Presidenza del Consiglio dei Ministri

HEALTH "WITHIN PRISON WALLS"

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INDEX

Presentation

The Opinion, deals with the issue of the right to health care for male and female prisoners, continuing and integrating the previous Opinion "Suicides in prison. Bioethical indications" (25 June 2010), the theme takes on particular ethical significance, for several reasons: in the first place because the prison population represents the high vulnerability category, whose level of health, even before entering prison, is, on average lower than that of the general population. Moreover, the principle of equal opportunities (between detainees and free individuals) to access health, perceived as a good, on the one hand it encounters obstacles represented by the need for security, while on the other, it is in contradiction with the practice of imprisonment which leads to suffering and disease. Consequently, all competent authorities, starting with those concerned with health care, have a duty to supervise and verify the effective compliance with the right to health of prisoners.

In line with international bodies and with the dictates of the prison health care reform of 2008, the right to health, even and especially in prison, is not limited to the provision of adequate healthcare services: special attention should be paid to environmental components, ensuring to those imprisoned acceptable living conditions and prison regimes that allow them to lead a dignified and fully human life. Therefore, problems such as overcrowding, poor sanitary conditions, lack of activities and opportunities for work and study, confined for most of the day in the cell, the difficulty in maintaining emotional relationships and contact with the outside world, are to be considered critical obstacles in exercising the right to health.

The Opinion aims to highlight the shortcomings of the prison system in relation to the health of prisoners and identify some key areas for intervention. In its recommendations, the NBC, taking as a starting point the condemnation of Italy for prison overcrowding by the European Court in Strasbourg in January 2013, reaffirms the value of prevention, in order to ensure that male and female detainees live in an environment that respects the rights and principles of humanity. Finally, it calls for supervision to ensure that the prison sector, which requires much effort to accomplish acceptable standards of living, and conversely does not have to suffer from the reduction of resources.

The Opinion was drawn up by Prof. Grazia Zuffa, coordinator of the working group. Numerous expert consultations have served to bring light on issues requiring attention by the NBC. Special thanks to those consulted by the Committee for their contributions: Dr. Laura Baccaro (Ristretti Orizzonti - Padova); Dr. Teresa Di Fiandra (Psychology Director for the Ministry of Health, Directorate-General for Prevention);

Dr. Ronco (Associazione Antigone); Dr. Antonio Cappelli (volunteer doctor in Rebibbia for the Associazione Antigone); Dr. Paola Montesanti (Director of the Department of Penitentiary Administration); Dr. Fabio Voller (Director of the Social Observatory of Epidemiology, Tuscany Regional Agency of Health); Dr. Alberto Barbieri (General Coordinator of the organisation Physicians for Human Rights); Dr. Adriana Tocco (Guarantor of persons subjected to restrictions of personal liberty); The lawyer Riccardo Arena (Director of prison radio); Hon. Rita Bernardini.

The following Professors participated in the working group: Canestrari, Caporale, Gensabella, Palazzani, Toraldo di Francia, Guidoni. In particular,

Amato, Canestrari, d'Avack, Toraldo di Francia contributed to the drafting of parts of the text and discussion.

The text was unanimously approved by the following professors who were present: Amato, Battaglia, Canestrari, D'Agostino, d'Avack, Da Re, Dallapiccola, Flamigni, Forleo, Garattini, Guidoni, Isidori, Morresi, Neri, Palazzani, Piazza, Possenti, Scaraffia, Toraldo di Francia, Umani Ronchi, Zuffa. Prof. Marianna Gensabella subsequently also expressed her approval.

The President
Prof. Francesco Paolo Casavola

Premise

The National Bioethics Committee has already expressed its opinion regarding the serious problems of those who are obliged to live in confinement "within prison walls" starting with the declaration of January 2003 denouncing the dramatic conditions of overcrowding in Italian prisons, and in the most recent Opinion "Suicides in prison. Bioethical indications" 25th June 2010. In that document, it is noted that the phenomenon can not be interpreted solely individually, as a sign of psychological distress or of the detainee's psychiatric disorder/pathology; but also as a symptom of a lack or insufficiency of collective responsibility towards the fundamental rights of detainees, particularly the right to health. In its previous standpoints the NBC did not decline to allude to the challenging problem of the almost irreconcilable incompatibility of the prison system with the right to health, in its broadest sense, it is of specific bioethical importance: this incompatibility is exposed day by day - at least in Italy - it is absolutely evident, at least to those who do not want to close their eyes to this reality.

