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MENTAL HEALTH AND PSYCHIATRIC CARE IN PRISONS

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Presentation

Mental health in prison is a particularly critical area in the context of the protection of the general health of persons sentenced to prison. This is true, despite the fact that protection of health is both a human right as well as a constitutional right, therefore equally valid "inside" and "outside" prison walls, in conditions of equal treatment for those who are free and those who are imprisoned.

Prison, by its very nature, compresses individual rights, mental health in particular is undermined by the suffering linked to the state of restriction and total dependence of the prisoner for provision of all the necessities of everyday life. From the incompatibility of prison with mental health stems the indication that the responsibility for treatment of persons with psychiatric disorders should as a rule take place out of prison, in regional community setting. Psychiatric care in prison should be limited to people with minor disorders, or to the small number of those for whom it is not possible to apply an alternative to imprisonment for therapeutic purposes. It should also be remembered that the safeguarding of mental health does not coincide with psychiatric care, however important it may be: the invitation is to set up a sufficiently adequate environment in order to maintain the mental balance of prisoners and not exacerbate the conditions of those already suffering from disorders, ensuring first of all decent conditions of detention and respect for fundamental human rights.

The crux of the problem of mental health-prison is complicated by other issues, including, from the start, the different treatment by the criminal justice system (the so-called `double track`) to which offenders with psychiatric problems may be subjected. Some (so-called “insane offenders”), judged to be non-imputable (not criminally responsible), for their offences by reason of (total or partial) insanity at the moment of the act and therefore acquitted, were however subjected to a security measure in the Judicial Psychiatric Hospital - OPG; this was the case before Law 81/2014 which closed OPGs: today, on the other hand, those acquitted are directed to the new articulated system of transferring responsibility for treatment to community regional facilities, which includes the Residences for the Execution of Security Measures-REMS. Others, so-called “mentally ill offenders”, judged to be imputable (criminally responsible) for their offences were sentenced to prison, where they developed a serious psychiatric disorder or faced with an aggravation of a previous pathology, were transferred to a Judicial Psychiatric Hospital. Today, with the abolition of OPGs “mentally ill offenders” do not enjoy the protection to which they are entitled, since there is no clear legislation to establish their incompatibility with prison and direct them to alternative therapeutic measures.

The legacy of the OPG is still alive both on a concrete level, due to the still uncertain fate of the various types of psychiatric patients who crowded these institutions; and above all on a cultural level, given the persistence of the old vision of the psychiatric patient as being per se’ dangerous, and therefore better locked up rather than treated. This concept is also fuelled by excessive recourse to the "track" of non-imputability and acquittal as a result of “mental defect", along with the correspondingly extensive use of security measures. Hence the reluctance to use legislative instruments that can favour treatment while not detained in custody for both mentally ill offenders and insane offenders, as well as the delays to regulatory changes moving in this direction.

Starting from these considerations, the ICB recommends: ensuring, as a basic form of mental health protection in prison, humane detention methods, respectful of people's dignity, offering treatment with opportunities for training and work within the perspective of re-socialization; the provision of health care for persons suffering from a serious mental disorder who have committed crimes should take place as a general rule in community–based settings, in therapeutic facilities and not in detention institutions, in compliance with the principle of equal protection of health for those who are free and those who have been sentenced to prison. Strengthening mental health services in prison, overcoming the historic "separateness" inherited from penitentiary healthcare: so that they function as an integral part of robust Mental Health Departments, capable of identifying community-based network resources for the treatment of serious pathologies out of prison and cooperate with the judiciary called on to ascertain the situation and the supervisory judiciary for this purpose.

The ICB also calls for some legislative innovations to protect both persons judged to be criminally responsible for their acts and sentenced to prison terms, as well as those declared not criminally responsible and acquitted. Specifically: the deferment of sentence when mental health conditions are incompatible with detention by analogy with the provisions of art. 146 and 147 regarding impairment of physical health; the provision of specific alternative measures for those who manifest a mental illness in prison; the introduction of Clinical Sections in prisons managed exclusively by health care services; a more incisive reform of security measures, to limit the use of the prison security measure. In addition, in accordance with the therapeutic purpose of REMS, it is necessary to limit the admission to REMS for subjects with a definitive custodial security measure. Lastly, the ICB invites reconsideration of the particularly problematic concept of "social dangerousness", which is at the basis of security measures, and the special "double track" legislation of imputability/non-imputability of subjects affected by mental disorder.

As part of the discussion, valuable contributions were obtained from the auditions of: Dott. Franco Scarpa, Psychiatrist, Director of the USL 11 Complex Operational Unit Tuscany (during the plenary session of 25 October 2018) and Dott. Andrea Bortolato, President of the Supervisory Court of Florence (during the meeting of the working group of 13 December 2018).

The working group was coordinated by Dr. Grazia Zuffa, who also prepared the initial draft.

Profs. Salvatore Amato, Carlo Caltagirone, Stefano Canestrari, Carlo Casonato, Anna Gensabella, Carlo Petrini, Tamar Pitch, Monica Toraldo di Francia contributed to the text.

The opinion was unanimously approved by those present, Profs: Salvatore Amato, Luisella Battaglia, Carlo Caltagirone, Stefano Canestrari, Carlo Casonato, Francesco D'Agostino, Antonio Da Re, Lorenzo d'Avack, Riccardo Di Segni, Silvio Garattini, Mariapia Garavaglia, Marianna Gensabella, Maurizio Mori, Assunta Morresi, Laura Palazzani, Tamar Pitch, Lucio Romano, Luca Savarino, Lucetta Scaraffia, Monica Toraldo di Francia, Grazia Zuffa.

Profs: Cinzia Caporale, Bruno Dallapiccola, Mario De Curtis, Gian Paolo Donzelli, Massimo Sargiacomo absent from the session subsequently approved the opinion.

