Presidenza del Consiglio dei Ministri

CNB

COMITATO NAZIONALE
PER LA BIOETICA

Suicides in prison. Bioethical indications

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Presentation

The opinion “Suicides in prison. Bioethical indications” departs from the ascertainment of the high number of suicides among the prison population which is far higher than that of the population in general, and from the consideration of the ethical and social importance of the problem, aggravated by conditions of noticeable crowding of prisons and the frequent recourse to incarceration. The fresh outbreak of suicides in 2009 and during the first months of 2010 makes it even more urgent to call the attention of the institutions and public opinion to this tragic phenomenon. In this document the Committee intends to draw the attention to collective responsibility with respect to the problem, in order to remove all those situations connected with custody which, besides the unbearable hardship of the loss of freedom, may foster or hasten the decision to take one’s own life.

The appeal to social responsibility is strengthened by the consideration of the particular bio-psycho-social *vulnerability* of the prison population compared with the general one. There is the moral duty to guarantee a prison environment that respects the dignity of the person in their journey towards social integration, in the light of a critical review of penal policies. The Committee considers that prison can take away only the right to freedom, without annulling the other fundamental rights, like the right to health and reintegration. The prisoner has the right to serve a sentence that does not degrade human dignity.

The Committee urges the competent authorities to set out a national plan for the prevention of suicides in prison, along the lines indicated by the European bodies. The plan should foresee indications: for the development of a punishment system that is more in line with the constitutional principles; for a greater transparency of the regulations within the prisons and for a greater personalisation of treatment, countering the ‘deresponsibilising’ and ‘infantilising’ practices which reduce prisoners to helplessness and humiliation; for a specific prevention not so much aimed at the selection of the inmates at risk of suicide, as to the timely identification of and intervention in situations at risk able to pass the ‘resistance threshold’ (like the psychological impact of being arrested, the trauma of incarceration etc.); for the development of monitoring and research into the phenomenon and for the specific training of staff starting with the examination of the single cases of suicide.

The opinion was drawn up in the working group coordinated by Prof. Grazia Zuffa, who prepared the draft, with written contributions from Profs. Salvatore Amato Stefano Canestrari, Francesco D'Agostino, Andrea Nicolussi and the indication for materials by Profs. Cinzia Caporale, Antonio Da Re, Laura Palazzani. The working group was also attended by Profs. Luisella Battaglia, Lorenzo d'Avack, Anna Gensabella, Demetrio Neri, Monica Toraldo di Francia, Giancarlo Umani Ronchi. Specialist opinions were given by Dr. Mauro Palma, president of the CPT (European Committee for the Prevention of Torture), Dr. Alessandro Margara, president of the Fondazione Giovanni Michelucci, formerly head of the DAP (Dipartimento Amministrazione Penitenziaria) and Dr. Sebastiano Ardita, Director General of the DAP prisoner direction and treatment.

The opinion was approved unanimously by those present (Profs. Salvatore Amato, Luisella Battaglia, Adriano Bompiani, Stefano Canestrari, Roberto Colombo, Francesco D’Agostino, Bruno Dallapiccola, Antonio Da Re,

Lorenzo d'Avack, Riccardo Di Segni, Emma Fattorini, Carlo Flamigni, Romano Forleo, Silvio Garattini, Marianna Gensabella, Laura Guidoni, Claudia Mancina, Assunta Morresi, Demetrio Neri, Andrea Nicolussi, Laura Palazzani, Alberto Piazza, Vittorio Possenti, Monica Toraldo Di Francia, Grazia Zuffa).

The President
Prof. Francesco Paolo Casavola

Premise: prison suicides in a bioethical perspective

In its decision to deal with the problem of the high prison suicide rate, the National Bioethics Committee was moved by the concern for a phenomenon that is undoubtedly not new, but of such social and ethical importance as to deserve consideration, particularly at this moment in history: there was the fear that today's serious hardships of prison life, owing to overcrowding, would have created the conditions for a fresh upsurge of the phenomenon.

Unfortunately these fears have turned out to be ustified, as 2009 set a negative record, with 72 suicides; in the first half of 2010, 32 inmates took their own lives and 44 attempted suicide.

The Committee is aware of the structurally afflictive nature of the prison sentence and of the evident incompatibility of prison with a balanced development of the person. Suicide is only one aspect of the wider and more complex identity crisis that prison brings about, as it alters relationships and relations, breaks up existential prospects and weakens projects and hopes. The clearest and most radical way to eliminate all these hardships would be that of an overall rethinking of the function of punishment and the role of the prison sentence. For some time now there has been talk of a criminal law crisis as a result of the increasingly widespread belief that punishment by means of the privation of freedom is today anachronistic and, in many of its aspects, in contrast with the rule of law and the respect of the psycho-physical integrity of the person. Prison Law arose from the need to guarantee prisoners the respect of those fundamental rights that are reduced, if not denied, by the conditions in which they are forced to live, seeking to avoid the afflictive elements precluding any future prospect of reintegration.

The sitting began with a consideration of the very nature of prison, thus going immediately to the heart of the problem. If the Enlightenment had succeeded in putting an end to the centuries old tradition of corporal punishment, one cannot see why our century should not question prison sentences. As much as this proposal arouses considerable ethical interest, the NBC considered it more opportune not to deal with this document in the debate on the function of the prison sentence, but to highlight those aspects that could make it possible, remaining within the present institutional framework, to reduce suffering and to pay greater attention to particularly vulnerable subjects like those serving a prison sentence.

Considering that the sphere of competence of bioethics is marked by the 'life sciences and the treatment of health', then it is its duty to bring the sectors to notice in which there exists a condition of hardship and crisis in relational and healthcare prospects, highlighting the social and political conditions fuelling them and proposing, at the same time, specific remedies and solutions. As the NBC points out in the introduction to the document on adolescent suicides, the concepts of the identity/subjectivity of the person in the juridical ethical sense and of society constitute inalienable points of reference that substantiate the bioethical debate[1]. There is an institutional and an individual profile in every bioethical problem. One does not exclude the other, but they present different features that allow them to be treated separately. In this document priority is given to the individual aspect, the improvement of the single aspects of prison

[1] NBC opinion "Youth suicide as a bioethical problem", 17 July 1998.

treatment, even in the awareness that a broader and more radical rethinking of the prison system is to be hoped for in the future.

