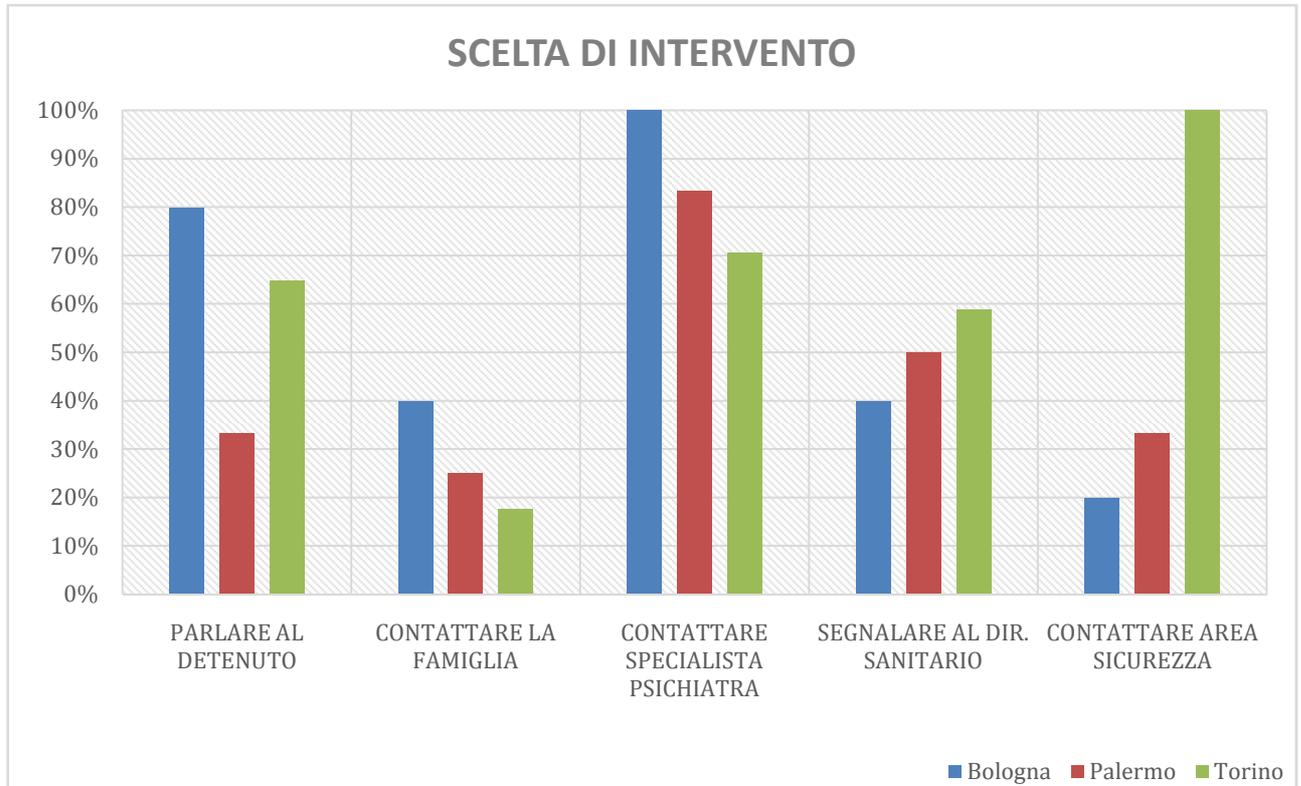


**Chart 3.2**



**Chart 3.3**

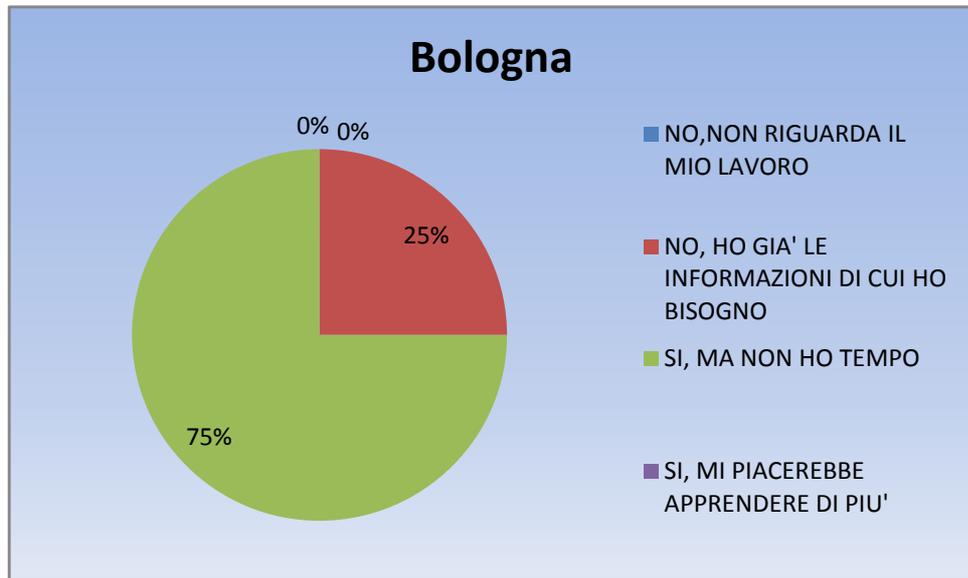
**“MODALITIES OF INTERVENTION FOR INMATES’ CARE DEVELOPING A PSYCHOPATOLOGICAL CONDITION”**



**Chart 3.4**

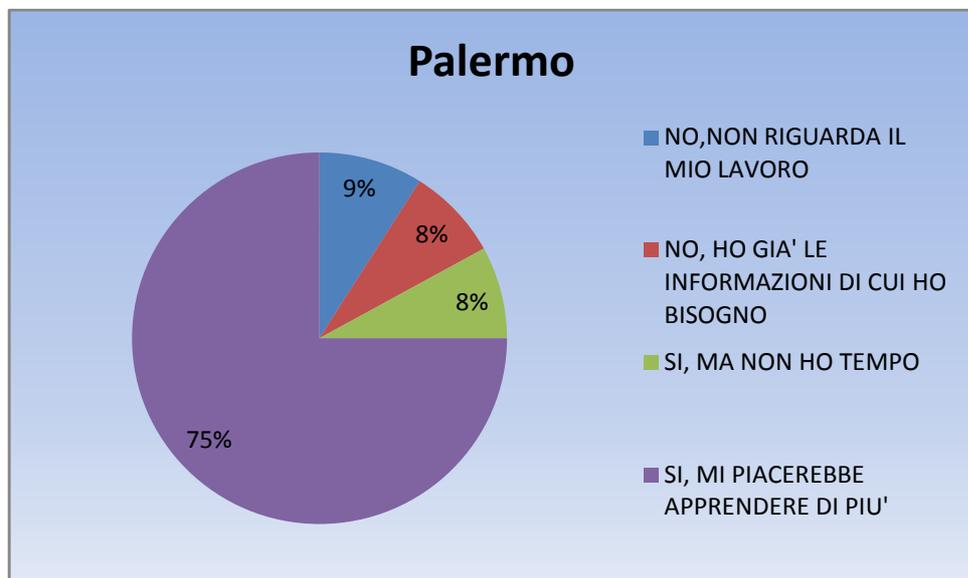
[TALKING TO THE INMATE- TALKING TO A FAMILY MEMBER- CONSULTING A PSYCHIATRIST- INFORMING THE CHIEF MEDICAL OFFICER- TALKING TO SECURITY OFFICERS]

**“BENEFITS FROM TRAINING COURSES ON MENTAL DISTRESS”**



**Chart 3.5**

[NO, IT'S NOT MY JOB- NO, I ALREADY HAVE THE INFORMATION NEEDED- YES, BUT I DO NOT HAVE TIME]



**Chart. 3.6**

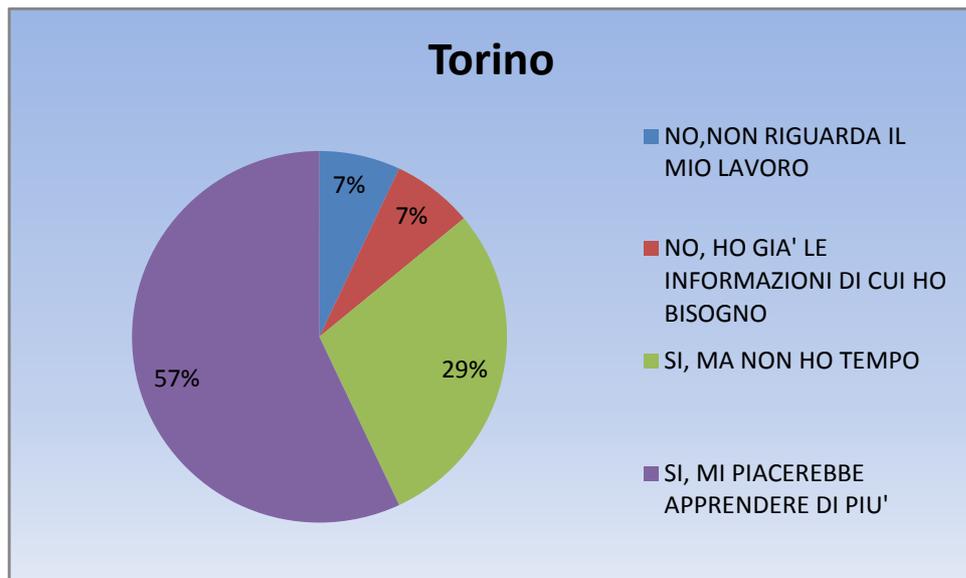
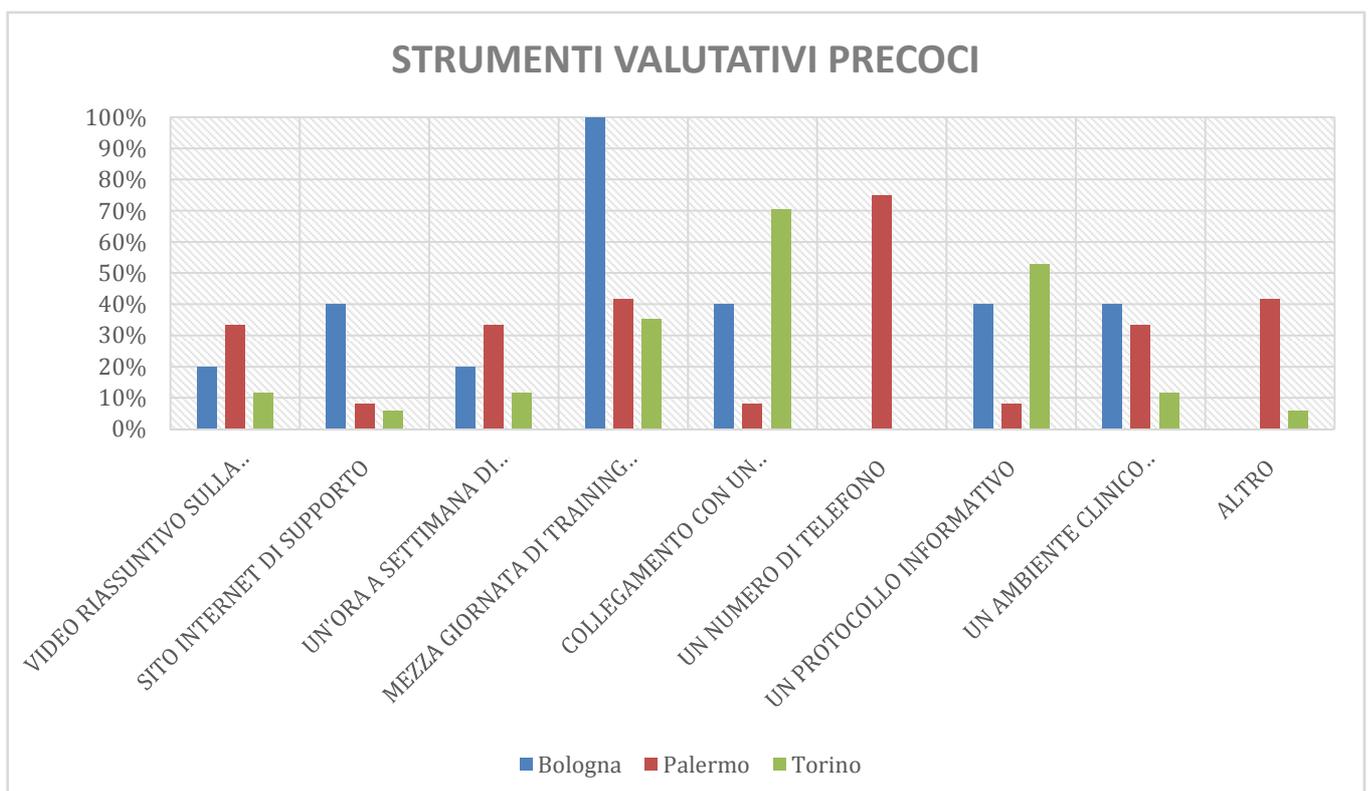