The minutes show the adhesion to the document, of the following delegates without the right to vote: Prof. Carlo Petrini, ISS delegate; dr. Maurizio Benato, FNOMCEO delegate; dr. Amedeo Cesta, CNR delegate.

Premise

The Italian Committee for Bioethics intervened in 2013 on the subject of health in prison (*Health within prison walls*), identifying mental health as one of the critical areas that need particular attention. The NBC considers a new pronouncement appropriate, given the persistent difficulties in recognizing concretely the right to health protection in prison, especially mental health. In particular, the equation of the right to health among citizens both inside and outside prison walls - the principle that guided the passage of prison health to the National Health Service - requires a more complex commitment in the field of mental health.

The main reason lies in the role historically held by the Judicial Psychiatric Hospital (OPG), for the custody of all offenders with psychiatric problems: both those declared not imputable by reason of mental defect at the time of committing the act and therefore acquitted and locked up in the OPG, subjected to security measures as considered to be socially dangerous; and those deemed imputable and sentenced to imprisonment and who develop a serious mental disorder while in prison. Even the latter, normally judged to be incompatible with the prison regime, were destined to the OPG[1]; as well as those considered in need of psychiatric assessment, as a rule, transferred to OPG for its completion.

The closure of the OPG is only one part – albeit fundamental - in the construction of a new system of care of subjects suffering from mental disorder who have committed offences. This system is slow to take shape, partly because the regulatory changes resulting from the abolition of the OPG have not been completed; partly because the paradigm shift in the field of mental health - from the custodial paradigm (based on the danger to oneself and to others of the person suffering from mental disorder) to the therapeutic paradigm - is more difficult in the case of offenders. This favours legislative inertia, in a vicious circle. To summarize: the protection of mental health in prison must deal with the cultural residue of the OPG, which persists even after breaking down the prison walls; as well as the general difficulty in asserting the right to health protection in prison.

Hence, the double cultural leap, that this document intends to examine in depth: in the hope that this will accelerate the completion of a new system of mental health protection, respectful of a fundamental bioethical principle: the right to health as a human and constitutional right, from which stems equity in the protection of health both inside and outside prison walls[2].

[1] While article 147 of the Criminal Code (CP) regulates the postponement of the execution of the sentence for serious physical infirmity, art. 148 CP (*supervening mental infirmity of the offender*) provides that "if, prior to the execution of a sentence involving deprivation of liberty or during its execution, the sentenced offender is affected by supervening mental illness, if the judge deems the degree of the illness such as to prevent execution of the sentence, he can order it to be deferred or suspended and the subject hospitalized in a judicial asylum".

[2] See ICB opinion *Health within prison walls* (2013) which in the introduction reconstructs the theoretical and conceptual framework regarding the protection of human health. From the recognition that the right to health is a fundamental human right; that the state of individual health is determined by the possibility of taking advantage of a multiplicity of resources, both direct and indirect (such as for example housing situations, healthy environment, lifestyle, level of education, work conditions, etc.); the need to overcome health inequalities, paying attention to the most vulnerable subjects. See also ICB opinion *Bioethical guidelines for equal access to healthcare* (2001).

The bioethical perspective and International indications

To determine how to unfold the protection of mental health in prison, it is necessary to start from observation of the most deteriorated level of health, in particular of mental health, of the prison population compared to the general population.

Despite the paucity of epidemiological research[3], international data tell us that prisoners enjoy lower levels of health than those who are not "behind bars" and that mental health is the most critical area. Therefore prison is called into question as an environment that undermines mental health. It is also recognized that inmates often have more precarious general health than the general population, including mental health, even before entering prison. The WHO also takes note of the intrinsically pathogenic nature of prisons, stressing that "*the prison environment is, by its nature, normally harmful to the protection or maintenance of the mental health of those who enter prison and are detained there"*.[4]

The link between imprisonment and mental disorders has been addressed by various criminological scholars. Attention is focused on the mental suffering of both male and female inmates which is linked to being incarcerated and totally dependent for the satisfaction of all needs: it is the pain of imprisonment related to the "immaterial prison", which cannot be channelled into the process of transformation and rehabilitation of the prisoner[5].

In this regard, it is worth mentioning the timely denunciation of the Comité Consultatif National d'Ethique pour les Sciences de la Vie et de la Santé, the French Ethics Committee (taken up in the ICB document *Health within prison walls*) regarding prison as "the cause of illness and death": (prisons ed.) "*are the scene of regression, despair, self-inflicted harm, suicide*[6]*.*"

From the incompatibility between prison and mental health comes the indication that the responsibility for treating persons with mental disorders should normally take place outside prison by services in community settings. Psychiatric care in prison should be limited to people with minor disorders, or to the small number of those for whom it is not possible to apply this therapeutic alternative[7].

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[3] Consider that most general epidemiological surveys at the national level exclude the prison population, such as the ISTAT surveys in Italy and in the United States *National Health Interview Survey* (ARS Toscana, 2015)

[4] WHO Europe, *Trencin Statement on prisons and mental health*, 2007, p. 5 (in the entire passage of the declaration we read: "*International research shows that prisons in Europe hold a very high proportion of prisoners with mental disorders. Reasons for this are: - number of prisoners already have mental health problems before entering prison; – prison environments are, by their nature, normally detrimental to protecting or maintaining the mental health of those admitted and held there*").

[5] Cf. N. CHRISTIE, *Limits to pain. The role of punishment in penal policy,* Universitetsforlaget, Oslo 1981, trad. ita. *Abolire le pene? Il paradosso del sistema penale*, Edizioni Gruppo Abele, Torino1985; E. GOFFMAN, *Asylums. Essays on the social situation of mental patients and other inmates*, Anchor Books, New York 1961, trad. ita. *Asylums: Le istituzioni totali: la condizione sociale dei malati di mente e di altri internati,* Einaudi, Torino 1968; Cf. anche D. GONIN*, La santé incarcerée. Médecine et conditions de vie en détention,* L'Archipel., Paris 1991; trad. ita*. Il corpo incarcerato*, EGA, Torino 1994.