The opinion quoted here above offers the precedent that is also useful to define suicide in prison as a bioethical problem, with all the due differences. It points out the way of 'a radical change in the way the adult world, in its multi-form expressions and functions, looks at adolescence' to significantly affect the dynamics more often underpinning adolescent suicide. Starting from here, in the chapter on bioethical indications the NBC reflects briefly on the delicate balance between the aspects of individual responsibilities and environmental/social ones concerning the understanding of suicide; between the risks of charging the phenomenon to individual characteristics with the consequent social deresponsibilisation, on the one hand or, on the other, of falling into a hyper/pseudo social protectionism of the subjects identified as being 'at risk of suicide'. Hence the NBC's option not so much in favour of a selective prevention for individuals/groups 'at risk', but of a prevention understood as the *promotion* of 'suitable elements to support a process of identity development in this phase of their lives'. This latter indication which distances itself from the increasingly pervasive use of the at 'risk' category, is particularly valuable with respect to the specific demands of prison.

Taking this document as a starting point, prison suicide can be tackled as both a warning light for the subjective hardship of the prisoner in the face of the loss of freedom, and as the symptom of social inadequacy, not so much to 'protect' the prisoners, but to respect their fundamental rights. The principle according to which imprisonment takes away *only* the right to freedom of movement is often disregarded: as a consequence, the rights to safety, health, reintegration and other rights too are not guaranteed. For this very reason the prison is often an environment that can foster or hasten a possible decision to kill oneself. As the French Committee of Ethics states, 'Prisons are also the cause of disease and death: they are the scene of regression, despair, self-inflicted violence and suicide'[2].

From this perspective the prevention of suicide is closely linked to the protection of health, with another important bioethical aspect concerning the equity of access to healthcare resources. There are two critical points therefore: the lack (sometimes even absence) of respect of civil and human rights; the imbalance in the exercise of such right among prisoners and free citizens: the figures on the high number of suicides in prison (about twenty times higher than the general population rate) can therefore also be interpreted as a discrimination index.

It is true that suicide is an act of will, the result of an individual choice, sometimes difficult to understand by others in its motivations and as such must always be looked upon with caution and respect. But the respect for the unfathomable suffering of whoever decides to resort to this extreme gesture does not only counter, but, on the contrary, spurs on the common commitment to remove all the conditions capable of fostering or bringing about suicide.

Therefore, the prevention of suicide comes under the defence of health and life to all effects, as the promotion of an environment that respects people and leaves open a prospect of hope and a horizon of development of subjectivity in the journey towards social reintegration.

[2] "La santé et la médecine en prison", Comité Consultatif National d'Ethique pour les Sciences de la Vie et de la Santé, opinion No. 94, 26 October, 2006, p.8.

In prison social responsibility is particularly implicated owing to the characteristics of the prisoners' bio-psycho *vulnerability*[3]. The prisoners do not represent the mirror of the society outside. They are younger, poorer, less integrated in social, economic and cultural terms, They suffer from more physical and psychic illnesses.

Therefore, the prison is a *place of contradictions* with respect to the protection of health: the contradiction between the need for safety and the respect of fundamental human rights. There is a second contradiction between the duty to treat the prisoners, entirely subject to the authority of the prisons and a prison which, as already mentioned, disturbs psycho-physical equilibrium and makes people ill.

The ethical responsibilities of the community to protect health and life in prison for the most part coincide with the compliance with the principles and laws that are at the basis of our societies[4]. From this viewpoint one can interpret the statement according to which prison conditions are the mirror of the state of civilisation of a society.

The NBC has on other occasions dealt with the issues concerning life in prison with a declaration of 17 January 2003, giving a number of bioethical considerations. The NBC considered the high suicide rate and the degree of self-harming behaviour as signs of 'very serious hardship'; it considered that the overcrowding hinders 'drastically the real guarantee of human rights recognised to prisoners by the Constitution and by the prison regulations, making the references to treatment or rehabilitating commitment plethoric'; lastly it stressed 'the need for a careful reflection on the fact that the prison population is made up in almost its entirety of people characterised by specific conditions of serious social hardship (it suffices to think of the very high numbers of foreigners and drug addicts), conditions it is dutiful to take charge of, with new methods of punishment in mind'.

Seven years following that declaration, not only have no improvements been recorded, but the situation has even worsened. For this reason the bioethical indications of 2003 are still dramatically topical, starting from the appeal to principles: the protection of the health of those subject to the limitation of personal freedom in prisons is the moral as well as the juridical duty of the public powers; a prison sentence must not imply the jeopardising of fundamental human rights. The final hope for 'a detailed study aimed at the introduction of principle punishment without detention' is still just as valid. The present emergency situation in the prison system spurs on the NBC to offer points for reflection along the lines of the detailed study mentioned then, mindful of article 27, para. 3 of the Constitution which states: 'Punishment cannot consist in inhuman treatment and must aim at re-educating the prisoner.

The limit defined by the norm – the non-contrariety to the sense of humanity – is clearly established in relation to the principle of human dignity which is the foundation of inalienable human rights. Even if the punishment

[3] For the concept of vulnerability, see the Barcelona Declaration, the result of work undertaken in the European Community to stimulate public debate on the ethical aspects of care (*The Barcelona Declaration Policy Proposals to the European Commission, November 1998).*

[4] These contradictions are highlighted in opinion No.94 of the above mentioned French committee, pag.5. The documents again points out a contradiction between "the meaning of punishment, based on the individual responsibility of those committing an offence, and the imprisonment of an ever increasing number of people suffering from serious mental disorders".

causes distress, it must be conceived in such a way as not to reduce the person to a simple means, 'morti'fying their dignity, and so compromise even the re-educational function.

It is true that in the assessment of punishment there is the problem of avoiding prison conditions that may damage health; but the non-contrariety to the sense of humanity expresses a need that transcends the protection of health and regards the human dignity itself to protect even in the infliction of punishment. Such serious issues as suicide and the self-infliction of wounds create an urgent need to reconsider the problem of the objective conditions of prisons; but before this it is necessary to highlight the indefensibility of a penal policy which is the very cause of overcrowding.

A penal policy that produces an overcrowding of prisons and as a consequence unbearable conditions leading to a considerable increase in the number of suicides, is directly against the principle of the humanity of punishment. Furthermore, there are hypotheses of anti-social behaviour with reference to which penal incrimination should be weighed up in relation to prison conditions, otherwise the punishment is only abstractly adequate to that behaviour while in fact it is not.

These reflections are an invitation to increase non-prison punishment. The widespread practice must be remembered of not fully applying the existing laws which would allow many people to avoid being kept in prison. This is the case for most of the prisoners in preventive detention, which the law foresees as an exceptional measure for those presumed innocent, and also for particularly weak subjects like drug addicts for whom alternative measures of treatment are foreseen. To imprison or to keep in prison people who according to the law would have the possibility of awaiting judgement or of being punished outside prison is a practice contrary to the sense of humanity and, as such, represents a denial of human rights.