Chart 3.7

### ***“ASSESSMENT TOOLS FOR EARLY DIAGNOSIS”***

Rehabilitation officers were asked to express their own opinion on which tools they consider useful for the early diagnosis of mental disorders.

They could choose one or more options (potential diagnostic tools).



### **Chart3.8**

[A SUMMARISING VIDEO- A SUPPORTING WEBSITE- AN HOUR OF TRAINING PER WEEK- HALF A DAY OF TRAINING- COOPERATING WITH A PROFESSIONAL- A PHONE NUMBER- AN EDUCATIONAL PROTOCOL- A CLINICAL ENVIRONMENT- OTHER]

The results of the survey show that the items they agreed on the most were:

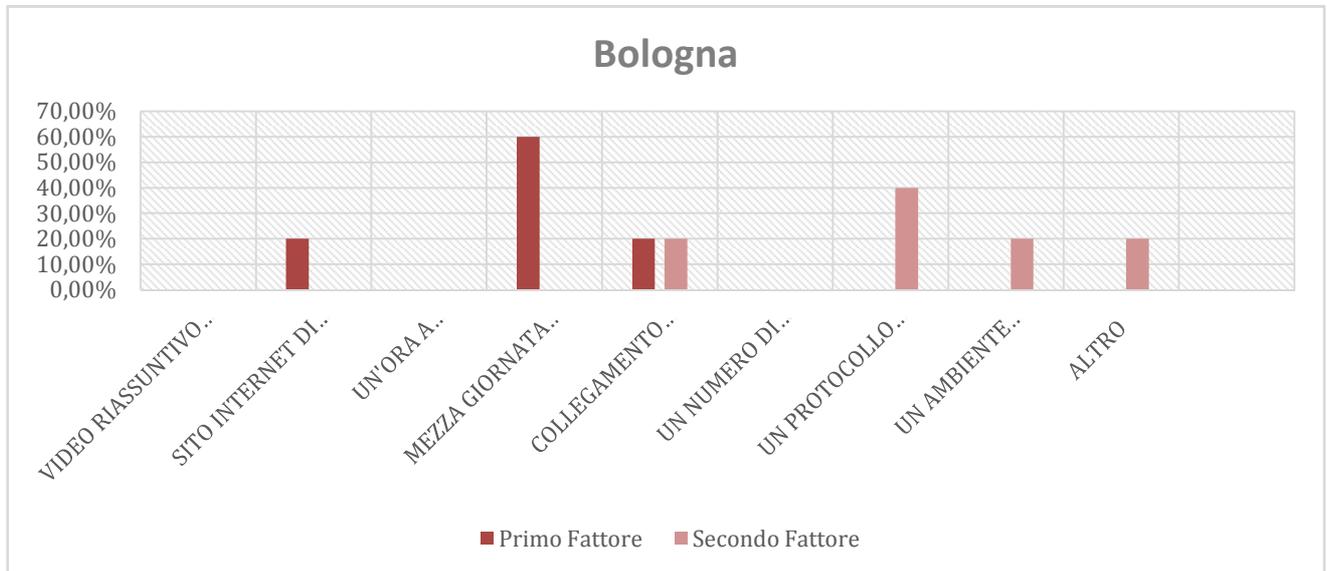
- *Half a day of training in order to learn how to identify the mental disorder;*
- *A video summarising mental disorders;*

### ***“ASSESSMENT TOOLS FOR EARLY DIAGNOSIS”***

Rehabilitation officers were asked to indicate which tools they consider useful for the early diagnosis of the mental disease choosing amongst the following items:

- 1) A summarising video on the mental disease and where to ask for help.
- 2) A website that helps planning the best way of safeguarding the patient/inmate;
- 3) An hour of training per week in order to learn how to identify psychiatric disorders related to aggressive and violent behaviours.
- 4) Half a day of training in order to learn how to jointly deal with the mentally disturbed inmate;
- 5) Cooperating with a professional who has specific knowledge on psychopathology;
- 6) A phone number;
- 7) An educational protocol;
- 8) A cosy clinical environment.

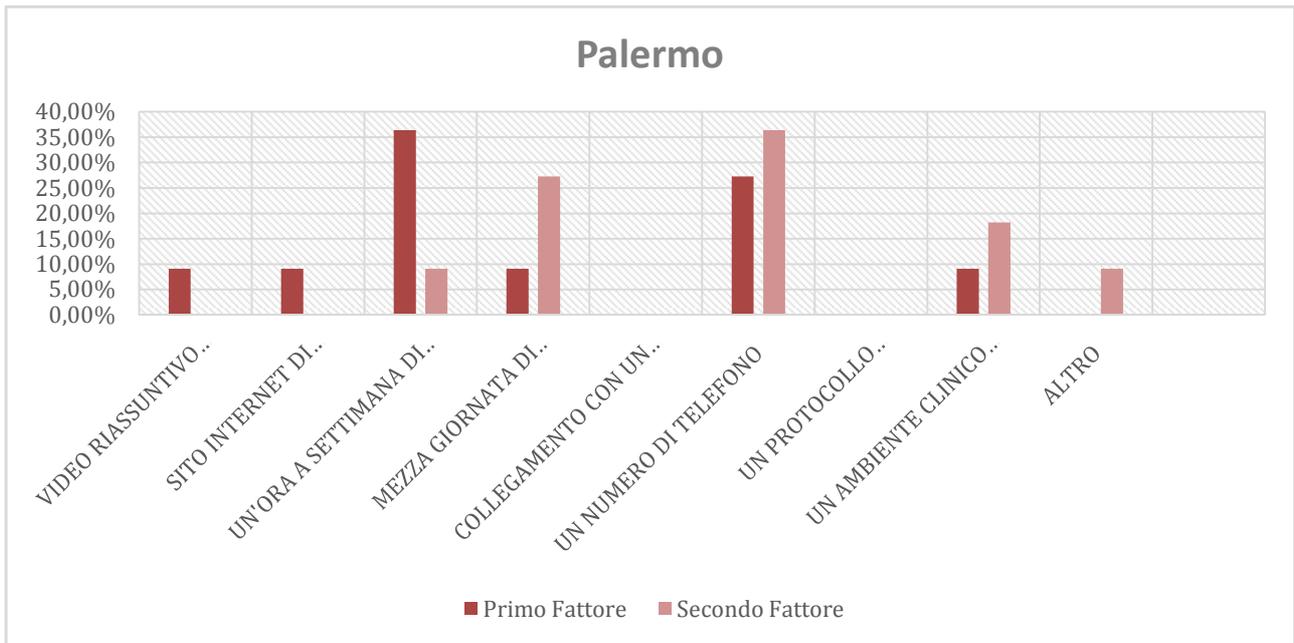
## ***“FIRST AND SECOND TOOL”***



**Chart 3.9**

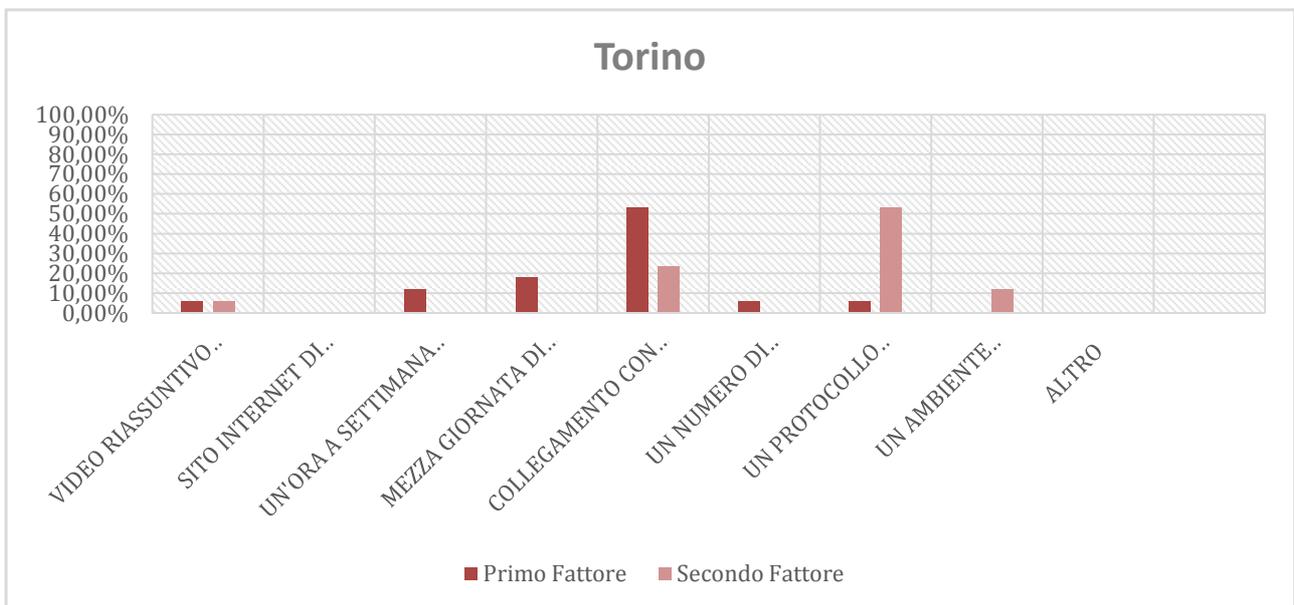
[A SUMMARISING VIDEO- A SUPPORTING WEBSITE- AN HOUR OF TRAINING PER WEEK- HALF A DAY OF TRAINING- COOPERATING WITH A PROFESSIONAL- A PHONE NUMBER- AN EDUCATIONAL PROTOCOL- A CLINICAL ENVIRONMENT- OTHER]

- The results of this chart show that the first useful tool for an early diagnosis is: **“half a day of training”**. The second useful tool is: **“an educational protocol”**.