[6] *Comité Consultatif National d'Ethique pour les Sciences de la Vie et de la Santé,* opinion n. 94 (*La santé et la médecine en prison)*, 26 octobre 2006, p. 8.

[7] WHO Europe, 2007, cit., p. 6. Among the key criteria, the first states: "*There must be a clear acceptance that penal institutions are seldom, if ever, able to treat and care for seriously and*

The critical moments of imprisonment must also be identified, those which most endanger people's mental health: one of these is entry into prison, which can generate a real "entry syndrome" with manifestation of the phenomenology of mental and psychosomatic disorders[8]. Regarding the state of mental health of people entering prisons, the WHO reminds that "prisoners often come from communities where there is significant deprivation or poverty.", citing research that shows that “the most deprived communities also have higher levels of ill health, greater psychiatric morbidity and many social issues” Keeping these factors of psychosocial vulnerability in mind has an impact on the operational plan, as the WHO explains in detail: “supporting prisoners in maintaining their well-being or treating those with poor mental health is *not only a matter of providing the right medication and psychological treatment, but is also about helping them to address their physical health and social needs*”[9].

Here summarized in a few lines is the operational corollary that derives from the concept of health as a right to “physical, mental and social well-being” (and not merely the simple absence of illness). It is also the cardinal principle of the health reform: protecting mental health does not only mean setting up an efficient system of psychiatric care, aimed at treating supervening pathologies and diagnosing them early on (however important the early diagnosis of psychiatric disorders in high-risk environments for mental health such as prisons may be); but first and foremost, "the importance of ensuring that all those incarcerated have their most basic needs and human rights met”. The invitation is therefore to prepare a sufficiently "healthy" environment: in the sense of sufficiently adequate to maintain the mental health of persons and not aggravate the condition of those already suffering from disorders. In addition to the structural requirements of the detention premises (sufficient size, lighting with natural and artificial light, ventilation, heating, provision of reserved, decent, rational and clean sanitary facilities), the recommendation is to pay attention to the psychological and relational aspects (such as the possibility for inmates to maintain significant relationships even intimate ones, respect for privacy, the offer of activities in order to be occupied and fill time).

These are the basic elements of mental health, on which the system of mental health services inside prison is based (or should be based). In establishing the basic standard of "well-being", it is recommended to keep in mind the point of view of both male and female inmates: in a research cited by the WHO, the priorities identified by prisoners concerned "the ability to form trusting relationships with health professionals", “continuity of care”, “clear and detailed information regarding the nature of their illness and the side-effects of medications”; “involvement in planning their own care and pathways of care.[10]

Note that these are also the key elements of the care relationship. In addition, inmates report the importance of timely support at times of particular difficulty (for example, the possibility of talking to someone, a professional, but also a "peer" mentor, to avoid the likelihood of any deterioration. The "stabilizing"

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acutely mentally ill prisoners. Such prisoners should be diverted to appropriate mental health services…”.

[8] The "entry syndrome" appears more frequently in people incarcerated for the first time, especially those in which the gap between the quality of life conducted when free and the quality of life in detention is wider.

[9] WHO Europe, *Prisons and Health*, 2014, p. 87.

[10] R. JAYNE, *Service user engagement in prison mental health in reach service development*, in “Mental Health Review”, 2006, 11 (2), pp. 21-24, cit. in WHO Europe, 2014, p. 90.

psychological value of being involved in activities that may help them on release from prison, is also reported[11].

This comprehensive approach to mental health requires the involvement of different levels of responsibility. The preparation of a (physical, relational, treatment) environment that is as healthy as possible depends on the prison administration, and in fact it is recommended that "the promotion of mental health and well-being are central factors in prison policy"[12]. However, after the transferral of healthcare to the National Health Service, the health authorities should also take care of these basic elements of mental health, as institutions that operate in the front line for the concrete affirmation of the right to health of inmates, and equality of protection with citizens enjoying freedom. This is the point of having a single system today for the protection of all citizens, male and female, both inside and outside prison walls.

There is a double difficulty here. On the one hand, despite the repeated calls of international bodies (which also reflect the original inspiration of health reform), the idea prevails that the protection of mental health is equivalent to ensuring only specialized psychiatric services, in line with the more general tendency to confuse health with healthcare. On the other hand, the new ownership of the NHS in prison has not completely eliminated the cultural heritage of penitentiary health in dealing with the conflict between the health needs of inmates and security requirements. In the context of prison health, health was seen as a variable dependent on the prevailing custodial mandate of the prison. After the reform, health, gains its autonomy *as a right*, to which the new health system - not by chance autonomous from the prison administration - is called on to represent and guarantee. But institutional autonomy does not always bring about cultural autonomy in the daily practices in which the staff, employed by the NHS, is engaged: it is evident that there is greater difficulty on the part of the social and health care staff to dialogue with the prison authorities regarding the psycho-social-environmental characteristics of penitentiaries, as far as they are personnel not legally dependent on the prison administration.

This brings us back to the conflict between the protection of mental health and the "structural" characteristics of prison: first and foremost as a place of segregation and "removal from sight" of individuals. In summary, prison compresses individual rights. To be remembered, in particular, is the contradiction between the assertion of right and fulfillment of the prison security mandate, which tends to limit it; the contradiction between the initial health deficit of those on entry, and the experience of prison itself which, far from working for equality, accentuates imbalances because it produces suffering and illness[13].