It should be recalled, however, very schematically, already in this premise some elements-principles which form the theoretical and conceptual framework within which the NBC has addressed, in several documents on specific themes and specific conditions, the problems connected with the protection of human health[1]. The first element is recognition that the problem of health comes necessarily within the broader framework of the discussion on fundamental human rights, as in Article 25 of the Universal Declaration of Human Rights, the actual enjoyment of these rights is a primary factor for the effective protection of health as a good[2]. From this there is also underlined how the health status of an individual is determined by the ability to take advantage of a variety of resources, both direct and indirect (such as e.g. housing situation, environmental health, lifestyle, degree of education, working conditions, etc...), corresponding to the different levels of possible interventions on the factors susceptible to modification and correction to mitigate existing inequalities. A second element concerns, more specifically, the theme of those inequalities in health that are considered unfair as predictable, preventable correctable, and therefore `morally unjust`. In this respect, the NBC has repeatedly reaffirmed the principle according to which the effort of the institutions in charge of ensuring equal opportunity to achieve the maximum health potential possible for each individual - which will necessarily be different from one individual to another - should be aimed at favouring, the most disadvantaged groups and individuals, when distributing scarce resources, such as those typical of the health sector; in other words, it is the same concept of (distributive) equity, or if one wishes, of substantive equality (expressed in the 2nd par., Art.3 of our Constitution), to require not only unequal treatment to compensate for situational disadvantages[3] but also careful monitoring so that forms of `covert

[1] See, in particular NBC *Bioethical guidelines for equal access to healthcare*, 25 May 2001, *Bioethics and the rights of the elderly*, 20 January 2006; *The living conditions of women in the third and fourth age: bioethical aspects of social health care,* 16 July 2010.

[2] See NBC, *Bioethical guidelines for equal access to healthcare*, cit.

[3] See A. Pizzorusso, Equality; Right, in "Encyclopedia of Social Sciences", Treccani, vol. III, 1993;

rationing` do not constitute actual barriers to access healthcare services for the weaker sections of the population.

Coming back to the prison situation, the disproportion between the dimensions of the gestures of self-harm and self-suppression of life within and outside "prison walls" has led the Committee to consider the harsh, often inhumane living conditions in Italian prisons as an environmental factor that adversely affects the physical and mental health of the prisoner and aggravates the discomfort inherent to the loss of freedom.

Hence the purpose of dealing with the various aspects of health in prison, in the belief that the right to health for prisoners represents the first right, which influences fulfillment of other rights; and conversely, that enjoyment of basic human rights conditions the state of health. To fully understand this statement, it is necessary to define the comprehensive meaning of the right to health: not only as a right of the detainee to be treated and as far as possible to not get sick, but also as a right to lead a dignified and fully human life, with the possibility of self fulfillment through some kind of existential projectuality. Claiming the right to health in the global acceptation is essential for anyone who is forced to live in prison where time is often devoid of purpose and meaning. For this reason, the achievement of this right meets serious obstacles in the concrete reality of prison itself: even more so because those who are not free have difficulty, due to their very condition, in making their voices heard.

A Prison is a place of contradictions[4]: the contradiction between the principle of equal rights inside and outside the prison walls (with the exception of freedom of movement), and the security requirements that tend to limit them; the contradiction regarding the norms according to which institutions must ensure the "healthiness of the living environment" and "the highest hygiene standards provided by law[5]", and the real living conditions in overcrowded cells; the contradiction between the significance of the sentence, based on individual responsibility, and the concentration in prison of an increasing number of people who belong to the most deprived strata of the population; the contradiction of the deficit in the health of those who enter penitentiary institutions and the prison which produces suffering and disease.

These are just some of the reasons which invoke ethical responsibility towards detainees in that they are from a biopsychosocial perspective a highly vulnerable group.