**Chart 3.10**

- The results of the chart show that the first useful tool for an early diagnosis is: **“an hour of training”**. The second useful tool is: **“a phone number”**.



**Chart3.11**

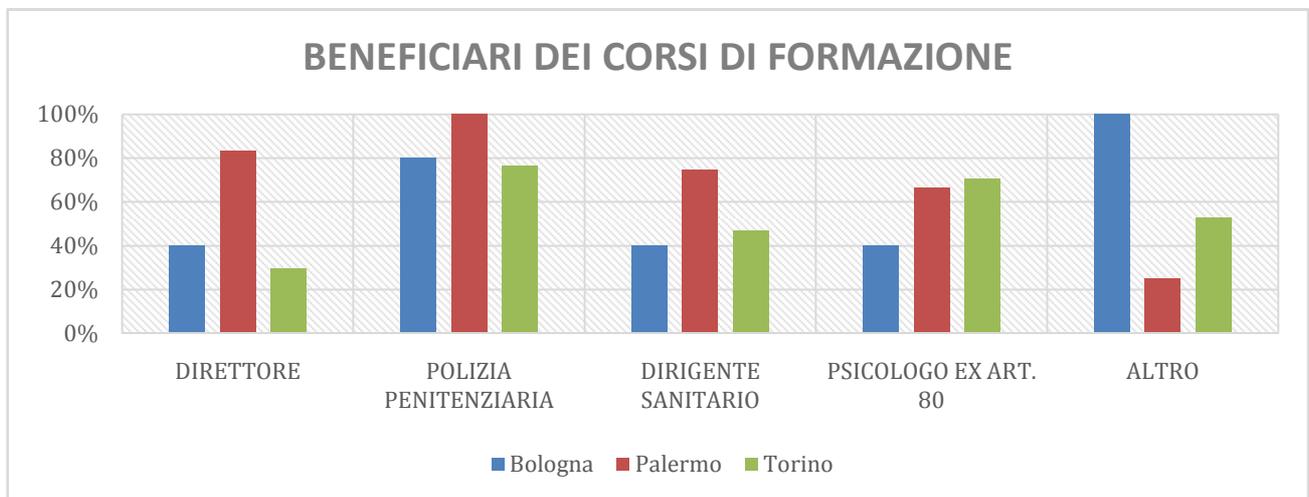
[A SUMMARISING VIDEO- A SUPPORTING WEBSITE- AN HOUR OF TRAINING PER WEEK- HALF A DAY OF TRAINING- COOPERATING WITH A PROFESSIONAL- A PHONE NUMBER- AN EDUCATIONAL PROTOCOL- A CLINICAL ENVIRONMENT- OTHER]

- The results of the chart show that the first useful item for an early diagnosis is: **“cooperating with a professional who has specific competence on psychopathology”**. The second useful tool is: **“an educational protocol”**.

***“PEOPLE WHO BENEFIT FROM TRAINING COURSES”***

Rehabilitation officers were asked to express their own opinion on which professionals within the penitentiary institution would benefit from the training courses.

The results of the chart show that the professional benefiting the most from the training courses is: **“Penitentiary Police”**.



**Chart 3.12**

[CHIEF OF THE INSTITUTION- PENITENTIARY POLICE- CHIEF MEDICAL OFFICER- PSYCHOLOGIST- OTHER]

## NURSES

### “SOURCES OF HELP”

Nurses were asked to express their own opinion on which sources of help can be implemented within the Penitentiary Institution. They had to express their own point of view on each item (potential sources of help) by using a Likert scale.

The results of the survey show that the items the three penitentiary institutions agreed on the most were:

- *Technical and professional update courses;*
- *Promoting training courses;*
- *Intra-professional training;*
- *Promoting communication courses.*

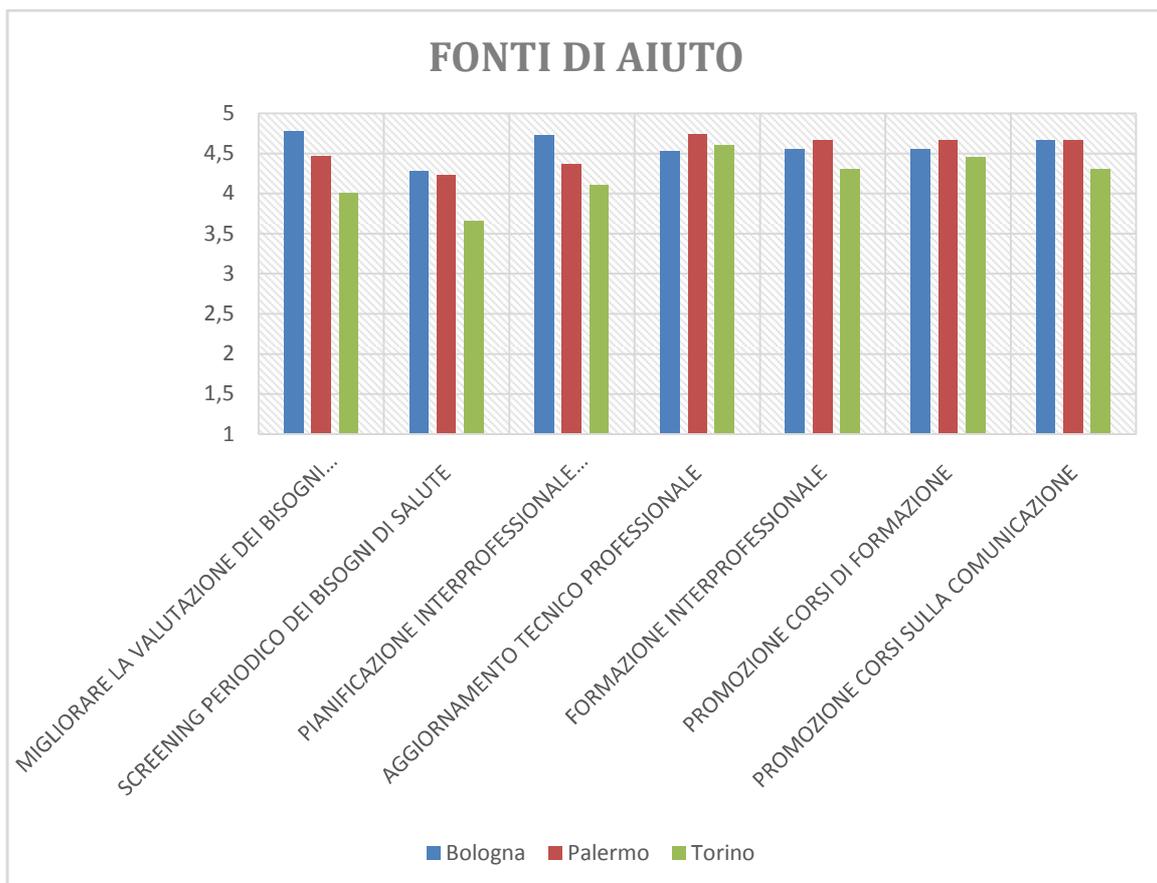


Chart 3.13

[IMPROVING ASSESSMENT OF NEEDS- RECURRING SCREENING OF NEEDS- TECHNICAL UPDATE- INTRA-PROFESSIONAL TRAINING- PROMOTING TRAINING COURSES- PROMOTING COMMUNICATION COURSES]

Y(abcissa): Likert's scale measures

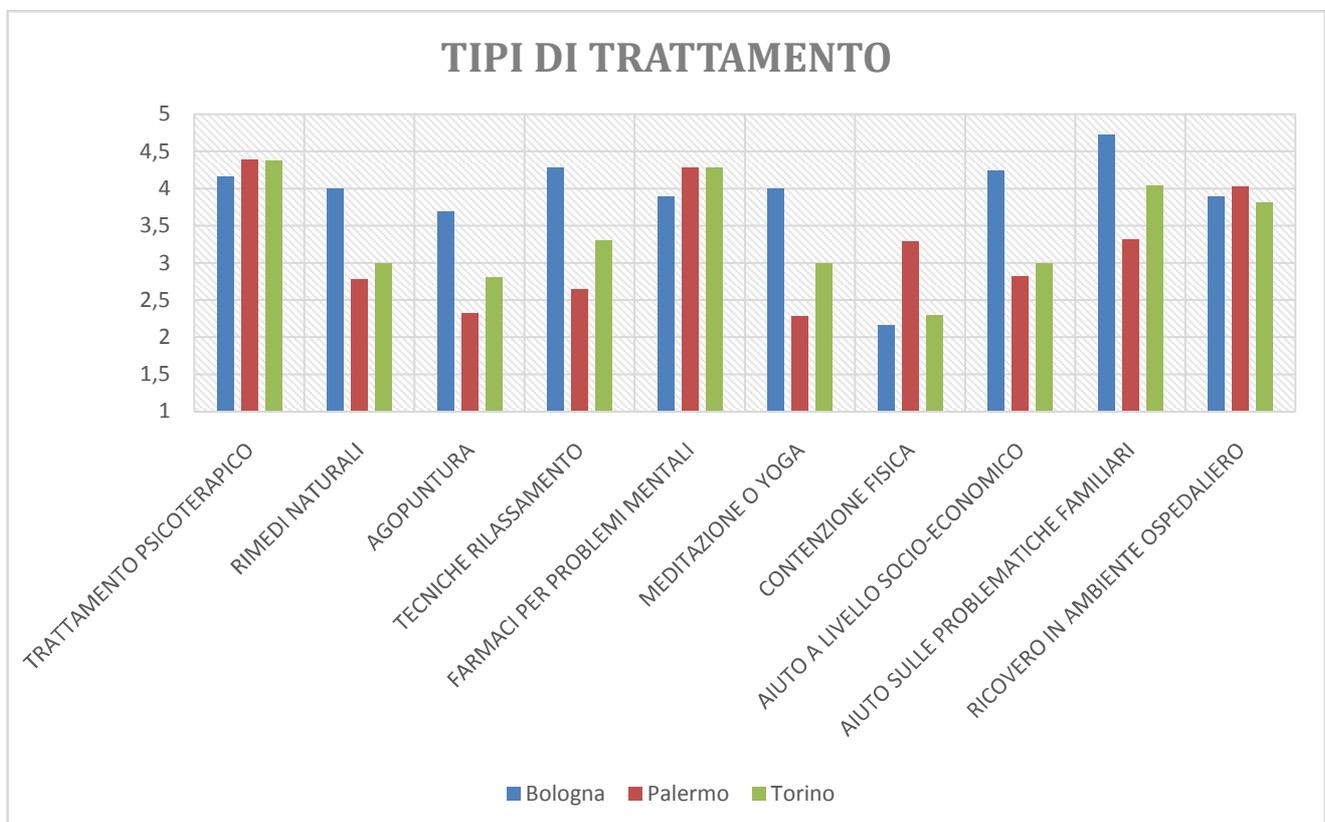
X(ordinate): Item

### *“Types of treatment”*

Nurses were asked to express their own opinion on which types of treatment can be implemented to limit the mental disorder within the penitentiary institution. They had to express their personal point of view on each item (potential types of treatment) by using a Likert scale.