Finally, with respect to mental disorder, there is one last bioethical problem, which has remained intact even after the closure of OPGs: the *non-imputability* provided for by the criminal justice system for psychiatric illness or serious personality disorder. The finding of non-imputability is based on the judgment that the perpetrator of the offence was "deprived of the capacity of understanding or volition at the time of the act": and in consequence acquitted (and therefore exempt from the prison sentence). However, the acquitted person is usually subjected to custodial security measures, based on the judgment of social

[11] G. DURCAN, *From the inside. Experiences of prison mental health care*, Sainsbury Centre for mental health, London 2008.
[12] WHO Europe, 2007, cit. p. 6.
[13] Cf. Opinion *Health within prison walls,* cit. p. 6.

dangerousness. This norm is configured as "special legislation" for people with psycho-social disabilities, expressly excluded by the Disability Convention[14].

Without going into the complex problem of the regulatory change, it should however be remembered that the so-called "double track" for those deemed to be imputable/non-imputable constitutes an unresolved problem, at the basis of regulatory and cultural difficulties, in ensuring the protection of offenders affected by mental disorders. Historically, the track of non-imputability, leading to the custodial security measure and internment in an OPG, has proved to be more afflictive than the track of imputability. On the cultural level, it gave vent to the concept of social dangerousness supporting the link between mental disorder and dangerousness; and thereby operating for maintaining the overall system of security measures (only partially modified by law 81/2014).

Advancing reservations about the concept of non-imputability of the subject suffering from mental disorder is not to deny his illness, rather it is to refuse the presumed naturalistic and deterministic automatism between illness and crime, and give back individuality and responsibility to the patient, and therefore the possibility of reworking an important part of one's personal experience linked to the offence.

To this end, it is essential to ensure a system of intervention that is able to meet the therapeutic needs of the person who has committed crimes, and which is also capable of acting in a preventive/proactive manner to intercept mental disorder in its initial phase.

Epidemiology of mental health in prison

Epidemiological research in prison is not yet sufficiently developed, at a national level and even less so at the local level. This situation is similar in many other countries.

For Italy, the most recent and most important study is the multicentric one in 2015, in which mental disorder is confirmed as being the most frequent pathology in penitentiaries: this is an already internationally known datum since the first investigations carried out at the beginning of the last century[15].

The impaired level of mental health of prisoners gives rise to difficulties in interpretation, influenced by two possible interacting variables: the pathogenic role of prison on the one hand, and the low level of mental health (and health in general) before entering prison on the other. The volume of studies on the relationship between the so-called "social gradient" and health inequalities would point to focusing on the relationship between the deterioration of health and the situation of social hardship from which a large proportion of the prison population originates[16]. This can raise numerous problems in the field of criminology, these

[14] United Nations, *Convention on the Rights of Persons with Disabilities*, 13 December 2016. According to the Convention (Article 12), people with psychosocial disabilities must enjoy equal rights, including the right to legal capacity.

[15] The study was conducted by the Regional Health Agency (ARS) of Tuscany in collaboration with the Ministry of Health: *The health of prisoners in Italy*: *the results of a multi-center study*, Documents of the National Health Agency of Tuscany, April 2015, n. 83. To show how psychiatric disorders have always been the prevalent pathology in prisons, an early-twentieth-century study is cited in the United States (p. 75).

[16] For example, a correlation was found between the socio-economic situation and the presence of the most common disorders, such as anxiety and depression. See J. ORFORD, *Community*

themes will not be dealt with in this opinion[17]. Compared to the specific subject of this document, the aforementioned studies would prompt careful consideration of the socio-environmental components of health (more than has been done to date). Nevertheless, epidemiological studies in the prison population, such as the one cited in 2015, do not provide sufficient insight in this direction. For example, the survey form is limited to indicating the level of education of the sample of prisoners (which shows a significant downward divergence compared to the general population)[18]

On observation of the types of disorders prevalent in the total number of male and female inmates enrolled, in first place we find addictions to psychoactive substances (23.6), neurotic disorders and adaptation reactions (17.3%), alcohol-related disorders (5.6 %), psychotic affective disorders (2.7%), personality and behavioural disorders (1.6%), non-psychotic depressive disorders (0.9%), senile and presenile organic mental disorders (0.7%), schizophrenic spectrum disorders (0.6%). Due to the scarcity of cases, it is not possible to calculate the percentage of oligophrenia and mental retardation, and the percentage of eating disorders.

Moving on to the distribution by gender of the diagnoses[19], the diagnosis of psychoactive substance addictions prevails among men (50,8% of men and 32.5% of women), and among women the diagnosis of "neurotic disorders and adaptation reactions" (36.6% of the diagnosed were female and 27.1% male); followed by “alcohol-related disorders among men (9.1% of men and 6.9% of women), and among women with psychotic affective disorders (10.1% of women and 4.1% of men), by personality and behavioural disorders (2.4% of men and 3.4% of women), non-psychotic depressive disorders (1.3% of men and 2.8% of women). In the ranking there are senile and presenile organic mental disorders, schizophrenic spectrum disorders, oligophrenia and mental retardation.

These differences in themselves would require targeted studies for gender specificity and in particular for women inmates, in order to investigate in depth both the state of mental health on entering prison, and the (different) capacities and strategies of resistance to the stress of imprisonment.

As can be seen, about half of the diagnoses concern disorders related to psychoactive substances (abuse and addictions), which is not surprising considering that in prison a large portion of the population is directly imprisoned for violating the anti-drug law[20]. Then come "neurotic disorders and adaptation reactions", which suggest the significant role played by incarceration stress in the

Psychology. Challenges, Controversies and Emerging Consensus, Wiley, Chichester 2008, pp. 102 ss.

[17] See the theme of "unequal" orientation of *law enforcement* and the prison response

[18] In particular: 7% of the prison population has no educational qualifications (compared to 4% of the general population); 58% (of the prison population) stopped at middle school level (compared to 29% of the general population); 10.7% stopped at secondary school level (compared to 36.5%); only 3.5% have a university degree (against 12.5%). The group of foreign prisoners has lower educational levels compared to Italians.

[19] The study uses the categorization of the Regional Information System for Mental Health (SIRM), with which the disorders detected in the mental health services of the territory are catalogued (see p. 75).