There are also other reasons to exercise constant public attention to the health of detainees. The effective exercise of the rights of those confined enters into contradiction, as we have said, with the very condition of the deprivation of liberty, a key aspect of which is constituted by "subtraction from view" of the bodies of the detainees and the environments in which they live. Although in recent decades there has been introduced as a democratic objective a prison

[4] Comité National d'Ethique Consultatif pour les Sciences de la Vie et de la Santé, *La santé et la médecine en prison*, Avis 94, 26 October, 2006. In particular the Committee denounces (p.8): "Prisons are also the cause of illness and death: they are the scene of regression, despair, self-inflicted violence, suicide".

[5] *Guidelines for the NHS interventions to protect the health of detainees and internees in penitentiary institutions and minors subjected to criminal measures* of the Decree of the President of the Council of Ministers of April 1, 2008 (*Procedures and criteria for the transfer to the National Health Service of health functions, employment relations, financial resources, equipment and capital goods in the field of prison health)*: "to guarantee the healthiness of the environment" is set as a priority.

which is (more) "transparent" and connected to the territory, modern prisons still retain to a large extent the historic character of "dungeons".

This requires the constant duty of knowledge and monitoring of the observance of the rights of detainees, as well as reporting violations and non-compliance.

Regarding this, we note with dismay the deterioration of the living conditions in prisons, during the ten years which separate us from the first statement by the NBC in 2003 to the ruling of European Court of Human Rights on 8 January 2013[6], which judged life in overcrowded Italian prison cells as "inhuman and degrading treatment".

1) Health in prisons and human rights: guiding principles

We do not intend here to enter into the debate on the role of the sentence. We start from the recognition that prisons in themselves can be pathogenic institutions, an inducer of psycho-physical disorders which determine in those imprisoned, in the form of legal suffering, a surplus of affliction and therefore of the sentence. The studies of Daniel Gonin, in the second half of the eighties of the last century, described in a scientific and articulate manner the suffering in prison and the illnesses that affecting the body of the prisoner during the course of segregation[7]. Legal suffering , if nothing else, with a wide exploitation of the offender, it is always the main cause of the altering in structure and of debilitation of the prisoner and determines a spectrum of pathologies, of "shadow diseases," considered as essential characteristics of "immaterial imprisonment". The successful expression of Nils Christie icastically summarises the essence of an unclassifiable sorrow and suffering for its own sake, completely extraneous to the development of the value of punishment, understood as the evolution and transformation of the prisoner[8]. The highest standards required in the protection of human rights and fundamental freedoms in modern societies involve correspondingly and unavoidably, greater firmness when assessing violations of the essential values of democratic societies, even towards prisoners.

It should be noted that Article 3 of the European Convention of Human Rights (ECHR) - in continuity with the provision in Article 27, III par., of the Constitution - provides the prisoner an absolute and binding protection, prohibiting the infliction of sentences which are of an inhuman and degrading nature. The most recent application of Article 3 ECHR can be considered as the normative cornerstone for the psycho-physical protection of the prisoner[9].

The judges in Strasbourg, while noting a minimum threshold of suffering intrinsically inherent to any form of deprivation of liberty, have identified a wide range of situations of an objective nature (such as overcrowding, poor sanitary conditions, lack of ventilation) and of a subjective nature (referring to the

[6] Torreggiani and others vs. Italy (Sent.8 January 2013).

[7] D. Gonin, *La santé incarcerée. Médecine et conditions de vie en détention*, L'Archipel, Paris 1991; ital. transl., *The body imprisoned*, EGA, Turin 1994.

[8] N. Christie, *Limits to Pain*, trans. ital. *Abolire le pene? Il paradosso del sistema penale*, Edizioni Gruppo Abele, Turin 1985. Nils Christie is epigone of abolitionist thought of imprisonment.

[9] Article 3 ECHR: no one shall be subjected to torture or to inhuman or degrading treatment or punishment.

incompatibility of detention with health conditions of the prisoner) which integrate a violation of Article 3 ECHR.

The assumption that is more frequent statistically is certainly represented by prison overcrowding, made the subject of recent critical condemnation in the judgment of the European Court of Human Rights (*Torreggiani and others vs. Italy*).