The results of the survey show that the items the three penitentiary institutions agreed on the most were:

- *Psychotherapeutic treatment;*
- *Hospitalisation.*



### Chart 3.14

[TYPES OF TREATMENT- PSYCHOTHERAPEUTIC TREATMENT- NATURAL REMEDIES- ACUPUNCTURE- RELAXATION TECHNIQUES- MENTAL DISORDERS DRUGS- MEDITATION OR YOGA- PHYSICAL CONSTRICTION- SOCIO-ECONOMIC SUPPORT- SUPPORT ON FAMILY PROBLEMS -HOSPITALISATION]

Y(abcissa): Likert's scale measures

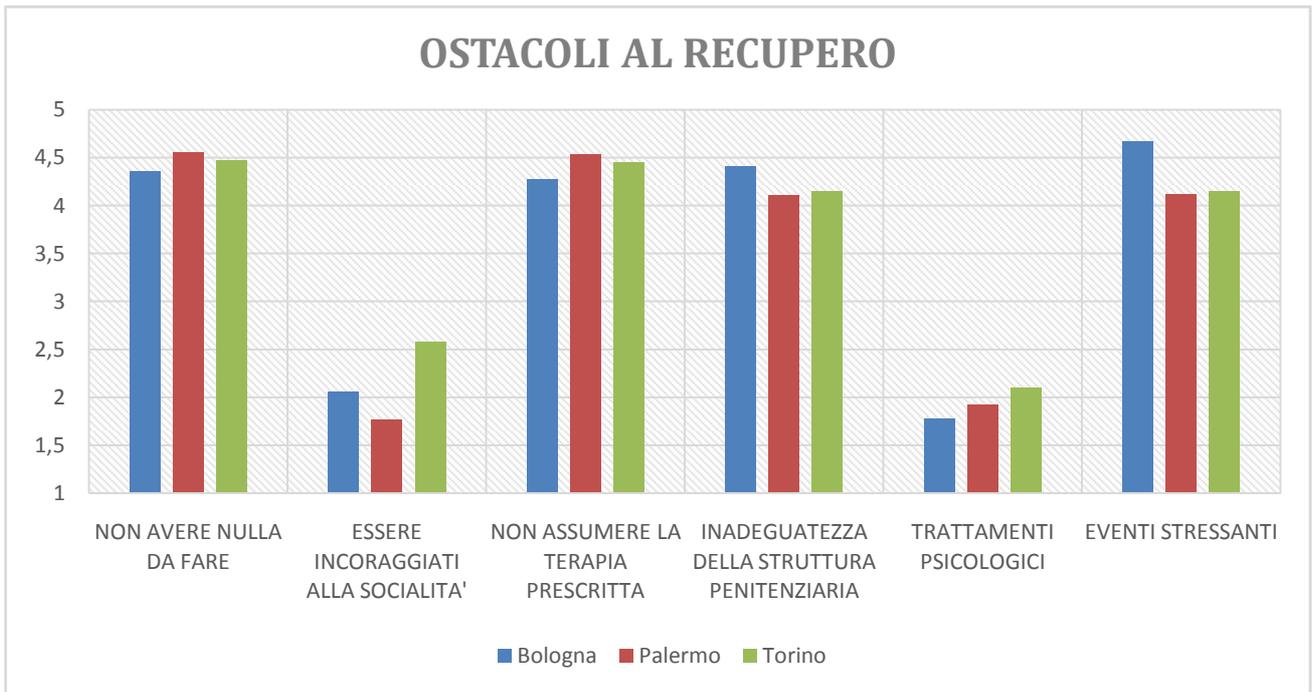
X(ordinate): Item

#### ***“Limits to psychic rehabilitation”***

Nurses were asked to express their own opinion on what can limit mentally disturbed inmate's rehabilitation. They had to express their own point of view on each item (potential limits to psychic rehabilitation) by using a Likert scale.

The results of the survey show that the items the three penitentiary institutions agreed on the most were:

- ***Patients do not respond to the therapies they are administered;***
- ***Inaction;***
- ***Inadequacy of penitentiary facilities;***
- ***Stressful situations.***



**Chart 3.15**

**Y(ascissa): Likert's scale measures**

**X(ordinate): Item**

[INACTION- TO GET INTO SOCIAL RELATIONS- DO NOT RESPOND TO THE THERAPIES THEY WERE ADMINISTERED- INADEQUACY OF THE PENITENTIARY FACILITY- PSYCHOLOGICAL TREATMENTS- STRESSFUL SITUATIONS]

## ***HEALTHCARE PERSONNEL***

### ***“INTERVENTION STRATEGIES ON PATIENTS WELL-KNOWN TO DSM”***

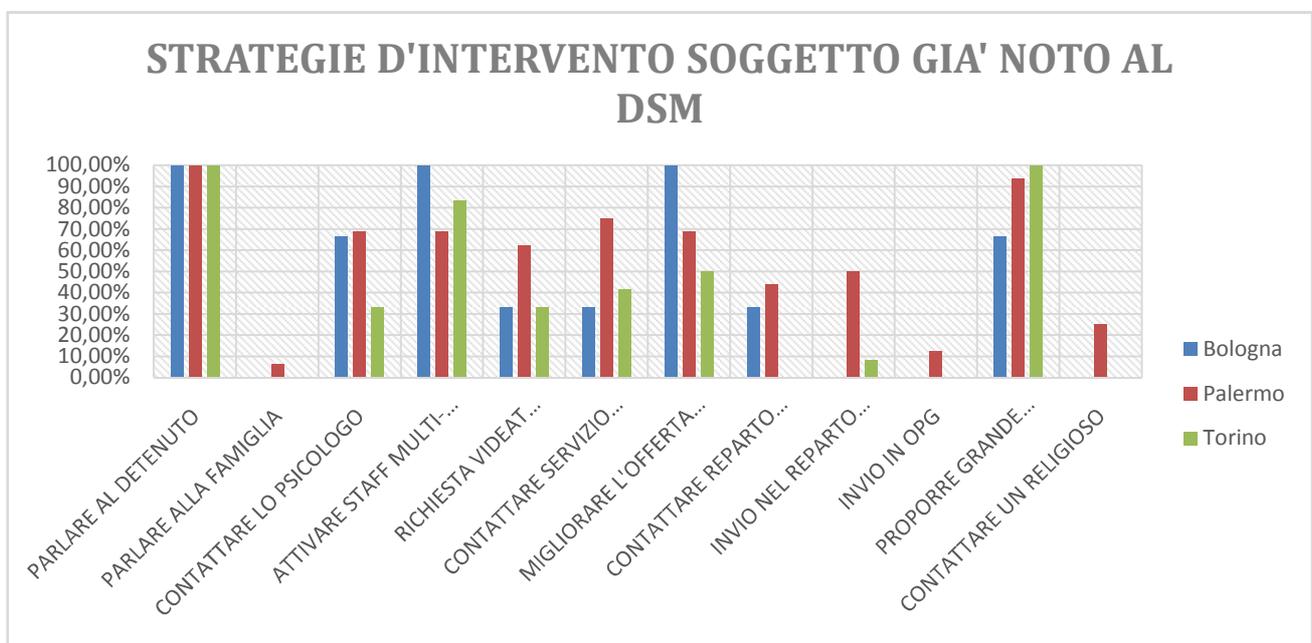
Subjects were asked to express their own opinion on those intervention strategies adopted when facing an episode of self-harming or suicide attempt during the first imprisonment. They could choose amongst one or more items (potential intervention strategies).

The items proposed were:

- 1) Talking directly to the inmate;
- 2) Talking to the family;
- 3) Consulting the psychologist for a personality profile and counselling;
- 4) Multidisciplinary staff's counselling;
- 5) Applying for a psychiatric test (videat);
- 6) Consulting the healthcare service which already knows the person;
- 7) Improving pharmacological offer;
- 8) Consulting the psychiatric monitoring ward under art. 112 D.P.R. 230/00;
- 9) Proposing to refer the patient to psychiatric monitoring ward under art. 112 D.P.R. 230/00;
- 10) Proposing to refer the patient to O.P.G. (Judiciary Psychiatric Hospital) under art. 222 C.P.;
- 11) Proposing Close Surveillance or 24/7 Sight-Surveillance;
- 12) Consulting a priest.

The results of the survey show that the items on which the three penitentiary institutions agreed the most were:

- *Talking directly to the patient;*
- *Multidisciplinary staff counselling;*
- *Proposing close and sight surveillance.*



**Chart 3.16**

[TALKING TO THE INMATE- TALKING TO THE FAMILY- CONSULTING A PSYCHOLOGIST- MULTIDISCIPLINARY STAFF- PSYCHIATRIC TEST (VIDEAT)- HEALTHCARE SERVICE- IMPROVING PHARMACOLOGICAL OFFER- CONSULTING THE WARD- REFERRING THE PATIENT TO THE WARD- REFERRING THE PATIENT TO O.P.G.- CLOSE OR 24/7 SIGHTSURVEILLANCE- CONSULTING A PRIEST]

## HEALTHCARE PERSONNEL

### “INTERVENTION LIMITS ON PATIENTS WELL-KNOWN TO DSM”

Subjects were asked to express their own opinion on what can limit intervention strategies. They had to express their own point view on each item (potential limits of the adopted strategies) by using a Likert scale.

The results of the survey show that the items on which the three penitentiary institutions agreed the most were:

- *Non-healthcare personnel’s fears of approaching someone suffering from psychopathology;*
- *Concerns that penitentiary system could act in ways which do not meet inmates’ needs.*