[20] In 2017, 29.37% entered prison in violation of Article 73 of Presidential Decree 309/90. For the same infringement, 34.3% are in prison on December 31, 2016. On the same date, drug addicts represent 25.5% of all prisoners present (DAP Data, Office for the development and management of the information system). See also Department of Anti-Drug Policies of the Presidency of the Council of Ministers, *Annual Report to Parliament on the phenomenon of drug addiction in Italy*, Year 2018 (Data 2017), pp. 34 ff.

development and/or emergence of the disorder[21]. Note the greater significant presence of these disorders among female prisoners: the same can be said for "psychotic affective disorders" and for "non-psychotic depressive disorders".

As for the scarce presence of serious disorders, such as organic mental disorders, the schizophrenic spectrum and oligophrenia, it should be remembered that at the time of the investigation Judicial Psychiatric Hospitals still existed, all severe mental illnesses were destined there, including those that occurred in subjects after their imprisonment.

Moving from epidemiological data to operational indications, especially with regard to the most frequent disorders such as those from adaptation reactions, the importance of identifying disorders that are the continuation or spotlight of already existing psychiatric illness immediately on entry into prison is evident; distinguishing them from the disorders that represent a psychopathological response to particularly traumatizing events linked to imprisonment (imprisonment, adaptation to an extraneous living environment, waiting to be prosecuted, being convicted, possible episodes of violence etc.). This is all the more important in terms of interventions, since the adaptive response to prison is based on different variables, modifiable to a greater or lesser extent: from individual ones of personality characteristics and previous life structure, to environmental ones related to particular contingencies (being locked up for many hours in prison cells, difficulty of cohabitation in prison cells etc.).

The legacy of the Judicial Psychiatric Hospital (OPG)

As already mentioned in the introduction, the closure of the OPG is merely a part of the change in legislation that occurred following the recognition of health as a right also for those detained and of the consequent equalization with all other citizens in the enjoyment of the right. Already the Prime Minister's Decree of April 1, 2008 (transition to NHS) outlined the lines of intervention for the OPG, later specified in laws 9/2012 and 81/2014, which designed the new system for taking charge of those acquitted. In the light of the right to health and appropriateness of care, an indistinct container like the OPG intended for a variety of subjects grouped together solely for custodial purposes, was no longer tolerable, The orientation of the legislator, from 2008 to 2014, was prompted by the positions taken by the Constitutional Court, which several times, between 2003 and 2004, recalled the pre-eminence of the right to health of persons suffering from mental disorders.

On the basis of this right, the Court paved the way for a system centred on the taking charge by community care, affirming the unconstitutionality of the automatism that required the judge to apply security measures in the OPG “even when a less drastic measure, and in particular a more flexible and non-segregating measure such as probation (...) appears capable, in practice, of simultaneously satisfying the needs of care and protection of the person concerned and of controlling his social dangerousness ". The pre-eminence of the protection of health is also reaffirmed in another passage of the pronouncement, which states that "The need to protect the community could

[21] In the "slatentization" of the disorder, to use a technical term.

never justify measures which would harm, rather than benefit the patient's health." Hence the invitation to rethink the whole system of security measures[22].

Along these lines, the laws cited, in particular Law 81/2014, have sanctioned a turning point, on the one hand by imposing to establish a term for the custodial security measure and therefore putting an end to "white life sentences"[23] on the other hand prefiguring “equal” care to that provided to all other citizens affected by mental disorder, and *therefore hinged on transferring responsibility for treatment in the community*. To this end, Law 81/2014 introduced another change, establishing the principle of the custodial security measure as a last resort as per the principle of *extrema ratio*, only when other less restrictive instruments - such as non-custodial security measures (probation) or entrustment to community-based therapeutic facilities - are judged to be unsuitable by the magistrate. It is therefore incorrect to say, what is often heard, that "the OPG has been replaced by the Residence for the execution of Security Measures - REMS", since being admitted to REMS should represent a residual solution for those acquitted.

The regulatory setback and “double track” of justice and care

The process of legislative adjustment was interrupted after law 81/2014. The “double track” of imputability/non-imputability which opens up before criminal offenders with mental disorders and produces the “double track” of treatment has been left untouched: the former regards “mentally ill offenders”, judged to be capable of understanding and therefore deemed criminally responsible; the latter regards so-called “insane offenders” considered not criminally responsible. Since law 81/2014 dealt only with the track of healthcare concerning “insane offenders” the fate of the other types of patients previously housed in the OPG remained uncertain: the persons considered imputable and therefore judged and sentenced to imprisonment, but during detention become affected by such mental disorder as to trigger incompatibility with imprisonment; persons with provisional security measures pending verification of non-imputability (with the possibility of a subsequent transformation of the temporary security measure into a definitive measure); and subjects under psychiatric observation (the so-called "Osservandi"), at the magistrate's disposal, in order to determine the existence or non-existence of mental infirmity supervening during detention.

With regard to persons with temporary security measures, their placement in the REMS contrasts with the eminently therapeutic nature of these structures, therefore it should be reserved only for subjects, once definitively acquitted, who can be the recipients of a personalized treatment plan: the ICB already expressed itself in 2017 on this regard.[24]

[22] Judgment of the Constitutional Court n. 253 of 2003. The principles to which this ruling refers were reiterated in sentence n. 367 of 2004 and n. 208 of 2009. Cf. K. PONETI, *Salute mentale in carcere: l’incerto destino dei rei folli,* in F. CORLEONE (a cura di), *Mai più manicomi*, Fondazione Michelucci Press, Firenze 2018, pp. 85 ff.

[23] With law 81/2014 the security detention measure (i.e. admission to REMS) is subject to a term identified by the maximum penalty prescribed by law for the committed crime. Beyond this term the measure cannot be extended and therefore must be revoked or transformed into a lesser measure, such as probation.