According to the now settled case law, the Court automatically includes as inhuman and degrading treatment when each prisoner has a personal space that is equal to or less than three square meters (compared to at least four sq. m. as recommended by the Committee for the Prevention of Torture of the Council Europe).

What matters, for the purposes of this document is the fact that the Court has clearly revealed the existence of the structural problems that are at the origin of the violations alleged in the serial appeals. In addition, while stressing that its task is not to indicate the specific measures to be taken in this context, the Court does not hesitate to provide some important indication in this regard, first of all, recalling the recommendations, Rec (99) 22 and Rec. (2006) 13 of the Committee of Ministers which invites States, and in particular prosecutors and judges, as widely as possible to resort to alternative measures to detention and to redirect their penal policy toward less use of detention for the purpose, among alia, to reduce the growth of the prison population (§ 95).

Secondly the Court points out that the Italian government should adopt - at the latest, as pointed out several times within one year from the passing of the court decision - a system of adequate domestic appeals to ensure a *preventive* remedy against violations of Article 3 ECHR borne by prisoners (and therefore suitable to stop the violations taking place), as well as a *compensatory* remedy in cases where infringement has occurred (§ 96).

In conclusion, it is clear that there is the need for a complete re-examination of the “government surplus” in a pluralistic and multi-dimensional approach, to allow the consolidation of different perspectives. If the prison sentence is unavoidable, it should be considered an expressive entity which can not impose the defense of liberty through its negation.

2) The prison population: health status

In penitentiaries there is a concentration of the persons belonging to the most marginalised groups in society, with low levels of education, with lower standards of health and with chronic diseases left untreated. This statement is contained in the "Moscow Declaration on health in prisons as part of public health", adopted in 2003 by the Regional Office for Europe of the WHO[10]. Among those subjects over-represented in prisons compared with the general population, there are also cited drug users, those most vulnerable and those involved in risk taking behaviour such as injecting drugs and sex for money. In fact, epidemiological studies on the prison population are limited, suggesting that prisons are still regarded as a separate world: the integration of health in prison in the channel of public health is to be considered an auspice rather than a reality. Just think of the national surveys on the health status of the general population which almost never include detainees: this applies for example to

[10] WHO Regional Office for Europe, *Health in prisons*, 2007, p.10.

the *National Health Interview Survey* (United States) and ISTAT surveys on the Italian population.

This oversight (or discrimination) is all the more deplorable when one considers the high numbers of people locked up in prison, and the number is constantly rising: in 2012, there were more than 10.1 million prisoners recorded in the world, the figure rises to 10.75 million if we consider the so-called "detention centres" where people are locked up even though they are not subject to criminal proceedings. The United States holds the record of the highest incarceration rate in the world (743 per 100,000), followed by Rwanda (595), Russia (568)[11].

Despite the lack of systematic measurement, the WHO informs that the major disorders in prison are mental, communicable, and gastrointestinal disorders. Certain unhealthy behaviours, such as tobacco consumption and alcohol abuse, associated with malnutrition and lack of physical activity, can aggravate serious chronic diseases such as diabetes and hypertension, which have a higher prevalence compared to the non-institutionalised population. A large part of non-communicable diseases, such as diabetes and heart disease could be reduced by acting on the major risk factors. Hence the WHO guidelines: 1) increasing physical activity; 2) information and education on healthy lifestyles; 3) special courses for more vulnerable persons, the elderly and the overweight; 4) special courses of gymnastics for vulnerable groups[12].

As to communicable diseases, the prison population is exposed to the spread of infectious diseases related to the use of injected drugs and risky sexual practices. A particular warning is launched by the WHO for HCV (Hepatitis C). Lastly, prisoners are subjected to high levels of stress, anxiety, sleep deprivation, which affect physical and mental health.

In Italy, with the Decree which set the passage of the prison health system to the National Health Service (see below, par.4), the acquisition and the organisation of epidemiological knowledge have been pointed out as priorities: Regions should activate in all penal institutions a systematic survey of data “on the prevalence and incidence of pathological states, also describing the conditions and risk factors that favor onset or hinder cure”[13].