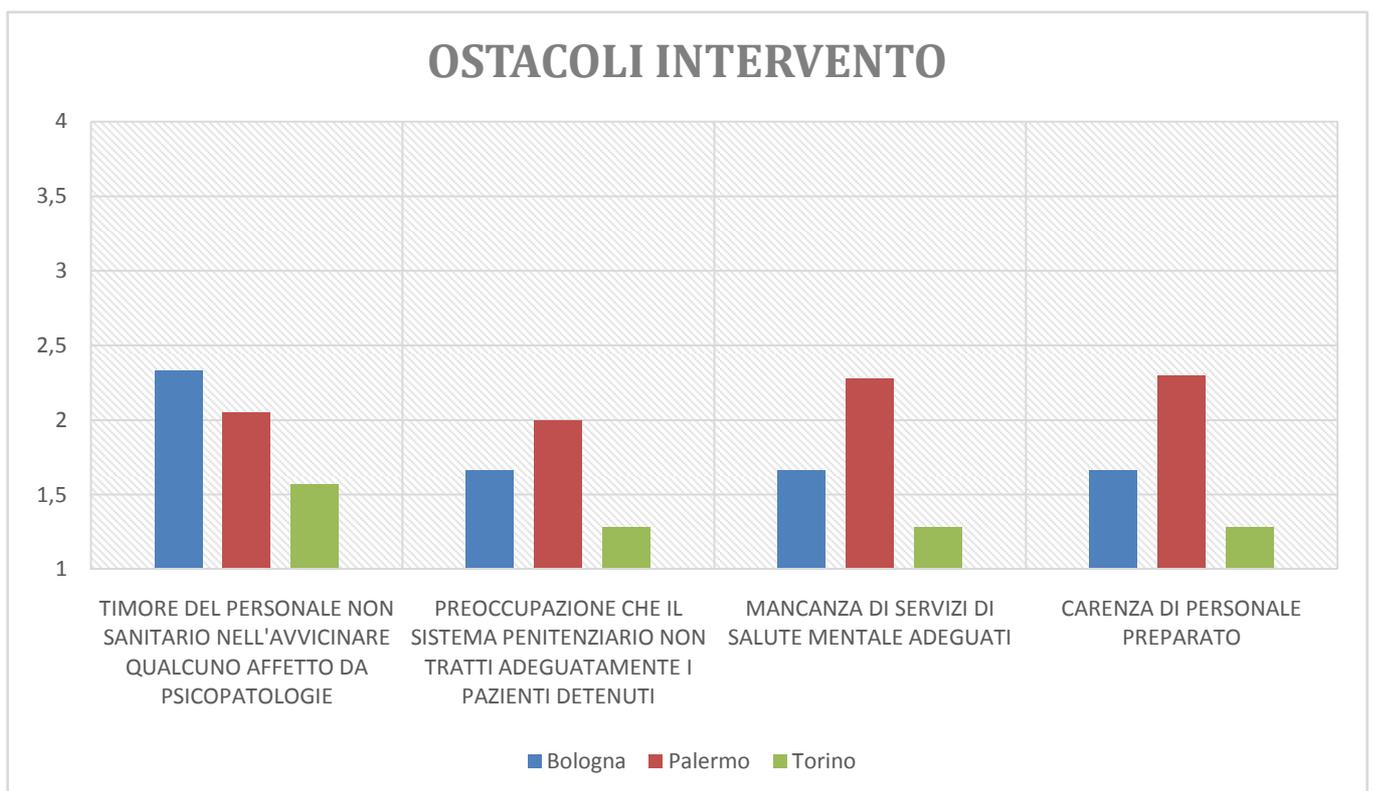


Chart3.17

[NON-HEALTHCARE PERSONNEL’S FEARS- CONCERNS THAT PENITENTIARY SYSTEM COULD ACT IN WAYS WHICH DO NOT MEET INMATES’ NEEDS- LACK OF ADEQUATE MENTAL HEALTHCARE- SHORTAGE OF EXPERIENCED PERSONNEL ]

Y(ascissa): Likert's scale measures

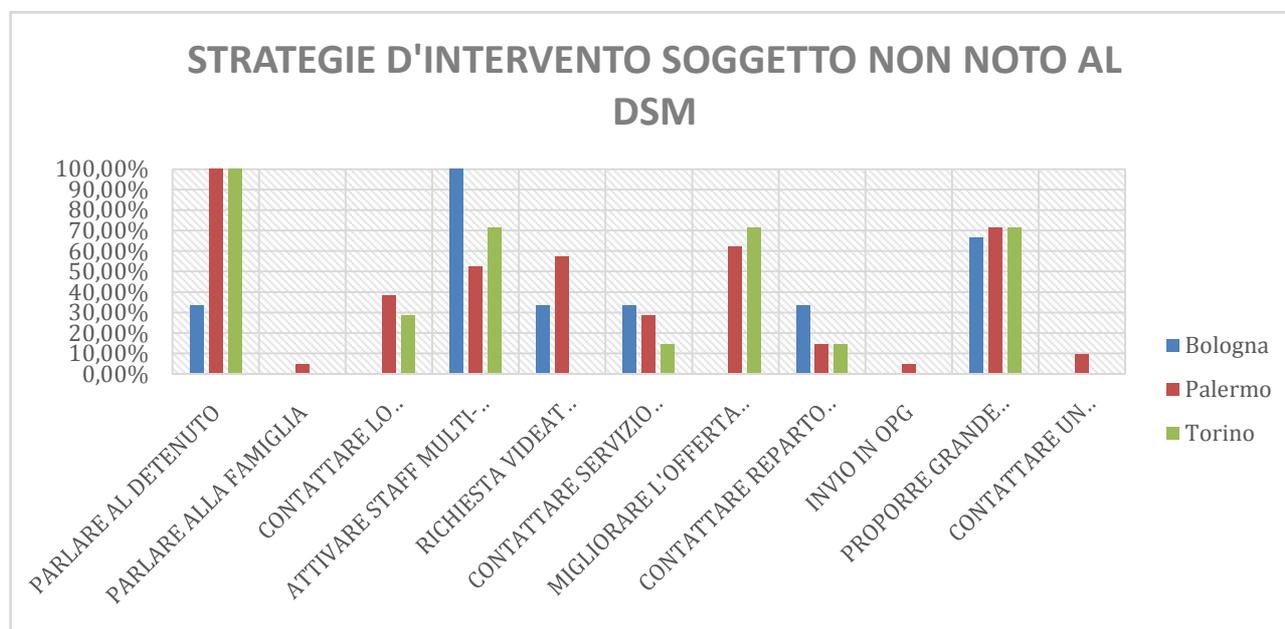
X(ordinate): Item

### ***“INTERVENTION STRATEGIES ON PATIENTS UNKNOWN TO DSM”***

Subjects were asked to express their own opinion on intervention strategies adopted when facing an episode of self-harming or suicide attempt during the first imprisonment. They could choose amongst one or more items (potential intervention strategies).

The results of the survey show that the items on which the three penitentiary institutions agreed the most were:

- ***Close and sight surveillance;***
- ***Talking directly to the patient.***



**Tab. 3.18**

[TALKING TO THE INMATE- TALKING TO THE FAMILY- CONSULTING THE PSYCHOLOGIST- MULTIDISCIPLINARY STAFF- PSYCHIATRIC TEST (VIDEAT)- HEALTHCARE SERVICE- IMPROVING PHARMACOLOGICAL OFFER- CONSULTING THE

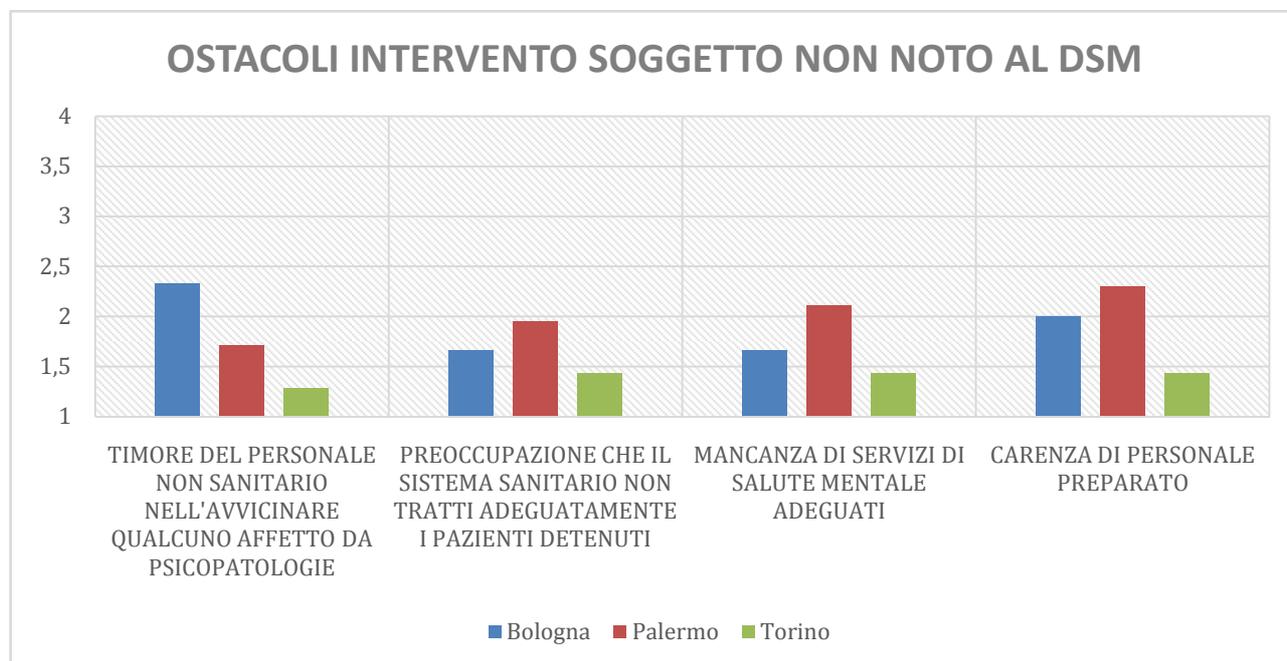
WARD- REFERRING THE PATIENT TO THE WARD- REFERRING THE PATIENT TO O.P.G.-  
CLOSE OR 24/7 SIGHT SURVEILLANCE- CONSULTING A PRIEST]

**“LIMITS AND INTERVENTION ON PATIENTS UNKNOWN TO DSM”**

Subjects were asked to express their own opinion on what can limit intervention’s strategies. They had to express their own point view on each item (potential limits of the adopted strategies) by using a Likert scale.

The results of the survey show that the items on which the three penitentiary institutions agreed the most were:

- **Lack of adequate mental healthcare service;**
- **Shortage of experienced staff.**



**Chart 3.19**

[NON-HEALTHCARE PERSONNEL’S FEARS- CONCERNS THAT PENITENTIARY SYSTEM COULD ACT IN WAYS WHICH DO NOT MEET INMATES’ NEEDS- LACK OF ADEQUATE MENTAL HEALTHCARE- SHORTAGE OF EXPERIENCED PERSONNEL ]