The historical evolution of suicide in prison

The growing number of prison suicides has been the subject of study since the XVII century, when some coroners, called upon to investigate cases of violent death in British prisons, began to establish a link between the episodes of self-suppression and some specific aspects of imprisonment. Not until the nineteenth century did a systematic study of suicide begin, within the general problem of deaths and health in prison. Writing in 1820, Dr. L.R.V. Villermé, studying the prisons of Paris, observed that 'the mortality of the prisoners is considerably greater than those living in freedom, directly owing to the bad state of the prisons and the poverty, hardships, affliction suffered by the prisoners before being incarcerated'. As far as concerns the living conditions in prison and the differences in treatment from one prison to another, Villermé was convinced of the importance of this factor: depending on the type of prison 'during their imprisonment these poor souls have lost on average the probability of living 17, and even 30 years of life'. Half way through the nineteenth century, we find studies that use the suicides and deaths in prison as indicators for the assessment of the different systems of treatment. We find that the systems characterised by the isolation of prisoners had 12 times more suicides than the so-called 'common prisons' (Baccaro, Morelli, 2009, 26 onwards).

With the publication of Enrico Morselli's work in 1875, we have a more complete picture of suicides in Italian prisons. Apart from the recognition of the greater frequency of suicides among prisoners with respect to the general population, other related environmental characteristics can be seen: 1) in the systems based on work (penal farming settlements), there are fewer possibilities of finding suicidal behaviour 2) the prisons resorting to the isolation of prisoners have higher suicide and attempted suicide rates 3) the negative effects of isolation are manifested in the first months 4) in all the regimes the highest number of suicides is to be found during the first two years of imprisonment 5) the age group in which suicide is more frequent is from 21 to 30.

Many of these observations are still valid, particularly the negative effects of isolation. It must be remembered that in the nineteenth century, owing to the influence of Cesare Lombroso, it was thought that there was a causal relationship between biological/genetic factors and deviant behaviour. Lombroso himself wrote about the suicide of prisoners, linking the urge to commit suicide to the mental structure of the delinquent, devoid of any spirit of conservation. Suicide would be one of the features of the criminal man, an expression of the insensitivity towards himself as well as towards others; as a consequence, attempted suicide became a useful element for identifying criminals.

Despite the prevalence of biological determinism leading to a different interpretation of the criminal's behaviour from that of the normal man, another consideration for the reasons for crime and suicide among criminals was also coming to the forefront. Morselli himself states that not all those who are in prison belong to the criminal man category as meant by Lombroso, some committed an offence due to the weakness of mind or character or due to bad education or 'because they found themselves in fatal circumstances'. Some take their own lives through remorse or repentance, to 'to free themselves of the shame of prison', or also to avoid imprisonment or, among those sentenced to be hanged, to avoid the death penalty.

In the twentieth century, the data on the prison population began to be collected in a more reliable fashion. The first systematic survey collected data on suicides and attempted suicides in Italian prisons from 1960 to 1969: 403 cases were analysed (100 suicides and 303 attempted suicides). The data collected concern different variables, from the juridical position (type of offence, juridical situation, length of imprisonment before suicide or attempted suicide), to the position of the prisoner inside the prison (isolated, under observation etc.), to the personal situation (health, family situation, behaviour). The study showed that almost ¾ of the cases of suicide concern prisoners that did no kind of work in the prison; furthermore, 64% of the suicides, both successful and attempted, concern prisoners awaiting first judgement. With regard to the suicide rate, in the 60s the average is stable at levels of 3.01.

In the seventies the number of suicides begins to rise: at the end of 1997 there are 11.15 (every ten thousand prisoners), in 2000 11.40, reaching a peak in 2001 (12.52).

The increase in suicides must be interpreted within a profound change in the prison population, both in terms of quantity and quality. Before the seventies, the prisoners came from extremely low social levels, with very high rates of illiteracy. For the poorer social classes, prison was an event lived in continuity with other events of life, rather than a traumatic interruption. There

existed a prison 'subculture', violent and coherent, which found its amalgam in the resistance /opposition to the place of custody. On the one hand, not much attention was paid to suicide, almost as if it belonged to the ordinary day to day prison violence; on the other, the strict control (the prisoners almost always lived together in 'dormitories') and the strong cohesion of the group discouraged individual acts of self-aggression.

The disappearance of this subculture is the result of the prison reform (1975), along with social change and penal policy thinking. Since the seventies the decrease of violent offences has not meant a decrease in rates of imprisonment, but rather the opposite. Considering that in 1975 the prisoners were 30,000, in 2008 this number had reached 57,000, touching 60,000 in 2009. In parallel, prisons are increasingly overcrowded with marginalised classes, particularly vulnerable from the bio/psycho/social aspect. In particular, the WHO identifies young men, people with mental problems, people who are socially isolated, subjects with problems of drug abuse and those with a history of suicide attempts as being the vulnerable groups being more at risk of suicide: these groups are over-represented in Italian prisons (WHO, IASP, 2007).

In the 2000s, starting with the already mentioned peak of 12.5 in 2001, the rates seem to stabilize to around 10 (every ten thousand) until 2008, when a rate of 8 was recorded. In 2009 though there was a sharp rise.

With regard to the attempted suicides, in the 2000s the percentage fluctuated from 180 (every ten thousand) in 1999 to 137.90 in 2007 (with a low of 127.8 in 2004).

It must be noted that, despite the progress, the data from institutional sources are not yet completely reliable, also due to the difficulty in finding univocal criteria for data collection and the very definition of the behaviour leading to death as suicide or attempted suicide (for example the fatal outcome of intoxications with substances having psychotropic effects). For this reason independent sources are valuable[5].

Another aspect of the problem is given by the number of suicides in relation to the overall number of prison deaths, compared to other countries.

Among European countries, Italy has a relatively high rate of suicidal behaviour with regard to the total number of prison deaths: out of an average of 50/60 deaths per year, suicides are about one third.

The cases of the suicide of prison guards must not be forgotten: from 1997 to 2007 64 guards took their own lives and many of these deaths were linked to the unrest owing to working conditions and *burn out*. A plan for intervention at staff level should take into consideration also the stress factors of the daily life of prison workers.

Studies on the variables affecting acts of self-aggression and suicide

[5] The work of data gathering and documentation carried out by some NGOs is of fundamental public importance, and in particular by the magazine and site of Ristretti Orizzonti, which has a quantitative and qualitative data base from 2000 onwards.
A Permanent Observatory for Prison Deaths has also been set up, born from the collaboration of Italian Radicals, Associazione "Il detenuto ignoto", Associazione Antigone, Associazione "A buon diritto", Radiocarcere, Ristretti orizzonti.

Despite the extent of the problem and its persistence over time, there are very few systematic studies on it, and the existing ones are mostly interested in the individual clinical perspective, without concentrating on the social and institutional variables affecting suicidal behaviour.