In fact, only few Regions have initiated such a systematic survey; let alone in each penal institution[14].

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[11] R. Wamsley, *Prison Population List* (9th Edition), International Centre for Prison Studies, 2012.

[12] Who Regional Office, *Final Report of the network meeting on Prison and Health*, Copenhagen 11-12 October 2012, presentation by Emma Plugge, Oxford University.

[13] Guidelines cit., Attachment A, p.4

[14] Of these indicated there is Tuscany, which provides for periodic surveys through the Regional Agency of Health. The Tuscan ARS has conducted a survey on the health of prisoners in Tuscany in 2009, a second has been ongoing since 2012. Here is the most significant data of the 2009 survey, which offer a glimpse of general validity: The detainees are predominantly young (86.4% between 18 and 49 years old), almost half foreigners (47.6%, against a 9.1% presence of foreigners over the whole population of Tuscany). The level of education is low: 84.7% with middle school certificate (while only 50.5% had this level of education in Tuscany). There is a high rate of obesity (11.5% among prisoners against 9.2% on the territory) a high prevalence of tobacco use (70.6% versus 33.2% among the free). Among the non-transmittable diseases, disorders of the digestive system prevail (25.1%), of which more than half are made up of dental and oral cavity diseases (covering 13.7% of prisoners). Digestive diseases are more prevalent among the prison population compared to the non-institutionalised, as well as diabetes and obesity. Following on are the diseases of the bone and muscle (11%) and circulation system (10.8%). Among infectious diseases, the most common

A recent study of national data confirms the different distribution of health problems among prisoners in relation to the general population: 13% of the prison population is at risk compared to 7% of the general population. The disproportion is particularly evident for some disorders: drug addiction reaches 21.5% among prisoners compared with 2.1% of the general population; 15.3% of prisoners have dental problems (compared with 4.5 among g.p.); 13.5% have osteoarticular and post traumatic diseases (vs. 11, 9 g.p.); 2.08% suffer from HIV infection (compared with 0.2 of the g.p.)[15].

Overall, the prison environment is confirmed as at risk: for mental disorders especially for neurotic and adaptation disorders, which are ten times higher among prisoners, confirming the stress of prison life; also infectious diseases, whose potential for transmission is made worse by promiscuity; as well as for cardiovascular disease and diabetes, linked to a sedentary lifestyle and poor eating habits.

3) A comprehensive approach to health in prison: international guidelines

As already mentioned, equality regarding health between detainees and free individuals does not only mean equality in the provision of health services: a good network of health services is, if anything, an instrument which is necessary but not sufficient, *to achieve equality in the levels of health.* Therefore, one must offer detainees *equal opportunities to access health*, as a good, taking into account the differences (in this case, the deficit) from the start in the levels of health, as well as the particular circumstances of life during deprivation of freedom which in itself represent an obstacle to the achievement of health goals. It should be mentioned that the lack of freedom is a major weak point in the patrimony of health in its social and psychological components. The most invasive consequence of institutionalisation is the loss of the dimension of privacy of the individual and his capacity to control the environment of everyday life, which manifests itself in loss of identity and the perception of insecurity.

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are hepatitis C virus (HCV), hepatitis B virus (HBV) and HIV infection. These figures are high in comparison with the spread of these infectious diseases among the free population: HCV prevalence was 9% compared to 3% of the general population; HIV prevalence is 1.4% against 0.1% of the resident population. In addition, infections are distributed differently between Italians and foreigners. For example, among Italians some infections are much higher: HCV reaches 14.9%, HIV-2%. Such differences so marked among Italians and foreigners, however, give rise to many questions. In fact, they seem to conflict with international literature that reports high prevalence of hepatitis C virus infections in Africa in particular (it should be noted that Africans make up a large proportion of foreigners in the prisons of Tuscany). It would appear that the different numbers observed between Italians and foreigners are affected by different levels of adherence to virology tests (which require consent by the individual): of these cultural differences or simply communication difficulties also have an influence. With regard to mental health, the prevalence of mental disorders among the prison population is 33.3% compared to 11,6% of the general population. Among the disorders: diagnosis of drug dependency (12.7%), followed by neurotic disorders adjustment reactions (11.6%). When comparing those in confinement and the free, there is a higher prevalence of alcohol-related disorders among the first (5.7% versus 2%) and neurotic and adaptation disorders (10.9% versus 0.8%), while non-psychotic depression disorders are more represented in the general population (6.5% among the free versus 1.9% among those in confinement) (Voller F. et al., *The state of health of the prison population inside the penitentiary facilities of the Tuscany Region, "*Epidemiology & Prevention*",* 35, 5-6 2011, pp.210-218).