Y(abscissa): Likert's scale measure

X(ordinate): Item

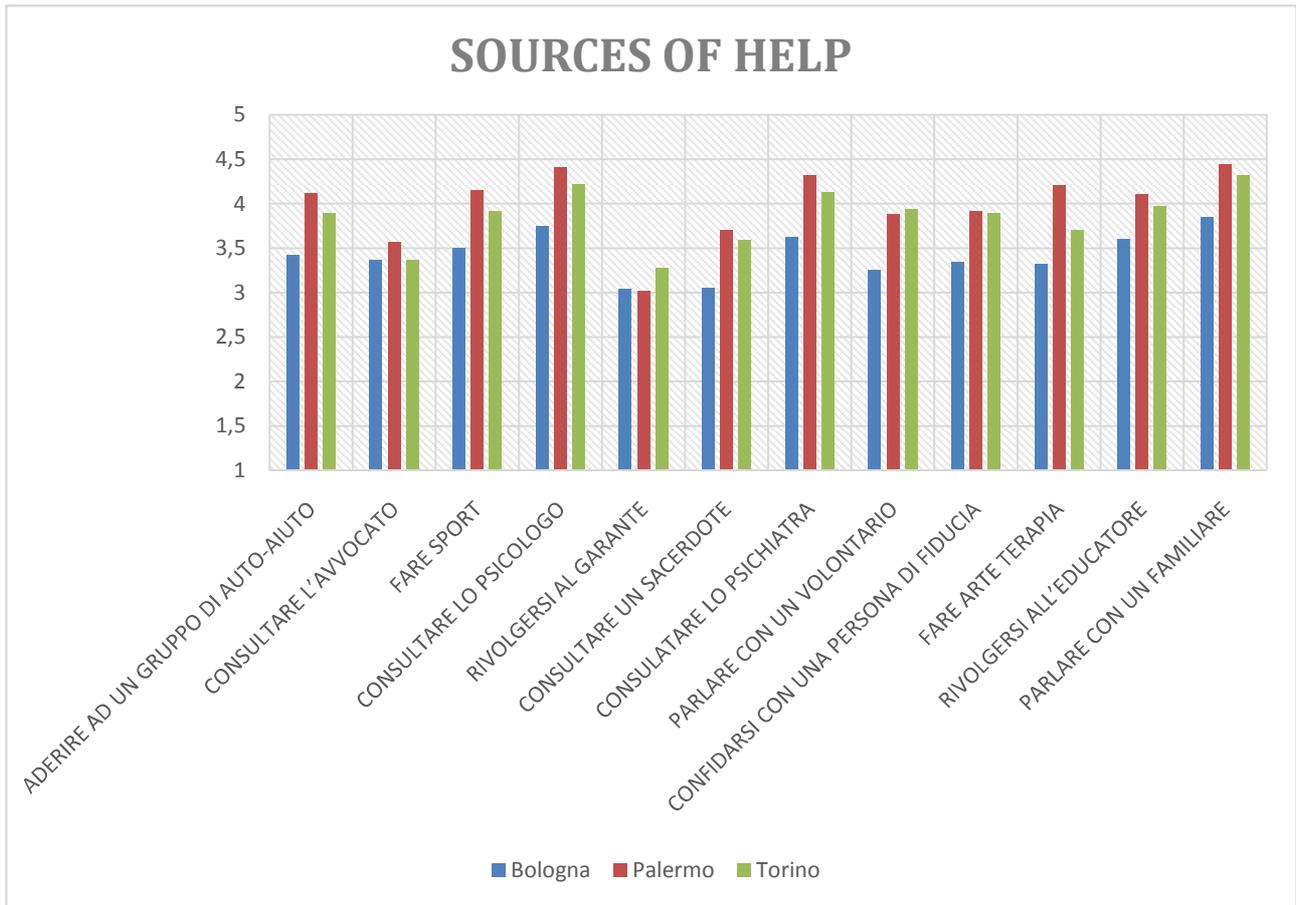
## ***PENITENTIARY POLICE STAFF***

### ***“SOURCES OF HELP”***

The subjects were asked to express their personal opinion on what they think could be a source of help within the prison. The tool included a series of items (that is, possible sources of help) and the subjects were asked to express their opinion on each of them by using a Likert scale.

The results showed that the items the three Institutions agreed on the most are:

- ***Consulting a psychologist;***
- ***Consulting a psychiatrist;***
- ***Talking to a member of the family;***
- ***Joining a group of self-help.***



**Chart 3.20**

**Y(ascissa):** Likert's scale measures

**X(ordinate):** Item

[Joining a group of self-help]

[Talking to a lawyer]

[playing sports]

[consulting a psychologist]

[talking to the guarantor]

[talking to a priest]

[talking to a voluntary worker]

[consulting with a trusted person]

[doing art therapy]

[talking to a rehabilitation officer]

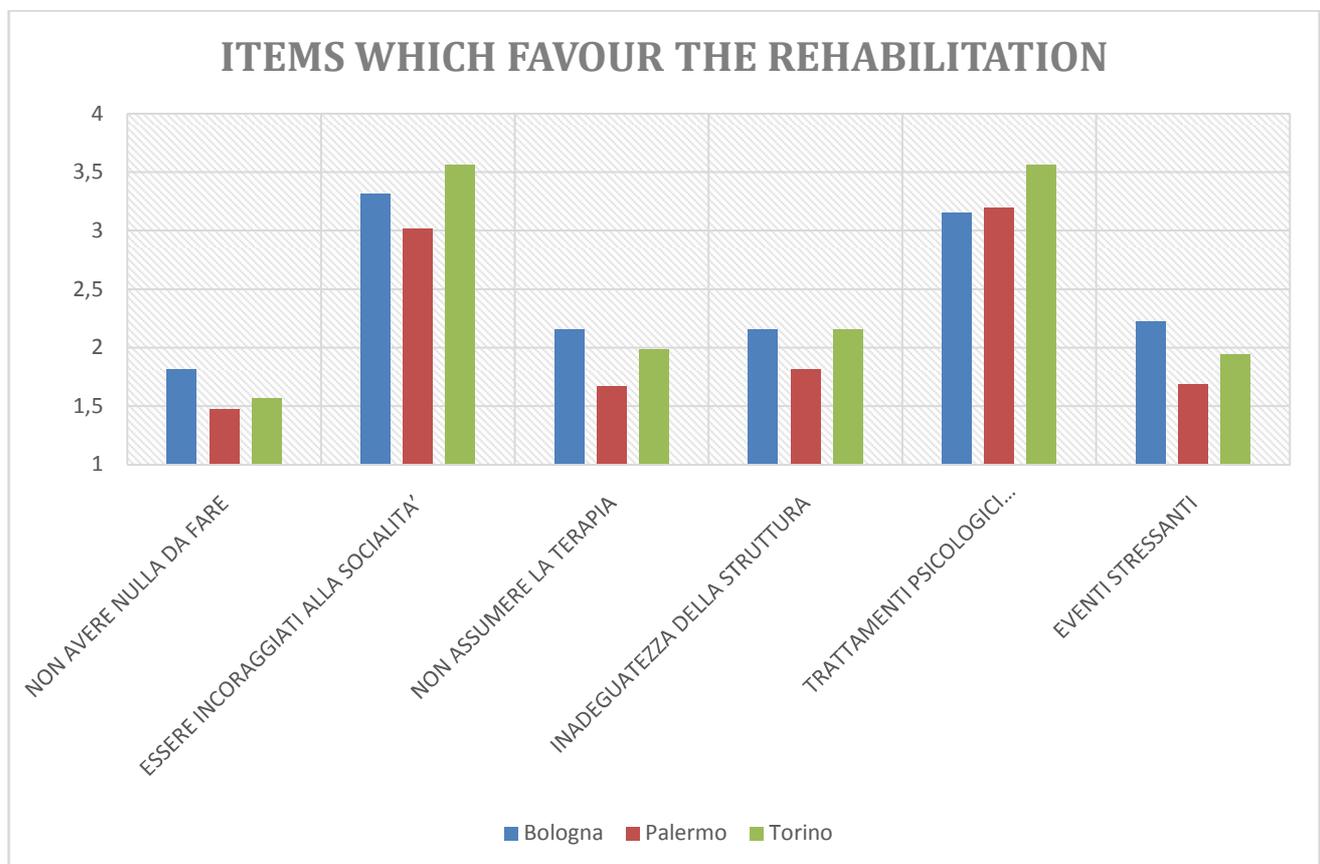
### ***PENITENTIARY POLICE STAFF***

#### ***“ITEMS WHICH FAVOUR THE REHABILITATION”***

The subjects were asked to express their personal opinion on those situations within the penitentiary which could prevent mentally-disturbed inmates from rehabilitating. The tool included a series of items (that is, possible sources of help) and the subjects were asked to express their opinion on each of them by using a Linkert scale.

The results showed that the items the three Institutions agreed on the most are:

- ***Individual/group psychological rehabilitation;***
- ***Encouraging subjects to get into social relationships.***



**Chart 3.21**

[having nothing to do]

[getting into social relationships]

[not responding to therapy]

[inadequacy of penitentiary facility]

[inadequacy of psychological treatments] (?)

[stressful events]

In this section we aimed at identifying the main strengths and weaknesses that penitentiary police staff has to face within prisons when dealing with distressing conditions and the increase of dangerous situations for the inmates (e.g. the increase of self-harming and suicide attempts).

An explanation of the in-depth analysed data is provided in order to clarify the results of the survey. This is made by taking into account the different professionals who took part to the survey. This method was chosen also by taking into account the training proposals which will be defined starting from what the statistical analysis will show.

The survey was divided into three different areas in order to better focus on the different aspects of the study.

As for the *rehabilitation officers*, the “best situation” facilitating inmates’ care was studied; the overwhelming majority of them feels like they can properly meet the needs of the inmates only when cooperating with National Healthcare System. This data seems to be linked to the raising awareness of officers, who have finally got into a new *modus operandi* in healthcare management, which no longer depends on penitentiary system. This gives credit to another opinion expressed by the rehabilitation officers, who believe it is important to contact a psychiatrist for the care

of a patient who was diagnosed with psychopathological symptoms. According to them, the most useful tools to understand if an inmate has a mental disorder are “half a day of training in order to learn how to identify mental disorders” and “a video summarising mental disorders”. Therefore, the result is that rehabilitation officers believe that training starts with the basic knowledge of mental disorders. Moreover, when asked who the recipients of a training course on mental disorders should be, they identified penitentiary police staff as further recipients of those courses aimed at providing training on the subject.

As for the nursing field, it would be both useful and interesting to understand which stand should be taken with regard to the kinds of treatment to be adopted within the prisons in order to limit mental disorders. The result is that the situation seems to have two different aspects. That is due to the fact that while on the one hand the “psychotherapeutic treatment”, namely a psychological support which includes the appropriate care of patients based on specific cases, is recommended, on the other hand “hospitalisation” is suggested. These figures show that nurses themselves acknowledge the potential that a psychotherapeutic intervention could have within prisons too but, at the same time, they point out their concerns about it and recommend a more appropriate intervention such as the hospitalisation of patients. Therefore, they acknowledge the need for best practices, but still they feel the limits of its fulfilment. As a matter of fact, when pointing out the limits of psychological rehabilitation, they list among their causes the “inadequacy of penitentiary facilities” together with the fact that “patients do not respond to the therapies they are administered”; they also state that “inmates have nothing to do” and this, again, is linked to the inadequacy of penitentiary facilities which induces inmates to be lazy.

The factors limiting those interventions which could be implemented within a prison in order to deal with inmates’ psychological distress are even clearer if we take a look at the figures provided by the *healthcare field*. Specifically, what was asked was how healthcare professionals intervene in case of suicide attempts or self-harming and how the kind of intervention changes if the inmate is well-known to the DSM or not.

The analysis showed interesting situations that, in some cases, seem to be complementary. If the subject is well-known to the DSM, then the procedure seems to have a pyramidal shape: the first attempt is trying to talk to the subject in order to limit the situation, then multidisciplinary staff intervenes and if this is not enough to limit the situation close surveillance is suggested. What goes against the kind of intervention described is the risk that non-healthcare personnel deals with the subject suffering from psychopathology and thus the penitentiary system could act in ways which do not meet inmates' needs. On the contrary, if the inmate is not known to the DSM the situation is reversed, which means that at first the close surveillance is suggested and then an effort is made to try to speak to the subject. The situation seems to be clear and it can lead to think that if the subject is well-known the penitentiary system has a greater flexibility and is more willing to intervene in a proper way. If the subject is not known the first intervention is aimed at guaranteeing the safety of prison, the needs of the inmate come after and penitentiary police officers have to deal with everything. This is confirmed by the pointed out limits, namely the lack of mental healthcare service and the shortage of experienced staff.

As a partial conclusion of this section, the very last data that should be shown – very important for the results achieved – concerns penitentiary police staff. Among the sources of help pointed out in order to deal with distressing situations and psychological problems there are: consulting a psychologist or a psychiatrist, talking to a member of the family or joining a group of self-help. According to the ones who carried the qualitative and quantitative study out, all these inputs sent by penitentiary police officers seem to confirm the initial hypothesis: there is an unseen and perceived data which comes out from the answers to the survey and which reveals that the penitentiary police staff interviewed actually detects the existence of mentally-disturbed inmates.