[24] See the ICB opinion *Caring for persons with mental illness: some bioethical issues*, 2017 p.36

With regard to the specific issue of healthcare in prison, the most delicate and controversial issue concerns those that have already been convicted and imprisoned and are assessed as having a severe psychiatric disorder while serving their sentence. For these subjects, the reference is to articles 147 Penal Code and 148 Penal Code (the first on the deferral of the sentence for incompatibility with detention, the second which establishes the transfer to an OPG). Article 147 allows those who find themselves "in a state of serious physical illness" to enjoy the suspension of the sentence, leaving the penitentiary circuit to be subjected to the measure of home detention in order to be treated. The lack of reference in this article to "mental illness" has so far prevented the extension of the possibility of suspension to subjects with psychiatric illness, leading to discrimination that is harmful to the principle of equality and the right to health protection. As for Article 148, the provision survives despite the fact that OPGs no longer exist. The problem therefore arises of where and how these people should be treated, respecting their right to health protection.

Even for these subjects, it is unthinkable for them to be admitted to a REMS facility, without its curative purpose being lost, and turning it into a replacement for the OPG.

The paradox of the survival of art.148 after the closure of OPGs leads us to reflect.

On the one hand, it is a direct indication of the lack of clarity regarding the overall design of care of "mentally ill offenders"[25] but also, an indirect indication, of the care of "insane offenders", because it puts strain on the new system of care outlined for the latter; on the other hand, it prompts to use REMS as if they were OPGs on a smaller-scale.

The lack of an organic project is evident analyzing in detail the regulatory process that has led to the current situation. The 2008 Prime Ministerial Decree called for the activation of specialized prison sections within institutes, specifically for defendants and those sentenced to prison who suffer from mental illness. With this, the decree gave the go ahead to emptying OPGs and returning the majority of patients to prison: the various State-Region agreements intervening after 2008 attempted to adapt to this line, hypothesizing "penitentiary psychiatric structures", based on art.65 of Penitentiary Regulations. After the closure of OPGs, the State Regions agreement of 22/01/2015 (point 3.2 of the annex to the agreement) opened the psychiatric divisions in prisons even to those prisoners with particularly serious pathologies, so serious as to be assessed as being incompatible with detention[26].

But "penitentiary psychiatric structures" present a series of serious problems: from the lack of adequate juridical coverage and indications regarding the structural characteristics[27]; to the lack of clarity regarding the management of the structures themselves (which are still prison sections under the responsibility of the Penitentiary Administration, insofar as "prevailing health management"[28]).

[25] Mentally ill offenders refers to defendants sentenced to prison and suffering from severe psychiatric disorder, as mentioned above.

[26] These are the persons previously assigned to OPGs according to the aforementioned art. 148 of the Penal Code

[27] Only a law, and not a State-Regions Agreement, can regulate the forms of deprivation of personal freedom; in addition, the agreement cannot abolish a law, art. 148 that destines the patients to the OPG, thereby maintaining the confusion

[28] This is the wording found in delegated law 103 of June 23, 2017, *Changes to the penal code, the criminal procedure code and the penitentiary system.*

In other words, penitentiary psychiatric structures seem to go in the opposite direction to the guiding idea presented at the beginning, according to which people with serious pathologies should have the right to be treated outside prison, on equal terms with those who are free.

Perhaps due to this initial confusion, many of the planned psychiatric structures have so far only remained on paper, while others appear to be devoid of any healthcare characteristics[29]; others, reconversions of former OPGs, such as the structures of Reggio Emilia and Barcellona Pozzo di Gotto, host prisoners to which Article 148 of the Italian Criminal Code has been applied, are cause for concern, either because of the high numbers of patients, or because they concentrate inmates who come from all parts of Italy[30].

The delegated law for the reform of Penitentiary Regulations of 2017, and the subsequent work of the ministerial commissions charged with studying psychiatric care problems, had indicated the first steps to overcome the difficulties[31]: both reiterating the destination of the REMS for those acquitted and subjected to a security measure (and only temporarily and alternatively for convicted subjects affected by mental disorder when the prison psychiatric structure proves to be inadequate for treatment purposes); and drawing the legal framework to reinforce out-of-prison psychiatric care, anticipating the priority of community-based treatment. In this direction, it provided for the repeal of Article. 148 and the modification of art. 147 (to allow the deferral of penalty also for supervening mental and not just physical illness). This, in order to allow home detention in the place of treatment, with the Department of Mental Health taking charge. Furthermore, a new method of probation was introduced for therapeutic purposes (based on the one for drug addicts): to be applied for under six-year sentences, or residual sentence.

However, the legislative decree n. 123 of 2 October 2018, implementing the delegated law, does not include most of these proposals, in fact it circumvents the mental health problem. Article 147 of the Italian Penal Code has not been amended nor has art. 148 been repealed; the new alternative therapeutic measures for mental patients have not been introduced and Clinical Sections inside penitentiary institutions under healthcare management[32] have not been established.

Not only was the crux of the "double track" of justice for imputable/not imputable offenders not addressed, neither were the suggestions for greater articulation of security measures accepted, which could have provided magistrates with a new intermediate measure, in between the custodial security measure in REMS and probation with therapeutic prescriptions: that is, admission

[29] See the case of psychiatric structure in the Dozza prison in Bologna. The Supervisory Judiciary was asked to rule on a case of deferment of sentence, sent to the psychiatric division of Dozza after the closure of the OPG. The response was that the person could not remain there because the structure had nothing to do with healthcare.

[30] In July 2018, in Reggio Emilia, there were 47 present, of which only 16 from Emilia Romagna; in Barcellona Pozzo di Gotto, 69 present, of which 53 from Sicily. Therefore the principle of territoriality is disregarded.