[15] M. Esposito, *The Health of Italian Prison Inmates Today: a Critical Approach*, in "Journal of Correctional Health Care"*,* 16 (3) 2010, pp. 230-238.

For this reason, the condition of imprisonment requires with even greater urgency *a comprehensive approach to health in prison*, starting with a careful investigation of health needs (and not just the needs of health services) of the prison population, involving the prisoners themselves and the voluntary organisations working in the prison. In this survey, the environmental variables of health are crucial, paying due attention to aspects of the prison regime and daily life inside prison.

Not surprisingly, the WHO emphasises the risk conditions common in prisons bullying, mobbing, forced inactivity. We therefore recommend pursuing the goal of a "safe" prison, both in terms of health hygiene as well as security understood as protection from violence and abuse. Respect of human rights, together with acceptable conditions of prison life are the foundations of the promotion of health since they embrace all aspects of the life of the prisoner.

The choice of the comprehensive approach to health allows for assessment under a different light and also to strengthen aspects, such as treatment and rehabilitation of the prisoner: these become essential elements of the right to health, which therefore is presented as the basic right which supports all others. Similarly, the relational needs of prisoners gain importance, so much so that the contacts with the outside world and the maintenance of family relationships are the subject of specific recommendations by European institutions[16]. This context should include the ability for detainees and spouses/partners to enjoy intimacy, so as to safeguard the exercise of affectivity and sexuality[17]. In this way the ethical principle of the centrality of the person is substantiated, even in conditions of deprivation of liberty.

On an international level, the following actions deemed to be fundamental for the protection of health of the prisoner are emphasised: 1) the treatment of detainees must always comply with the law; 2) the cells and the services must be clean and well equipped; 3) it is necessary to pay attention to the demands of the prisoners; 4) it is necessary to protect detainees from harm; 5) the prison regime should be bearable; 6) the staff must behave in an ethical and supportive manner.

Also indicated are some basic health interventions in relation to the specificity of prison life, to which a response must, in any case, be given[18].

- Information and counselling on the prevention of communicable diseases, including those transmitted sexually, HIV and hepatitis;
- Information and counseling on lifestyles at high risk, including the risk of drug overdose immediately after release;
- Support for healthy lifestyles, including physical activity and diet;

[16] See the September 22, 1997 n.1340 Recommendation of the Committee of Ministers of the Council of Europe, Article 6 which affirms the need to "improve the conditions for visits by families, in particular by providing places where prisoners can meet their families alone"; January 11, 2006 and Recommendation No. 2 Rule No. 24, paragraph 4 states that "the arrangements for visits shall allow prisoners to maintain and develop family relationships as normal as possible".

[17] There are many European countries where the visits of partners are held in private spaces. In Italy, this is prevented by Article 18 of penitentiary regulations which imposes surveillance on sight of meetings between prisoners and family members by the Penitentiary Police. This norm has raised the objection of unconstitutionality by the Probate Court of Florence (Order n.1476/2012). Bills on affectivity in prison have been lingering in Parliament for many legislatures.

[18] WHO, 2007 (cited above), pp.16-17.

- Measures to promote mental health, including an appropriate space of time for social life; an occupation that is meaningful for the detainee (work, artistic activities, exercise); contacts with the outside world and aid so as to keep relationships with the family. If it is true that prison itself is a risk factor for health, it is also true that it can provide opportunities for health to persons who are particularly marginalised, who even when free did not have access (or full access) to public healthcare: in particular, migrants and the most disadvantaged and stigmatised population groups.