### **3. EVALUATION OF REAL FIGURES**

#### ***Palermo***

**Self-harming episodes which took place in the period between the 1<sup>st</sup> of January 2013 and the 31<sup>st</sup> of December 2013 and the first four months of 2014**

| <b>SELF-HARMING</b>               | <b>WOMEN</b>                                     |  | <b>MEN</b>                                       |  |
|-----------------------------------|--|--|--|--|
|                                   | <b>FROM<br/>JANUARY TO<br/>DECEMBER<br/>2013</b> | <b>FIRST<br/>FOUR<br/>MONTHS<br/>OF 2014</b> | <b>FROM<br/>JANUARY TO<br/>DECEMBER<br/>2013</b> | <b>FIRST FOUR<br/>MONTHS OF<br/>2014</b> |
| <b>SLASHING</b>                   | 4  | 1  | 45   | 12                                       |
| <b>HANGING</b>                    | 3  |  | 8  |  |
| <b>LIP SEWING</b>                 |  |  | 1  |  |
| <b>AMPUTATION</b>                 |  |  |  |  |
| <b>FOREIGN BODY<br/>INGESTION</b> |  |  | 5  | 1  |
| <b>TOTAL</b>                      | <b>7</b>   | <b>1</b>                                     | <b>59</b>  | <b>13</b>                                |

**Suicide attempts: figures for the pathology in the period between the 1<sup>st</sup> of January 2013 and the 31<sup>st</sup> of December 2013 and the first four months of 2014**

| DIAGNOSIS                          | ITALIANS |       | NON-EU NATIONALS |       | RECENT-EU-MEMBERS' NATIONALS |       |
|------------------------------------|----------|-------|------------------|-------|------------------------------|-------|
|                                    | MEN      | WOMEN | MEN              | WOMEN | MEN                          | WOMEN |
| AT LEAST ONE PSYCHIATRIC DIAGNOSIS | 3        |       | 2                |       | 1                            |       |
| SUBJECTS UNDERGOING TREATMENT      | 7        | 5     | 3                |       |                              |       |
| NO DIAGNOSIS                       | 5        |       |                  |       |                              |       |
| TOTAL                              | 15       | 5     | 5                |       | 1                            |       |

**Suicide attempts: figures according to gender and country of origin in the period between the 1<sup>st</sup> of January 2013 and the 31<sup>st</sup> of December 2013 and the first four months of 2014**

| ACTION          | ITALIANS |       | NON-EU NATIONALS |       | RECENT-EU-MEMBERS' NATIONALS |       |
|-----------------|----------|-------|------------------|-------|------------------------------|-------|
|                 | MEN      | WOMEN | MEN              | WOMEN | MEN                          | WOMEN |
| SUICIDE ATTEMPT | 15       | 5     | 5                |       | 1                            |       |
| SUICIDE         | 1        |       |                  |       |                              |       |
| TOTAL           | 16       | 5     | 5                |       | 1                            |       |

**Figures according to diagnosis provided using the DSM-IV in the period between the 1<sup>st</sup> of January 2013 and the 31<sup>st</sup> of December 2013 and the first four months of 2014**

| DIAGNOSTIC CATEGORIES     | TOTAL FOR THE YEAR 2013 | FIRST 4 MONTHS OF 2014 |
|---------------------------|-------------------------|------------------------|
| SCHIZOPHRENIA             | 40                      | 19                     |
| PSYCHOTIC DISORDERS       | 10                      | 16                     |
| PERSONALITY DISORDERS     | 38                      | 30                     |
| MENTAL RITARDATION        | 6                       | 2                      |
| MOOD DISORDERS            | 50                      | 45                     |
| ANXIETY DISORDERS         | 85                      | 40                     |
| ALCOHOL-RELATED DISORDERS | 10                      | 2                      |
| OTHER                     | 28                      | 20                     |
| UNCERTAIN DIAGNOSI        | 7                       | 4                      |
| TOTAL                     | 274                     | 178                    |

## *Turin*

Self-harming during 2013 and the first 4 months of 2014

**No answer to the question**

Suicide attempts for the pathology during 2013 and the first 4 months of 2014

**No answer to the question**

Suicide attempts: figures according to gender and country of origin during 2013 and the first 4 months of 2014

**No answer to the question**

**Figures according to diagnosis provided using the DSM-IV in the period between the 1<sup>st</sup> of January 2013 and the 31<sup>st</sup> of December 2013 and the first four months of 2014**

---

| <b>DIAGNOSTIC CATEGORIES</b> | <b>TOTAL FOR THE YEAR 2013</b> | <b>FIRST 4 MONTHS OF 2014</b> |
|------------------------------|--------------------------------|-------------------------------|
| <b>SCHIZOPHRENIA</b>         | 2                              |                               |
| <b>PSYCHOTIC DISORDERS</b>   | 40                             | 13                            |
| <b>PERSONALITY DISORDERS</b> | 51                             | 12                            |
| <b>MENTAL RETARDATION</b>    | 6                              |                               |
| <b>MOOD DISORDERS</b>        | 4                              | 3                             |

|  |            |           |
|--|------------|-----------|
| <b>ANXIETY DISORDERS</b>               | 26         | 6         |
| <b>ALCOHOL-RELATED DISORDERS</b>       | 70         | 11        |
| <b>OTHER</b>                           |            |           |
| <b>UNCERTAIN DIAGNOSI/NO DIAGNOSIS</b> | 45         | 11        |
| <b>TOTAL</b>                           | <b>244</b> | <b>56</b> |

## *Bologna*

**Self-harming episodes which took place in the period between the 1<sup>st</sup> of January 2013 and the 31<sup>st</sup> of December 2013 and the first four months of 2014**

---

| <b>SELF-HARMING</b>               | <b>WOMEN</b>                                     |                                       | <b>MEN</b>                                       |                                       |
|-----------------------------------|--|---------------------------------------|--|---------------------------------------|
|                                   | <b>FROM<br/>JANUARY TO<br/>DECEMBER<br/>2013</b> | <b>FIRST 4<br/>MONTHS<br/>OF 2014</b> | <b>FROM<br/>JANUARY TO<br/>DECEMBER<br/>2013</b> | <b>FIRST 4<br/>MONTHS OF<br/>2014</b> |
| <b>SLASHING</b>                   |  |                                       | 10   | 4                                     |
| <b>HANGING</b>                    |  |                                       | 1  |                                       |
| <b>LIP SEWING</b>                 |  |                                       |  | 1                                     |
| <b>AMPUTATION</b>                 |  |                                       |  |                                       |
| <b>FOREIGN BODY<br/>INGESTION</b> |  |                                       | 7  | 5                                     |
| <b>TOTAL</b>                      |  |                                       | <b>18</b>  | <b>10</b>                             |

Suicide attempts for the pathology during 2013 and the first 4 months of 2014

**No answer to the question**

Suicide attempts: figures according to gender and country of origin during 2013 and the first 4 months of 2014

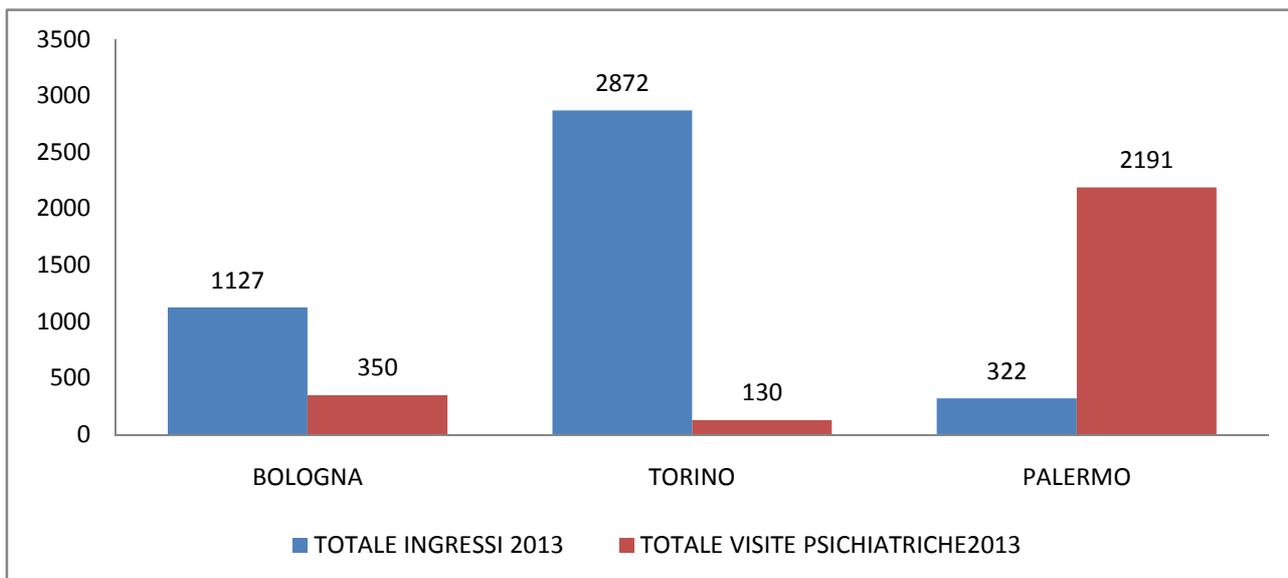
No answer to the question

**Figures according to diagnosis provided using the DSM-IV in the period between the 1<sup>st</sup> of January 2013 and the 31<sup>st</sup> of December 2013 and the first four months of 2014**

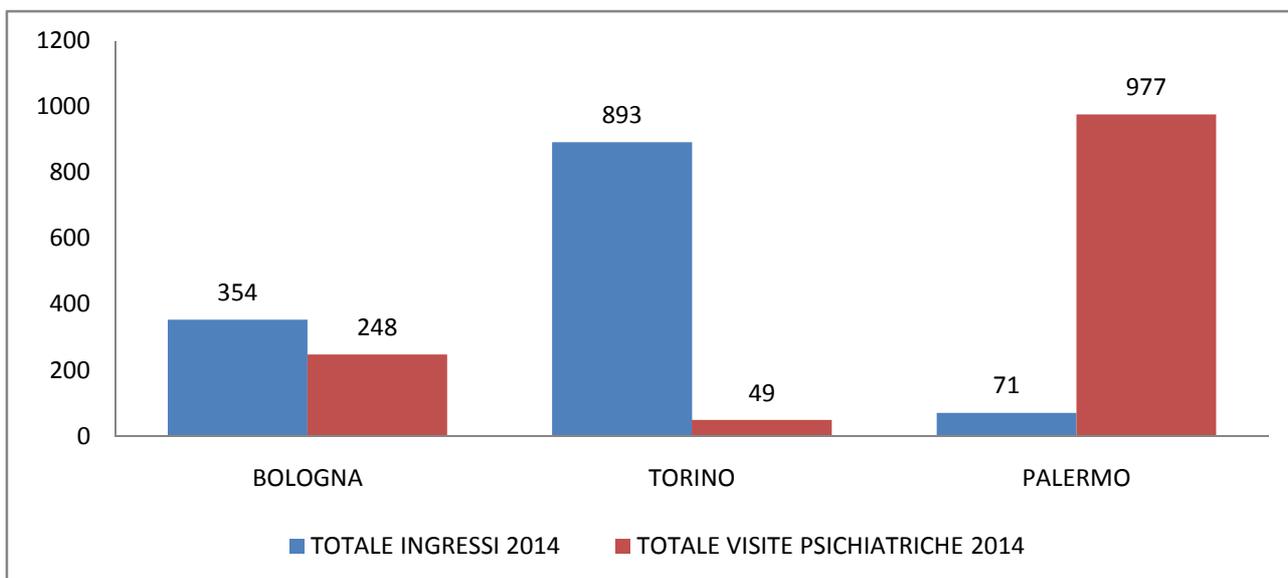
| DIAGNOSTIC CATEGORIES     | TOTAL FOR THE YEAR 2013 | FIRST 4 MONTHS OF 2014 |
|---------------------------|-------------------------|------------------------|
| SCHIZOPHRENIA             | 2                       | 2                      |
| PSYCHOTIC DISORDERS       | 13                      | 7                      |
| PERSONALITY DISORDERS     | 160                     | 90                     |
| MENTAL RETARDATION        | 6                       | 2                      |
| MOOD DISORDERS            | 75                      | 30                     |
| ANXIETY DISORDERS         | 40                      | 25                     |
| ALCOHOL-RELATED DISORDERS | 100                     | 45                     |
| OTHER                     |                         |                        |
| UNCERTAIN DIAGNOSIS       | 100                     | 80                     |
| <b>TOTAL</b>              | <b>496</b>              | <b>281</b>             |