[31] Delegated Law 103 of June 23, 2017, Changes to the Criminal Code, the Criminal Procedure Code and the Penitentiary System

[32] The draft legislative decree of December 2017 (not implemented) in a first version spoke of "exclusively healthcare" management. Parliament has changed the expression to "predominantly healthcare". In any case, the competent Region should manage the Clinical Section autonomously and mainly with its own staff.

to a community under a semi-custodial regime. Just as the proposal to limit the custodial security measure to the most serious crimes was not accepted.

Faced with this legislative inertia, there have been interventions by the Judiciary. The order of the First Section of the Court of Cassation 13382/2018 refers to the Constitutional Court the question regarding art.148, inapplicable after the closure of OPGs and therefore considered to be implicitly repealed. The pronouncement of the Council is expected soon.

At the same time, the Court of Cassation reported that the failure to modify Article 147 has created a vacuum in the protection of inmates affected by psychiatric illness[33]. More radically, the order of the Messina court of surveillance (February 28, 2018), considering art.148 Penal Code automatically abrogated, considers that the deferral of the execution of the sentence in the form of home detention in a therapeutic structure, established by art .147 for physical pathology, can be applied by analogy also to mental illness, therefore "filling a regulatory gap" - the judge writes -, according to a totally acceptable perspective.

"Mentally ill offenders" and "Insane offenders": the system in total crisis

The uncertainty regarding care to "mentally ill offenders" concerns both the provision of adequate instruments and organization in prison (the Clinical Sections mentioned above); and more at the root, is the question of the non-compatibility of the illness with imprisonment, considering as a rule treatment outside prison. The choice of community based care was made by law 81/2014 for "insane offenders", establishing the custodial security measure (to be carried out in REMS) as the extreme solution in the articulated system of taking charge of not imputable subjects.

At the moment, we are faced with a general crisis of the system, as manifested by the waiting lists for admission to REMS: in part, because improperly pressured by "mentally ill offenders" who cannot remain in prison due to incompatibility with their state of mental health, but neither can they be referred to community care due to the lack of legislation, as mentioned above; partly because the connection between psychiatric disorder and social dangerousness on the cultural level feeds the track of non-imputability and excessive recourse to the provisional security measure, regardless of the seriousness of the crime. For example, it may happen that a person with mental disorder commits a petty crime (such as stealing an apple in a supermarket). The magistrate may conclude that the mental disorder affects the subject's imputability and that there is the risk of re-offending if the person is not treated: in this case the provisional safety measure[34] can be applied. Consider that as many as 40% of those sent to REMS are submitted to a provisional security measure.

[33] The lack of protection consists in the fact that the prisoner suffering from mental illness cannot access, like the prisoner suffering from a physical pathology, suspension of the sentence and home detention in the place of treatment)

[34] Today we have statutory provisions for limits to maximum penalties, which for theft can even be up to ten years, so a person could remain in the REMS for the theft of an apple even for ten years.
From the audition of President Marcello BORTOLATO, who brought this example to support the proposal to limit the provisional security measure to the risk of committing crimes against the person using arms or for organized crime, following the example of what already applies to the measures applied to minors (Article 37 paragraph 2 of Presidential Decree 448/88).

Once again the cultural opacity regarding the binomial "insanity-crime" acts as an obstacle to the principle of transferring responsibility for treating both imputable and non- imputable offenders to community settings For the non-imputable, this is demonstrated by the widespread use of the custodial security measure in REMS (despite the already mentioned principle of "extrema ratio" of the custodial measure), together with the reluctance to broaden the range of security measures with less restrictive options. For the imputable, this is evidenced by the regulatory inertia regarding delineation of the system assigning responsibility for their treatment.

With regard to the phenomenon of waiting lists in the REMS and more generally the taking charge of "insane offenders", the resolution of the Superior Council of the Judiciary (CSM) of September 2018 relates the high number of provisional security measures to the "excessive recourse to the application of Article 88 of the Italian Criminal Code (insanity) ", with the consequent excessive number of subjects to be submitted for appraisal with the application of the most restrictive measure (the one in REMS)[35]. With the same aim of reducing the "*massive and indiscriminate access to REMS*", the CSM recommends that "the assessments relating to any mental disorder or illness related to the crime be entrusted to the competent community mental health service".

The resolution of the CSM recommends *an integrated system through collaboration* between the various "nodes" of the institutional network (with the drafting of operational protocols between the Judiciary called on to ascertain the situation, the surveillance Judiciary, the External Criminal Execution Office, Mental Health Departments). The CSM reaffirms the cardinal principles for the protection of people suffering from mental disorder: “the principle of the priority of providing the necessary health care; the principle of territoriality which establishes that assignation of responsibility for treatment to mental health service facilities in the territory of residence or in any case of origin of the person concerned; the centrality of the personalized treatment plan*; admission to REMS being an instrument of extrema ratio, and only when non-custodial security measures are absolutely not practicable”*

In application of these principles, the CSM recalls the centrality "of mental health departments, which are in charge of rehabilitative therapeutic programs *in order to implement, as a rule, treatment in community and residential settings"*. And again: "*The REMS are only one element of the complex system of treatment and rehabilitation of psychiatric offenders. With law 81/2014, internment in REMS has taken on not only (...) the character of exceptionality, but also of transience*”.

If the resolution of the CSM deals with the specific issue of security measures for those deemed non-imputable, the principles to which it refers (in particular, *the priority of* necessary *care*) and the consequent operational indications (in particular, *the implementation, as a rule, of the treatment in community* and residential *settings*) it also provides guidance on how to build a valid system for the assigning of responsibility for the treatment of imputable subjects.

[35] Superior Council of Magistracy, *Risoluzione sui Protocolli operativi in tema di misure di sicurezza psichiatriche,* Rapporteur Councilor Nicola CLIVIO, September 24, 2018.

Guidelines for the system of care of “Mentally ill offenders”

To the regulatory difficulties described extensively in order to provide adequate care to "mentally ill offenders", there are those related to the functioning of mental health services, since the transfer of competences to the National Health Service has yet to give the promised benefits, especially in the field of mental health.