4) From the prison healthcare system to the National Health Service: the decree of transfer of health functions and planning objectives

To ensure adequate levels of health services to prisoners, it is necessary for healthcare in prison to become fully part of public healthcare, coming under the same authorities which preside over the services on the country's territory. This indication was reiterated in 1998 by the Committee of Ministers of the Council of Europe. Some European countries had previously conformed, such as Norway in the eighties or France in 1994. Others have done so later, such as the UK in 2002. In Italy, the passage of prison healthcare to the National Health Service took place in 2008[19]. In the attachment containing guidelines, particularly significant and advanced are the so-called "reference principles", including "recognition of the full equality of treatment for free individuals and detained individuals and internees and juvenile subjected to criminal measures"; "the need for full and fair inter institutional cooperation" between the NHS and Penitentiary Administration and the juvenile justice system.

Moreover, in full adherence to the comprehensive concept of health already mentioned, there is the complementarity between interventions in protection of health and interventions aimed at the social recovery of the offender, through actions and programs conducted with the participation of all the institutions concerned, social cooperatives, voluntary associations." In addition, the prominent role of detainees in the construction of health[20] is recommended. Once again, explicit reference is made to "ensure environmental and living conditions of detainees that meet the criteria of respect for the dignity of the individual: avoiding overcrowding, respect for religious and cultural values etc".

The section on "Health Objectives and basic levels of care" is not limited to the field of provision of care services and adaptation of this offer within "prison walls", but aims at prevention both in terms of individual responsibility (health education programs to promote healthy habits), as well as collective responsibility ("promotion of a healthy environment and healthy living conditions, while taking into account the needs of imprisonment and restricting freedom").

The programmatic priorities are: 1) general medical practices; 2) specialist services; 3) responses to emergencies; 4) infectious diseases; 5) pathological addictions; 6) mental health; 7) protection of women prisoners; 8) protection of immigrants.

[19] Decree of the President of the Council of Ministers of 1st April 2008 (cited above).
[20] "The effectiveness of such integrated interventions is favoured by the direct participation of prisoners to prevention, treatment, rehabilitation, and preparation for exit".

In addition, the Prime Minister's Decree (Appendix C) indicates the guidelines for interventions in Judicial Psychiatric Hospitals and nursing homes and custodial facilities, with a view to their being superseded: in particular, in compliance with the principle of territoriality, the established user base of the regional service areas of individual institutions, in order to facilitate the taking in charge of the internees with a view to their discharge after completing the detention measure; and it is foreseen that there will be sections activated for treatment and rehabilitation inside penal institutions for individuals with a psychiatric diagnosis.

To facilitate and coordinate the action of the institutional levels involved in the implementation of the reform - in particular, the collaboration between healthcare institutions and penitentiaries - the cited Decree of the President of the Council of Ministers has set up two national coordination boards within the Conference State Regions: the first for healthcare in prison, the second to supersede the JPH.

At the regional level, coordination is entrusted to the regional permanent observers for prison healthcare, for constant monitoring of the quality of the care in prisons.

After five years from the Prime Minister's Decree of 2008, there are still several problems, both institutionally - the perfection of the functioning of the new system -as well as - and more importantly - as concerns the fruition of services by detainees and, even more so, in terms of a real equalisation of levels of health inside and outside prison walls.

The main open issues

Among the various problems and shortcomings reported during the course of the consultations of experts, we particularly bear in mind:

- *The consequences of differences in the levels of healthcare services from one Region to another.* Following the process of regionalisation of public healthcare (amendment to Title V of the Constitution), the competencies have not passed from the Ministry of Justice to the Ministry of Health, but from the former to the Regions and Local Health Authority of areas in which the penitentiaries are located. This process of decentralisation has very different consequences on detainees compared to free individuals: indeed the former often find that they have been transferred from one institution to another, situated in different regions, and therefore may receive different services. As is known, the broad measure chosen to ensure some kind of national homogeneity to the regional system is the establishment of Essential Levels of Care This measure is undoubtedly useful for the general population and has an important social purpose. However, this basic homogeneity is not enough, for those who, like detainees are transferred from one region to another not of their own will and therefore can be denied treatment which they had received until the previous day in a different prison. In other words, there is a breach of the right to continuity of care. Continuity of care is also undermined by the absence of computerised medical records, to the detriment of *promptness* in the transmission of health information, as will be described below.