***PSYCHIATRIC COUNSELLING WITHIN THE THREE  
PENITENTIARY FACILITIES***

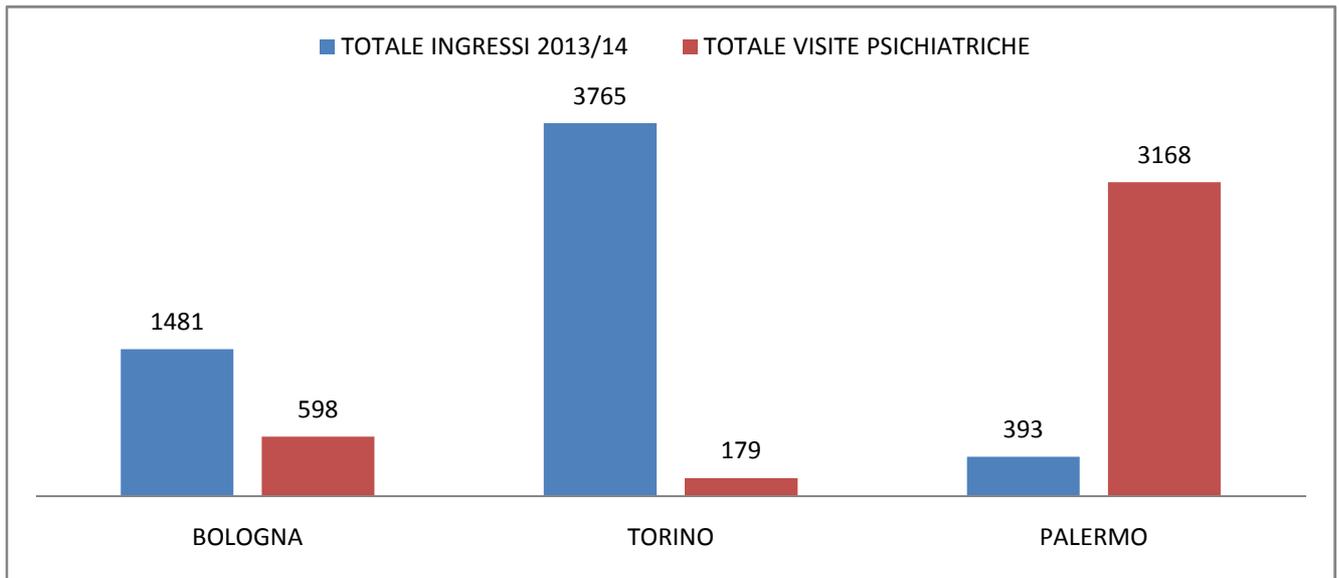
Charts concerning the psychiatric counselling declared within the three penitentiary facilities below. A comparison with the entrances recorded in the years 2013-2014 was made in order to give more value to the figures.



**Chart 4.1**



**Chart 4.2**



**Chart 4.3**

This section aims at showing the “real figures”, namely those figures which far from being gathered by a statistical analysis are real numbers, which were then written into charts created ad hoc in order to quantify the number of episodes of self-harming, suicide attempts and the diagnosis made on the basis of DSM-IV. Moreover, a micro-section only dealing with psychiatric counselling made within the three penitentiary facilities in 2013-2014 was created.

We should start by saying that the fact that the majority of surveys of this section were not completed does not make it possible for us to examine in-depth and correlate the “real figures with the perceived ones”. But the “missing figures” have a different connotation that allows us to make an hypothesis which finds its answer in the missing number itself. The most complete figures come from Palermo’s institution, the only prison in which the shift of the healthcare from penitentiary administration to local health service still has not taken place. Taking into account the reality, it is believed that it is probably this lack of shift to make healthcare service more effective and capable of offering a balance of the actual services provided by healthcare system. The illusory inconsistency in the answers about the service provided by Palermo’s institution, where the number of medical examinations

exceeds the number of entrances, is actually meant to show an overlapping in different kinds of medical examinations taken by the same inmate. According to the people who carried the study out, this does not mean that Palermo's healthcare service does not work properly but, on the contrary, it indicates a more complete service which guarantees inmates a more efficient healthcare even though it is not regulated by NHS.

As for Bologna's institution, what we could notice was the existence of a weak healthcare service - we do not know the kind of people who entered the institution nor the kind of treatments they asked for. The number of people who asked for psychiatric counseling was less than 50% of the people who entered the penitentiary facility.

Finally, in order to provide a further explanation of the figures, it is necessary to specify that the figures collected in Turin refer to the care of inmates within the psychiatric department of the institution with respect to the total of people who entered the penitentiary facilities, rather than the ones who benefited from psychiatric counseling.

## ***FINAL CONSIDERATIONS***

Even though this consideration is typical of every outcome linked to this kind of cognitive rather than statistical study, as the work is about to come to an end it seems useful reminding that its meaning is a consequence of applied methodology and thus of the limits it includes. Therefore, the outcomes are to be considered valid only when linked to those parameters which were taken into account and they could lead to further considerations if compared in a different way, taking even more into account the importance of the meeting to be held as an essential part of our project. The methodology in question was in line with the task we had previously set, that is a cognitive study - mainly a qualitative one - which sheds light on the “perceived” data, everyday more reported and recalled – and not only in our country.

As a matter of fact, the title of an article issued by The New York Times on the 5<sup>th</sup> of March 1998 was: *Prisons replace hospitals for the Nation’s Mentally Ill*; it pointed out that almost 200,000 people behind bars - more than 1 in 10 of the total - are known to suffer from serious psychiatric conditions.

Of course the situation in the US is much different from Italian’s but it stresses how in few decades prison has become an extreme place hosting and inevitably treating mentally disturbed people.

There is the need to conceive and create an operative model not only being a therapeutic tool “within” the prison, but something conceived together “with” the prison<sup>1</sup>.

However, considering the expectations about the possible outcomes coming from the three institutions asked to collaborate and the collection and assessment of the surveys, what is stressed is a high percentage - 20% - of superficial and partially-

---

<sup>1</sup>De Risio A. (1999): *La relazione che cura: linee di indirizzo sulla razionalizzazione dell’intervento psicoterapeutico e psichiatrico in ambito penitenziario*. In: *Richiesta e offerta di psicoterapia*. (by) Pier Maria Furlan, pp. 487 - 492, Centro Scientifico Editore, Turin

completed questionnaires which had to be invalidated or contained comments not giving any food for thought for the study field.

What can be assumed by this is a low degree of involvement and interest (**objectified reason**) by the above-mentioned percentage of subjects.

Personal details (see from chart 1.1 to 1.8 above) of the three target Institutions' staff revealed a high percentage of men (70%) if compared to women (30%) and an average age of 34.5 years, the most representative age being in the range between 35 and 44 year olds.

It is important to highlight how experience in the field turns out to be the “tool” of knowledge (see from chart 1.9 to 1.12 above) adopted by interviewed professionals, despite this recalling the inefficiency of basic/not-basic paths taken by different professionals, no matter if they are provided by Penitentiary Administration or the NHS.

In particular, the healthcare field (see charts 1.13; 1.14; 1.15) shows a poor involvement of specialised healthcare, being this a data which could on one hand refer to the fear of physical contagion – just like the figures shown in the charts about inmate's critical past– and on the other hand be linked to a misuse of psychotropic drugs to sedate ability-to-adapt-related psychotic disorders, seen as a reaction to imprisonment.

Mental disorders which seem to threaten inmates' mental stability the most – like it is shown in chart 2.1 about Penitentiary Police – are depression, imprisonment-related stress, simulation for judiciary purposes, drug use, psychotropic drugs abuse and psychosis. Sense of guilt for the crime and homosexual panic can be added to them, even though they seem to be less threatening than the ones mentioned above.

This last data is also made clear by the answers provided by nursing professionals (chart 2.10 Nurses) and is also linked to the fear of being transmitted an STD.

The above-mentioned data is linked to the iatrogenic effect of imprisonment itself, both in its environmental and judiciary aspects and in the subject's personal and socio-familial aspects.

As it was said in the introduction, the peculiarity of this study is that of identifying not only the inmate's real/perceived mental distress, but also outlining those intervention strategies which can be adopted within the penitentiary institution and that can be addressed to the staff operating in these places and dealing with these situations daily. What comes out from the analysis of the data is that subjects feel the need of an updating on the themes of psychic distress in a percentage which ranges from 75% (Bologna and Palermo charts 3.5 and 3.6) and 57% (Turin chart 3.7). These values lead to a consideration on the big shortage of knowledge on this issue and, at the same time, on the proposal to train in order to improve the quality of their intervention. This need is once again stressed by the data obtained about the so-called "sources of help" where the three Institutions agree on underlining the urging need of updates both on a technical and professional level, training courses, intra-professional training and communication courses (chart 3.13 "sources of help").

As for intervention strategies, another important data concerns the kinds of treatments which are believed to improve the response to the distress. Among them the ones which obtained a higher level of agreement seem to be the psychotherapeutic treatment and the hospitalization (see chart 3.14 "kinds of treatments" above). It is also very important focusing our attention on the psychotherapeutic treatment, also taking into account those factors pointed out by penitentiary police staff as tools which could favour the rehabilitation, namely individual/group psychological treatments and encouraging subjects to get into social relationships in order to face distress (see chart 3.21 "factors which favour the rehabilitation" by Penitentiary Police). On the basis of a qualitative interpretation of the data reported so far, it can be assumed that the focus on the need of an increase in the psychological treatment – expressed by the different subjects involved – could indicate the substantial shortage of psychological interventions aimed at limiting the distress. According to what was

just stated, the subjects identify in the fact that patients do not respond to the therapies they are administered, that they have nothing to do, in the inadequacy of penitentiary facilities and in stressful situations the factors which seem to prevent inmates from rehabilitating (see chart 3.19 above).

Therefore, it seems essential to underline a relevant data, that is the importance given to the architectural inadequacy of facilities and to limited and abandoned meeting places – as a result of the spending review – which lead inmates to spend much time within the “cell blocks”, where laziness becomes a joint cause of forms of maladjustment. Fighting the tendency to be lazy, also as means to safeguard the mental health of inmates, means allowing them get into relationships with those people (namely, family members, communitarian institutions, voluntary work) who could be useful, or even essential, not to isolate the subject. The isolation linked to their mental health condition, which is very often hidden by the inmates, is worsened by the fear of a possible marginalization. Therefore, this seems to be an operation which does not involve the legislator, but makes it necessary to carefully read the Penitentiary Act.