As already seen, there is no adequate epidemiological research and therefore no plan of action. In a large part of the country, the protection of mental health in prison is not yet an organic part of the activity of the Mental Health Department, integrated with local mental health services and in synergy with the entire network of health and social services: psychiatry in prison is still too often an isolated sector, which maintains many of the characteristics of the previous management of the Penitentiary Administration Department. An example of this separateness is the type of personnel, which presents a multiplicity of contractual work relationships largely deriving from the previous management. We are faced with a traditional organization, similar to an ambulatory "on call" service, without the continuity of presence and the planning of activities that would be necessary.

Not only the management of health in prison is still not very attentive to the environmental components of health from a preventive perspective[36]; the persistent separateness of services "inside prison walls" means that the system is ill equipped to provide adequate *alternative care out of prison*. If new regulations are important to ensure inmates greater therapeutic opportunities outside prison, their concrete application depends on the ability of mental health services to develop personalized projects, making use of all the health and social opportunities, present in the community.

On the other hand, the ability to manage community resources by services is essential also in order to foster communication with the judiciary, which is too often lacking. In practice, it may happen that the judge called on to ascertain the situation applies the most restrictive measure in prison when instead transfer to suitable facilities for therapeutic purposes could be applied, if properly reported by the services.

Once these delays have been overcome, the system should develop with a view to the priority of care out of prison, within the local community. In the presence of serious mental disorders occurring during detention, the Mental Health Clinical Sections in prison, once effectively established and entrusted to the management of the health care service, *should function as transitory places, of development and preparation for individualized therapeutic-rehabilitative care plans, to be carried out in the community.* The elaboration of the plans is the task of the Department of Mental Health, which needs a strong territorial projection and intense collaboration between the units operating inside and outside prison. The Clinical Sections should be suitably equipped with spaces and the organization of life appropriate to treatment. In the event of individuals experiencing a mental health crisis, the person should be transferred immediately out of jail, to the Hospital Psychiatric Diagnosis and Care Services (SPDC), and once the critical phase has passed, re-enter the Clinical Sections.

A first problem concerns the confusion between the Clinical Sections under healthcare management and the Psychiatric Structures understood as wards

[36] By checking and dialoging with the Prison Administration about the existence of adequate spaces, the organization of daily life, etc., as mentioned above.

managed by the Penitentiary Administration. The latter risk reproducing the logic of segregation, disregarding therapeutic needs. It is therefore necessary to prevent the "psychiatric ward" from becoming a dumping ground for people with particular disorders, those that make routine prison management “awkward”[37].

To avoid this, it is necessary to strengthen "normal" basic mental health care, reserving admission to Clinical Sections when there is a relapse of the mental disorder during detention. The admission to the Clinical Section should therefore be limited to the time necessary to "recalibrate" care: that, in the case of less serious disorders, will again take place in the "ordinary" prison. When there is an efficient and well-connected system of services, the relapse of the mental disorder can also be managed by community services while released under home detention.

In the case of more serious disorders, the priority of care when out of prison requires a regulatory adaptation: in order to enable hospitalization in health care facilities while released under home detention; and to expand the possibilities of entrusting therapeutic care to local community services or residential or semi-residential facilities that are part of the Mental Health Department[38].

Recommendations

This opinion comes at a particularly difficult time for prison life, the rising overcrowding rates and a new peak in prisoner suicides. This draws attention to the general living conditions of persons in detention, which can put mental health at serious risk.

In the specific case of the provision of care to offenders suffering from mental disorder, the opinion, while wanting to examine in depth the treatment of "mentally ill offenders", could not overlook the problem of "insane offenders". The fundamental unifying element lies in the legacy of the OPG, not only in the concrete management of the subjects once destined to OPGs and who now await a different location, albeit not yet well defined; but, it goes further back, to the cultural heritage that still survives in the "double track", or "special track" of non-imputability as a result of mental defect. The excessive recourse to non-imputability and the judgment of "social dangerousness" (and consequent extensive use of safety measures) is an indicator of the old vision of the psychiatric patient as a dangerous subject, who should be restrained rather than treated. Hence the reluctance to introduce regulatory adaptations, for both “mentally ill offenders” and “insane offenders”, which could favour *care without being detained in custody*.

On the basis of this, several recommendations are put forward:

- To ensure humane forms of detention, respectful of people's dignity, offering treatment with opportunities for training and work in a perspective of re-socialization, is the basic objective to protect the mental health of all male and female inmates.

- On the basis of the right to the protection of health and equality of rights "inside" and "outside" prison walls, *the care of people suffering from serious*

[37] See the audition of Dr. Franco SCARPA

[38] The delegated law for the reorganization of the aforementioned Penitentiary Regulations moved along these lines.

mental disorders who have committed crimes should, as a rule, take place in community and residential treatment facilities and not in custodial institutions.

- In line with this principle, certain regulatory changes are urgent in order to protect imputable subjects that have been convicted, such as: deferment of sentence when the conditions of mental health are incompatible with detention by analogy with the provisions of art. 146 and 147 on impairment of physical health.

- To ensure the same principle, also the system for assigning responsibility for the treatment of persons deemed non-imputable and acquitted, outlined by law 81/2014, requires new regulatory measures: first of all, a more incisive reform of security measures, to limit the use of the custodial security measure. Furthermore, consistently with the therapeutic purpose of REMS, it is necessary to limit admission to REMS for subjects with a definitive custodial security measure.

- More generally, there should be reconsideration of the particularly problematic concept of "social dangerousness", at the basis of security measures and the special "double track" legislation of imputability/non-imputability for persons affected by mental disorder.

The Mental health services in prison must overcome the historical "separateness", that is the legacy of penitentiary health care, and function as an integral part of robust Mental Health Departments, capable of identifying the resources present in the community network for the treatment of serious pathologies outside prison and collaborate for this purpose with the Judiciary called on to ascertain the situation, and the surveillance Judiciary.