However, at the beginning of 2000 a series of studies began in Italy making it possible to set out a first risk profile with respect to the situational and environmental variables (Manconi, 2002; Manconi, Boraschi, 2006). Prisoners take their own lives with greatest frequency in the first year of custody (64.5% in the two-year period 200-2001, 61% in 2002, 63% in 2003); most of the suicides of the first year are concentrated in the first days and weeks. This is related to the traumatic impact with the prison environment as a factor that drives people to acts of self-suppression.

Furthermore, a connection is highlighted between suicides and the overcrowding of prisons: overcrowding, besides limiting the spaces and causing the deterioration of hygiene, jeopardises relations with the personnel and limits the possibility of accessing opportunities for recreation, training and work.

Even the hardship linked to overcrowding would be a factor that drives inmates to take rash actions, besides being predisposing.

Another element concerns the signs preceding suicide: in both the studies mentioned it seems that a considerable number of suicides could have been defined ‘announced suicides’, since the prisoners were suffering from bad or chronic depression or had already attempted to take their life on more than one occasion.

With regard to the juridical situation of those serving a prison sentence and the relative psychological implications, the two studies highlight the lower number of suicides among definitive subjects (e.g. in 2000/2001 44.2% of suicides was committed by definitive prisoners; 36.4% in 2002 and 48.3% in 2003). This shows that there are more suicides among those awaiting committal for trial or a first degree sentence or an appeal, even though with noticeable fluctuations. Aside from these variations, there is sufficiently stable data represented by the over-representation of suicides among the non-definitive inmates with respect to the whole non-definitive prison population (those with a definitive sentence are more than 60% of the prisoners). This means that, among the definitive prisoners, the propensity to suicide is considerably lower than that recorded among the non-definitive ones.

With regard to age, it is mainly the young men that take their own lives. Considering the cases of suicide in the various age groups and comparing them with the distribution of the prison population in these groups, a strong propensity to suicide between 18 and 23 can be seen. When a comparison is made with the general population referring to the 2002 data for example, it can be said that between the ages of 18 and 44 there are 50 times more suicides inside prison than outside (Manconi, Boraschi, 2006, 22 onwards).

Another survey confirmed that the narrowing of spaces and the deterioration of relations, together with the lack of opportunities, can in fact be related not only with suicide but more generally with self-harming and an aggressive attitude towards the staff and other inmates (Buffa, 2003). This study also showed that such phenomena are not distributed uniformly in the overcrowded prisons, but are more frequent in those sections with prisoners having less personal and social resources, who are less able to adapt and to take advantage of the few opportunities that prison life offers, particularly in situations of overcrowding. According to the author, this is a reconfirmation of

E. Goffman's hypothesis on the total institutions and the so-called 'sector system': in the competition that is aroused, the least gifted part finds itself living in the worst conditions in that context and this sparks off an escalation of marginality and suffering.

In general the literature on this issue examines suicidal behaviour separately with regard to acts of self-harming, since the deep motivations for this are assumed to be different. Furthermore, self-harming in the prison environment is interpreted as an instrumental and 'manipulative' way of obtaining concessions of various types.

Recently a different standpoint has been gaining ground: the manipulative element does not exhaust the motivations at the root of self-harming in prison, there is a 'continuum of self-destruction' that starts with the least violent self-harming behaviour, developing then into self-suppression. This does not mean interpreting the set of phenomena from a psycho-pathological viewpoint, but as seeing them as the expression of a state of hardship that can take on different forms (more or less serious) in relation to the subjects' ability to *cope* in the (specific) stressful situations.

With this premise, the most recent study carried out by the Italian Department of Penitentiary Administration analyses all the data on self-aggressive behaviour: suicides, attempted suicides, self-harming behaviour (e.g. body lesions or the swallowing of foreign bodies), abstentionist behaviour (e.g. the refusal to eat or to take drugs) (Buffa, 2008)[6].

The most interesting results are the following: first of all, the greater frequency of prison suicide with respect to the general population is reconfirmed: in the period examined, there were 41 suicides among prisoners, equal to a rate of 4.6 per ten thousand, 7 times higher than the rate of the general population[7].

On the other hand, the hypothesis of a more frequent recourse to suicide and in general to acts of self-aggression of drug addicts is not confirmed. With respect to the general data on the presence of drug addicts in prison admissions (24.85%), they committed suicide in 9.8% of cases and attempted suicide in 11.2%.

With regard to the foreigners comprising a general presence of 48.% of prison admissions, the suicides, attempted suicides and abstentionist behaviour recorded a share of foreigners lower than the above-mentioned report (26.9, 42.1 and 39.6 respectively). Only for the self-harming behaviour is the number greater than the general figure (53.7%).

With regard to the ways of committing suicide, 87.6% hang themselves, 7% inhale gas.

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[6] The study, carried out by Pietro Buffa analysed the Dap data on Italian prisons from 1st July 2006 to 31 June 2007. From the methodological point of view, different indicators are used to calculate the prevalence of the phenomena inside the prison. By tradition, the prevalence was calculated on the basis of the average presence of inmates recorded in one day. Buffa instead uses the total number of admissions to prison in one year. According to the author, this would allow a more exact comparison between the prevalence of suicide (and other self-harming behaviours) in prison and within the general population. However, the different methodology does not permit a comparison with the data collected by the independent organisations.

[7] One must be mindful of the fact that this rate is calculated on the basis of the admissions in one year, a considerably higher figure than the average presences calculated on one specific day of the year. This accounts for the difference in ratio with suicide in the general population (20 times higher, as was said at the beginning, compared with the 7 times higher of the Buffa research).

With regard to their juridical position, most of the prisoners resorting to self-aggressive behaviour have no definitive sentence (56.4%). The divide between non-definitive and definitive prisoners widens even more when the suicides (65.9%) and attempted suicides (62.1%) are considered. The phenomenon of over-representation already mentioned can again be seen: in the same period, the percentage of detainees in preventive custody or with non-definitive sentences was equal to 46.8% out of the total number of prison admissions. These data confirm (and stress) what has been put forward in previous studies. The same can be said for the concentration of self-aggressive behaviour in the initial phases of imprisonment. 32.8% of the incidents took place during the first three months following prison admission (26.8% for suicides and 45.6% for attempted suicides). In the second trimester the percentages go down by almost half and the decrease in the following trimesters continues in a similar way. If the suicides in particular are examined, over half (51.2%) were recorded in the first year.

The research has also highlighted the geographical distribution of self-aggressive behaviour: considerable differences are to be found, with regions having a number of incidents that are higher than their number of admissions (particularly in Lombardy, Campania, Lazio, Sicily and Tuscany). From the study of eight large metropolitan prisons, it can be seen that the incidents are concentrated in some sections[8].

This observation on the 'geography of privation' highlights the importance of the context variables. From a study on the motivations declared by the personnel in the reports made in prison on self-aggressive behaviour, it appears that the motivations of a psycho-pathological nature are only mentioned in 0.06% of cases. Here too, as for the drug addicts, the hypothesis of a greater recourse to self-aggressive behaviour by these subjects, as found in international literature, is disclaimed. Further investigation is therefore necessary in order to go into these aspects in more detail.

The meanings of prison suicide and the steps towards understanding and intervention

This document has chosen not to go into the huge issue of suicide and to concentrate on the particular phenomenon of suicide and self-harming in prison. Moreover, with the disappearance of the inclination to interpret suicide from a pathological point of view in modern times, its understanding is still particularly complex, since it is a question of integrating the work and results of research of sociologists, psychologists, anthropologists and historians (Barbagli, 2009; De Leo, 2009). Even in the psycho-dynamic perspective it is difficult to identify the specific fundamental dynamics of this self-destructive act which entirely annuls every aspect of self-conservation inherent in human nature. The contradictions are not lacking: in a certain sense, suicide is presented as the solitary act par excellence, of the denial of the relationship with others. However, seeking to go beyond the act in itself, the meta-communicative aspect of it can be grasped: while at a conscious level suicide seems to want to deny any relationship with the world, at an unconscious level

[8] A particular concentration is found in the prisons of Milan-Bollate, Turin, Naples-Poggioreale (Buffa, 2008).

the act is presented to others, in a dramatic tension of affective relationship, both positive and negative (Fornari, 1981).

With regard to suicide in prison, on the one hand the factors of individual vulnerability must be considered, and the role (predisposing or catalysing) in the suicidal behaviour of some psychological and psychiatric disorders; on the other hand, one cannot disregard either the particular pathogenic/stressful characteristics of the prison or the specific levels of psycho-physical health of the detainees, which are lower than those of the general population. The combination of these two variables is such that the WHO considers prisoners as a group that is vulnerable with respect to suicide. The identification of individuals within the group that are particularly vulnerable to suicide due to their psycho-pathological characteristics is more complex and controversial. Moreover, in prison, unlike the outside, every self-harming act tends to be interpreted in the logic of custody, as resistance /rebellion of the detainee against the prison. It suffices to think of the 'communicative' dimension of self-harming acts mentioned above: it is usually interpreted as an intrinsic part of suffering, as a form of expression of the individual's malaise. On the contrary, with regard to the detainees, one reasons over their self-aggressive behaviour, trying to distinguish between 'manipulative' acts and acts that express a 'real' malaise.

It is true that the understanding of self-aggressive acts in prison cannot ignore the conflict, symbolic in primis, that is going on in individual bodies. For the prison, the management of custody is a problem of the control/protection of the prisoners' bodies. In final analysis the loss of freedom is realised in the 'handing over' of the body to the place of custody. The body is therefore the space of communication which becomes common to both the detainee and to the prison. In this sense, the prison is the place of the 'body language' par excellence. It is the immediate and regressive way that prisoners have to express themselves publicly, to communicate their own malaise to others, at times to claim their own rights. It is a 'speaking' by means of the injured body that betrays a relational helplessness and a profound anxiety in communication.

Once again, from the viewpoint of the 'prison that makes one ill', the reflection on the 'total institutions' is well-known, starting with E. Goffman's: all the aspects of the daily routine of the detainee are placed under another's authority, with the result that it annuls any private dimension or individuality. It is the 'depersonalising aspect of the prison', or 'a space devoid of symbolic expressions of identity, relations, history' (Bauman, 2002). The prison is therefore a particularly fertile context for experiences of *learned helplessness* and *hopelessness*, two signs of suicide risk (Beck et al.1975).

Prison is thus a place that creates the suicide risk, 'insofar as custody in itself and for itself is a stressful event that deprives the person of basic resources'; but it is also a place 'that imports the suicide risk', due to the precarious state of the psycho-physical health of the prison population, as declared by the WHO. However, the WHO also states that very few studies have identified elements that are able to distinguish the prisoners that commit suicide from the rest of the prison population (WHO, 2007, 7).

Hence the caution towards an approach (prevalently) aimed at identifying the subjects 'at risk', as a privileged form of suicide prevention: in a word, to 'psychiatrise' suicide in prison. This kind of approach, which psycho-social literature has for some time now defined as 'exceptionalist', focalised on

subjects labelled as carriers of deficit, has the defect of increasing individual stigmatisation, with the risk of not grasping the interaction between individual and environment. A 'universalist' approach is therefore preferable, that sees a more favourable context in the development of environmental opportunities for the fostering of the inmates' skills, starting with the weaker ones. This is the promotion of health approach, also and above all in prisons. There are two advantages to this: it removes the above mentioned dangers of the psychiatrisation of suicide, which is particularly insidious in prisons since it offers a culturally fertile ground for the recovery of the custodial tradition which was the task of psychiatry until not many decades ago; it avoids the excessive 'specialisms', in favour of a community approach involving all the personnel and the prisoners themselves in the creation of a 'healthier' or at least a 'less ill' prison.

Suicides in prison: can they be avoided? An ecological perspective

The choice of a universalist prevention approach in psycho-physical health means in other terms to privilege an ecological perspective, which considers the subject's position in the context of life and the relative interrelation arising from it. This is contrary to the firmly rooted idea that suicide is a psycho-pathological manifestation of an individual disorder. In support of the ecological perspective, some important studies on self-aggressive behaviour carried out in different towns of the United Kingdom, have highlighted the importance of situational and environmental factors such as social class and the area in which one lives. These studies have shown both the role of the adverse factors of stress (like poverty and unemployment), and that of the protective ones (relational support, marriage and partnership, with significant sexual differences) (Orford, 1992).

The choice of the ecological approach has important operational consequences: as highlighted by Laura Baccaro and Francesco Morelli, authors of the most recent and comprehensive study on the subject, in the first assessment of people who have just been admitted to prison (the so-called new arrivals) the classical psycho-pathological factors of psychiatric diagnosis are generally taken into greater consideration than the psychological reactions to the traumatic event which could foresee the coming on of a crisis (state of anxiety, the self-perceived ability to *cope* in the new situation). The 'continuum of stress' is also decisive, the continuous finding oneself in stressful situations, without being able to elaborate the different experiences of trauma and loss. "The psychological impact of being arrested and incarcerated, the fear of being abandoned by family and friends, the problem of withdrawal for drug addicts, the consciousness of a long prison sentence, the daily stress of prison life, are all elements that can go over a person's 'resistance threshold'" (Baccaro, Morelli, 90 onwards).

In the perspective of understanding the interaction between the individual and their context, one of the most substantiated models for the interpretation of psychological disorder is that of *stress-vulnerability* and the mutual influence between individual psychological factors and environmental factors. The traumatic event of self-aggressive behaviour is seen as a symptomatic reaction to a combination of adverse environmental forces: the seriousness of the privation is proportional to the individual vulnerability factors, which result from

the relationship between adverse factors and protective ones, accumulated over time.

Adverse factors

Let us examine some of these factors:

Individual factors of a psychological and psychiatric nature: from the assessment records of the pathologies in the prison population, the data on depression are particularly significant. The prevalence of depression in the prison population results as 10.25%, but only 5% suffer from acute forms.

It must be noted that depression represents the group of psychiatric disorders with the highest rates in the general population too, even if there are noticeable differences in the estimates that can represent the effect of different criteria or methods of diagnosis. According to one of the most recent epidemiological reviews in affective disorders, the life time prevalence for the most serious depression is estimated at 6.7%, while the one year prevalence is estimated at 4.1% (Waraich et al., 2004). With regard to the Italian data, following the first epidemiological study carried out over a representative sample of the general adult population in Italy, depression records an annual prevalence of 3.5% (De Girolamo et al., 2005). For the purposes of the specific context of the issue dealt with in this document, the often crucial importance must be underlined that stressful lifetime events have in causing depression, as is found in a large amount of research on the subject. The lifetime event that is most frequent in association with depression is an experience of loss (not having interpersonal relations, the fall of role and self-esteem): these are experiences that concern most of the detainees, especially those in prison for the first time. Generally, the studies on lifetime events show that the risk relative to suffering from depression in the six months following a serious stressful lifetime event is six times higher than for an ordinary period (Paykel et al., 1996).

With regard to other mental pathologies, 6.4% are subject to these. Some research carried out on a sample from Padua prison in 2005 gives a high percentage of psychiatric co-morbidity among drug addicts in prison. This study is not however able to give an interpretation of the variables that contribute to such a concentration of psychic malaise (Bentivogli, 2006).

Situational factors: an important factor seems to be the amount of time spent in the isolation cell. A detainee that is ‘isolated’ or that undergoes specific custody regimes in a single cell to which he/she cannot adapt is at high suicide risk.

These cells are called smooth cells, because there is no furniture except a camp bed. They are used to isolate prisoners who appear to be unsuitable for collective life, and for inmates who could attempt or make another attempt at suicide. However, the privation of any form of community life and the removal of objects used in daily life accentuate the depersonalisation of prison, while the detainee is reduced to a state of total dependence on the staff for the most elementary needs. A high percentage of suicides takes place in isolation.

Another factor is that of the ‘admission trauma’: subjects can react to the stress of incarceration with an adaptation disorder, which can develop into a real post-traumatic disorder brought on by stress.

Psycho-social factors: the insubstantiality of family and social support is quite common among prison suicides. Social isolation is a risk factor for suicide.

Institutionalisation factors: besides the 'stripping of identity' of the subject, as the effect of the institutionalisation process, the total dependence on others for every aspect of daily life, leads to the 'infantilisation' of the prisoner.

In conclusion, the WHO lists some individual and environmental risk factors, which, if present in any combination or interaction, could contribute to increasing the suicide risk:

- groups considered vulnerable to suicide concentrated in prisons
- the trauma of admission and the daily stress of prison life can go over the resistance threshold of the average detainee and all the more so of those at high risk
- the procedures for the identification of prisoners at suicide risk do not exist in all prisons and, even when they do exist, there is not sufficient monitoring of the prisoners' stress and hence there is little probability of identifying very high risk cases
- even if the procedures exist, there can be a problem of the overworking of staff
- prisons can have a limited or totally lacking access to psychiatric services

The Judicial Psychiatric Hospitals

In the JPHs the suicide rate is over double that of the overall prison population[9].

Apart from these figures, specific studies on the environmental variables in the interaction with the individual psycho-pathological factors are lacking. It must be noted that the population of the JPHs is composite, not all detainees are offenders who are declared mentally ill, acquitted and subject to security measures. There are also accused persons held under provisional custody, as well as people simply under observation, awaiting psychiatric report. Over the last years, perhaps owing to overcrowding, the flow from prison to JPHs has grown for 'observation' reasons.

Among the adverse environmental factors must be considered: the trauma of admission to prisons bearing the stigma of a criminal mental hospital; the suspension of a number of rights, primarily the uncertainty about the duration of custody, since the security measures can be renewed ad infinitum; the fact that in many cases security measures are renewed, not because it is thought that elements of social dangerousness exist, but owing to the lack of external residential facilities that can house the detainees.

With the passage of prison healthcare to the NHS, the management and organisation of the JPHs has been undergoing a radical shake-up. It is foreseen that internment in a JPH will be limited to people subject to definitive

[9] These are the results of the DAP data processing with regard to 2004-2007. The prisoners, representing 2.59% of the prison population, committed 5.83% of the suicides and 3.26% of the attempted suicides. As far as concerns self-harming behaviour and the refusal to eat and be treated, the relation is reversed (1.63% of self-harming and 0.65% of abstention from eating and being treated).

security measures, with a reduction of about one third of the number of detainees. A regional distribution of detainees is also foreseen to encourage the discharge and the impact with the outside of those who have already completed the security measure period.

Female suicides

It is difficult to find figures on prison deaths with any particular attention to difference in gender. The justification adopted is that women in prison are considerably fewer than men. Most of the international literature on suicide has not found noticeable differences between the sexes in the suicide rates. It must however be noted that the extremely limited number of female suicides in the sample groups invalidates the soundness of the results. From the Italian data however, it results that women prisoners take their own lives more than men[10].

As well as the statistical surveys and the quantitative research, qualitative research would also be important, in order to identify the female perception of prison stress and the differences in the protection and vulnerability factors.

According to the 'Women in prison' research, women find it harder to live the 'life times' on their bodies (menstruation, maternity, menopause and ageing) compared with men. Women often somatise their malaise, having problems with their menstrual cycle and breathing disturbances. It is as if women lived on their bodies not only the burden of being forced to live in a limited environment, but also the passing of time, the anguish of separation, the negation of femininity and maternity (Campelli et al, 1992).

The answer from the institution

To guarantee the safety of the detainees is a duty of the prison administration and comes into the tasks of custody. This is a different point of view from that of the prisoners' subjective right to health and life. From a security point of view, the prevention of suicide can lead to a more intensified control of inmates and the self-harming act can be defined as an act of insubordination; from the point of view of subjective rights, prevention demands the elimination/reduction/countering of environmental factors that can bring about suicide, starting with the guarantee of the respect of fundamental human rights.

Over the years, prisons have taken on the protection of the detainees' right to health as one of their tasks, but the contradictions remain: not by chance, the same measures are applied to prisoners who have attempted suicide as those that are given as sanctions against detainees that disturb prison order. Whether prisoners disturb prison order thus endangering security, or whether they attempt to take their own lives, the 'constant watch' regime is usually applied: in this way prevention measures coincide with those of punishment. This is the case of the isolation regime in 'smooth' cells, but also admission to a JPH for observation can be seen as punishment by the prisoner[11].

[10] From DAP data referring to 2004-2007 female suicides make up 6.2% of the total number of suicides, while only 4.4% of the prison population.

[11] With the entry of the NHS into the prison service, prisons should be given the possibility to carry out the task of psychiatric observation, as it is not right that it is done by the JPH (Margara, 2010).

The prison administration began to deal with the problem of suicide and self-harming more specifically in the eighties when a number of categories of prisoners at risk were identified (those with mental disorders, drug addicts, young offenders, first time arrivals, and generally speaking all those who experience the privation of freedom in a particularly difficult and traumatic way)[12].

In 1987, the "Servizio Nuovi Giunti" (the New Arrivals Service) was set up: it consisted in psychological aid (with psychiatrists, psychologists, criminologists) working together with the doctors, with the aim of identifying the subjects at risk on the basis of psycho-pathological diagnosis. The new arrivals diagnosed as being at risk were sent to a specific sector[13].

From the year 2000 onwards, further guidelines were issued for the reduction of prison suicides. The New Arrivals Service (Servizio Nuovi Giunti) was substituted by the Reception Service (Servizio di Accoglienza) for new arrivals, with a more 'ecological' setup, less specialist and psychiatrising[14]. These guidelines require prison officers to encourage new arrivals to master their new situation, in an attempt to give a new dimension to the experience of disorientation and helplessness, advising them: 1) to immediately inform the prisoners of the possibility of speaking to specialised personnel 2) to inform the prisoners of the regulations marking prison life. 'Listening centres' are created with operators from different areas (health, prison treatment, prison officers), whose task it is to intervene in the event of family or personal problems, to offer psychological support, see to basic needs, and to assist the needs linked to the status of foreigner[15].

Recently, with the rising unrest in prisons and the increase in the number of suicides, the Dipartimento Amministrazione Penitenziaria has once again issued guidelines to reinforce the observation of and attention paid to detainees, both by involving prison officers in this activity to a greater extent, together with the education staff and volunteers, and by fostering a greater participation of volunteers and representatives of the external community, during afternoons and evenings too. The need is stressed to guarantee the exercise of a number of rights – like meetings with one's defence – and to pay attention to the 'spaces and moments of intimacy between prisoners and their family and spouses': in this sense previous specific regulations are mentioned to facilitate the access of children who have to meet a parent in prison[16].

Lastly, useful initiatives set up in some prisons at an experimental level must be mentioned: in the district penitentiary of Turin, 'attention groups' have been created to identify critical situations in the bud; in the San Vittore prison in

[12] See circular 3182/5632 of 1986.

[13] Circular 3233/5683, "Protection of the life and physical and psychic safety of prisoners and the inmates. Institution and organisation of the New Arrivals Service".

[14] To be noted is the DARS project (prisoners at suicide risk), financed by the Lombardy Region and active since 2004 in the prisons of San Vittore, Opera, Pavia, Monza, Como, Busto Arsizio e Bergamo, after the service had been started experimentally at San Vittore in 2001. When an inmate at risk has been identified the DARS psychologists intervene promptly.

[15] See circular 3524/5974 of 2000, "Acts of self-harming and suicides in prison. Operational guidelines with the aim of reducing prison suicides", and the circular of 2007 setting down indications and rules for the reception of prisoners coming from freedom.

[16] Circulars of January 2010 "Suicides emergency – the setting up of a Penitentiary Police listening unit" and April 2010 "New interventions for the hardship deriving from the condition of the privation of freedom and self-aggressive phenomena". The latter circular refers to the note of 10 December 2009 "Prison treatment and parenthood".

Milan, help groups have been set up by the prisoners themselves to support the inmates that appear more fragile.

At a European level, some countries, like France and Spain, have launched plans of action over the last few years which have led to a substantial reduction in the number of suicides. According to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the plans should foresee indications to set up an effective survey system for suicides and self-harming incidents, organise the training of staff to work on specific cases, to create structured integrated teams, guaranteeing also the presence staff involved in prison treatment, volunteers and their coordination with prison officers.

Bioethical stances and conclusions

In conclusion, the prevention of suicide passes above all through the guarantee of the right to health (understood, as happens nowadays, as the promotion of the psycho-physical and social wellbeing of the person) and of the right to serve a sentence that does not degrade human dignity.

From the ethical point of view, the first thing to do is to ask whether prison, as we know it today, in fact guarantees such rights. In the daily life of custody, many obstacles come between their full exercise. The following points list some of the most serious:

- overcrowding, which has reached unprecedented levels: this reflects on the staff's workload, with the result, among others, of the further narrowing of the spaces for the prisoners to move inside the prison;
- in the daily prison life the detainees often face further restrictions with respect to those intrinsically connected to the limitations of prison (work opportunities, training and education, the control of mail, the availability of personal belongings, relations with the staff, other inmates and the external society). In overcrowded prisons it happens that people spend even 20 hours out of 24 in their cells, without being able to do any kind of activity or education or work;
- the high number of persons in preventive custody (almost half the prison population): this is an anomaly in itself in the first place since, according to the law, preventive custody is foreseen as an exceptional measure (on the basis of the assumption of the innocence of the accused); as a bitter paradox, it is the prisoners awaiting judgement, who as such receive no prison treatment, who are forced into inactivity and find their spaces and exercise reduced;
- the high presence of inmates diagnosed with addiction pathologies, who are in prison in spite of the fact that the law states that treatment outside prison is a valid alternative (drug addicts represent 33% of prison admissions)[17]. If recourse to preventive custody were reduced and better use were made of the norms on alternative therapeutic treatment to prison, the problem of overcrowding would be considerably reduced, if not overcome;

[17] The figure refers to 2008. Over recent years there has been a growing cause for concern: not only has the entrusting of prisoners to alternative therapy decreased, but those from freedom have considerably gone down. This means that prison, also in preventive custody, is becoming the norm for drug addicts (Parliamentary report on drug addiction 2009).

- overcrowding and the overburdening of staff with work have immediate effects on the risk of suicides, which, as has been outlined, are more frequent in the first months of imprisonment and in preventive custody. In the so-called 'transit area', where the prisoners wait to be sent to the various sectors, the registration proceedings often take place in precarious logistic situations with great psychological tension;
- the particular limitations in the communication with family that concern the foreign prisoners (calls to mobiles, not authorised until a few months ago, are still generally difficult);
- lastly, the unacceptable use of violence towards detainees, some cases of which have recently been reported by the press and through initiatives of the public prosecution.

The general picture given above highlights a contradiction between the exercise of the prisoner's first right – the goal of custody being social reintegration – and a life in prison that forces people to regress, without any aim in life, in some cases even being subjected to violence.

The rectification of this contradiction is not only the task of the judicial and penitentiary institutions, but is the ethical responsibility of the whole society. Nowadays public opinion is particularly sensitive to the issue of the 'respect of legality'. It must be remembered that this principle is not valid only for people who have committed an offence and for this reason are serving a sentence: the principle according to which the privation of freedom does not take away the other human and civil rights is also totally deserving of respect. The fact that this aspect is often left out in the present debate is an indicator of the difficulty that our society has in fully recognising prisoners' rights.

Lastly it must be stressed that, with the end of prison healthcare, the institutional responsibility for the protection of health in prison is under the NHS. The health facilities are called upon not only to improve the quality of the individual clinical treatment, but to take on the responsibility of environmental protection, paying due attention to the sanitary conditions of the prisons and guaranteeing the necessary control.

More generally, the health reform in prisons opens up new possibilities for a relationship and continuity between the prison and the outside, to fill the gap between the protection of health inside and outside prison, bearing in mind the particular vulnerability of the prison population. From this viewpoint the prevention of suicide in prison is an area of intervention also for the local health authorities, in particular by means of mental health services outside prison.

The NBC considers that the prevention of suicide should go through a change of context in prisons, motivated by the respect of the prisoners' rights of citizenship and human rights. In the final analysis, 'to humanise prison' means to restore a horizon of hope and autonomy to the detainees.

In this framework of the assuming of collective responsibility for the respect of prisoners' human rights, specific interventions should be promoted: the setting up of *a national plan of action for the prevention of suicides in prison* is recommended according to the guidelines indicated by the European bodies. The plan should foresee recommendations for:

- the development of monitoring and research on suicide and acts of self-harming for a better understanding of the phenomenon;

- normative guidelines for the introduction of the mainstream non-prison punishment, lacking until now – except for the modest mention of a mere fine and some measures given by special judges – in the Italian legal system. This is to be hoped for in consideration of the specific conditions of the serious social hardship of today's prison population, with the high number of foreigners and drug addicts;
- greater transparency of the internal rules, overcoming the institutional opacity that makes suffering in prison unacceptable, insofar as being indecipherable. For this aim the general 'de-responsibilising' and 'infantilising' attitude towards prisoners must be stopped along with the use of particularly risky practices such as the recourse to isolation.
- an immediate plan of action to decrease the detainees in the JPHs according to the indications foreseen by the passage of prison healthcare to the NHS
- the organisation of specific training for personnel in suicide prevention, starting with individual cases
- the development of the personalisation of treatment, guaranteeing the actual presence of specialists, especially psychiatrists, in the observation and treatment staff
- the improvement of communication between prisoners and staff; in particular the creation of informal networks to listen to and support detainees that use all the resources available, formal and informal (from operators of all professions to detainees), for timely 'crisis interventions'.

Bibliography

Baccaro L.,Morelli F. (2009), *In carcere: del suicidio e di altre fughe*, Ristretti orizzonti, Padua
Barbagli M. (2009), *Congedarsi dal mondo*, il Mulino, Bologna
Bauman Z. (2002), *Modernità liquida*, Laterza Bari
Beck A.T., Beck R., Weissman A. (1975), "Hopelessness and suicidal behaviour: an overview", in *Journal of American Medical Association*, December issue.
Bentivogli S. (2006), "Pillole e umanità", in *Fuoriluogo*, May 2006
Buffa P. (2003), "L'attenzione al disagio psichico in carcere: dalla responsabilità formale al pragmatismo etico", in *Autonomie locali e servizi sociali*, XXVI, 1, Il Mulino, Bologna
Buffa P. (2008), "Alcune riflessioni sulle condotte autoaggressive poste in essere negli istituti penali italiani",in *Rassegna Penitenziaria*. No. 3*,* Review of the Ministry of Justice and the Department of Prison Administration
Campelli E., Faccioli F., Giordano V., Pitch T. (1992), *Donne in carcere*, Feltrinelli Milan
De Girolamo G. et al. (2005), Prevalenza dei disturbi mentali in Italia, fattori di rischio, stato di salute ed uso dei servizi sanitari: il progetto ESEMED-WMH, in *Epidemiologia e Psichiatria Sociale,* suppl. 8
De Leo D. (2009), "Quando la prevenzione del suicidio incontra le questioni del diritto alla morte: alla ricerca della prospettiva medica", in Baccaro L. and Pegoraro L. (edited by), "Salute mentale e garanzia dei diritti", *Quaderni di Etica e Medicina-Fondazione Lanza*, June 2009
Fornari F. (1981), *Il codice vivente*, Boringhieri, Turin
Goffman E. (2003), *Asylums. Le istituzioni totali: i meccanismi dell'esclusione e della violenza*, Einaudi, Turin (I ed. 1968)
Manconi L. (2002), "Così si muore in galera. Suicidi e atti di autolesionismo nei luoghi di pena", *Politica del diritto*, No. 2, Il Mulino, Bologna
Manconi L., Boraschi A. (2006), "Quando hanno aperto la cella era già tardi perché. Suicidi e autolesionismo in carcere 2002-2004", in *Rassegna Italiana di Sociologia*, No. 1, Il Mulino, Bologna
Morselli E. (1875), "Il suicidio dei delinquenti", Rivista sperimentale di Freniatria, Reggio Emilia
Morselli E. (1879), Il suicidio. *Saggio di statistica morale comparata*, Dumolard, Milan
Mosconi G. (1996), "Tempo sociale e tempo del carcere", in *Sociologia del diritto*, No. 2, Franco Angeli, Milan
Orford J. (1992), *Community Psychology. Theory and Practice*, Wiley, Chichester
Pagano L. (1995), *Rapporto degli ispettori europei sullo stato delle carceri in Italia*, Sellerio, Palermo
Paykel E.S. (1996), Life events, social support and marital relationships in the outcome of severe depression, in *Psychol. Med*., 26, 121-133
Villermé L. R. (1820), *Des Prisons telles qu'elles sont et telles qu'elles devraient etre*, Mequignon-Marvis, Paris
Waraich P. et al. (2004), Prevalence and Incidence studies of mood disorders: a systematic review of studies, in *Can. J. Psychiatry*, 49, 124-138

Declaration of the National Bioethics Committee on the problem of prisons (17 January 2003)
Dossier “Morire di carcere” 2000-2010, Centro di documentazione Ristretti Orizzonti, www.ristretti.it
Health care services in prisons (1999), European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
La prevenzione del suicidio nelle carceri, WHO, IASP, Dipartimento di Salute Mentale e Abuso di Sostanze- World Health Organization
La santé et la médecine en prison, Comité Consultatif National d’Ethique pour les Sciences de la Vie et de la Santé, opinion No. 94, 26 October, 2006
Il suicidio degli adolescenti come problema bioetico, opinion of the National Bioethics Committee, 17 July 1998
Parliamentary report on the state of drug addiction in Italy 2009
Women’s health in prison (2009), WHO Europe, UNODC