- *The lack of homogeneity from one Region to another in the implementation of the Permanent Observatory for prison healthcare*. The failure or inadequate functioning of the Observatory, not only retards the acquisition of epidemiological knowledge necessary for health planning, which is essential for effective implementation of the reform itself; but it undermines the

confrontation/dialogue/dialectic between institutions responsible for health and institutions responsible for custody, given that the Observatory represents the highest instrument of inter institutional coordination. In the light of this failing, the custodial logic is likely to prevail over the right to health, in the name of preponderant security needs.

- The difficulty in finding a framework for the implementation of the reform on a national level, always following the process of regionalisation. To overcome this, Board of ongoing consultation on prison health at the State-Regions Conference conducted in 2011 a series of consultations with representatives of regional permanent observatories. However the problem still remains.

Beyond equality of treatment

Certain problems stem from a mistaken conception of equality regarding the right to health, which is sometimes understood as "equal" treatment, without considering the different health needs of the prison population.

An example is booking for *external specialist examinations or hospital admissions for operations to be scheduled: the inclusion of prisoners in normal waiting lists* penalises them, because the possibility of attending the examination appointment once it is their turn depends on the availability of the police escort, which is not always assured. In these cases, the detainee misses the appointment and it can take a long time before another opportunity arises. More serious still is the case in which the prison administration must consult individual hospitals in search of availability for hospital admissions: while waiting for the response, further attempts to different structures are not carried out and in the not uncommon event that hospitals do not respond the hospital treatment does not occur or is postponed far off in time[21]. The difficulties in obtaining external examinations for prisoners are confirmed by the data: the average wait is 40 days in Italy with a maximum of 90 and a minimum of 10 days[22].

Another critical area is *dental assistance* and the supply of dental prostheses. It is true that the NHS offers this service in a very limited manner to all Italian citizens and of course this is not about claiming superior services for prisoners. However, to be kept in mind are the special health needs of the group represented by detainees upon which this general lack of public health services has far more serious implications in relation to the particular severity of their oral conditions (see above paragraph 2). Therefore dental care in prison should be a priority for health planning: for example reconstruction of proper masticatory function has important positive effects on the conditions of the digestive system and helps to restore a dignified look to the individual. Nevertheless, the reform did not increase this form of assistance evenly in all the Regions; indeed in some cases, assistance has even been reduced, without the intervention of some voluntary associations[23].

Inadequate responses to the specific health needs of the prison population are also recorded in the field of physiotherapy rehabilitation and *psychological assistance*[24]*.* Typically, psychological assistance is provided upon entry into

[21] The case in example is the Poggioreale prison.
[22] M. Esposito, 2010, cit. p.236.
[23] The case in example is Rebibbia.
[24] The general shortage of psychologists is also reported in the expert consultations of the Permanent Regional Observatories of 2011 cited above.

prison, but there is a lack of continuity later on. As regards the taking into care of mental disorders there is a lack of measures in the prevention of mental illness, particularly in the formation of self-help groups.

Lastly, *respect for privacy* is a critical point, as shown by studies conducted among prisoners[25].

5) The right to healthcare related to security requirements

As already stated, there is a contradiction between the assertion of the right to health of male and female detainees and the security requirements that tend to limit its being exercised (see the premise). Security requirements exist, moreover, also in the aforementioned *Guidelines for action to protect the health of prisoners* reference is made to the services to be provided "respecting the security measures". For this very reason it is important that the contradiction is always evident, especially to the institutions that deal with health. But also the institutions that preside over security must be fully aware of it, in order to exercise their duties having clear the limit represented by respect of the fundamental rights of detained persons. The translation of the right to health in concrete terms into "health as a good" depends on the government being aware of this contradiction, from its ensuring that this right is not in fact nullified in the name of a preponderant logic of security.

Even in this regard, the health care reform is a major breakthrough because it opens the doors of prison to an institution, the institute of health, *whose first and only mandate is to promote the health of individuals and their protection as patients.*

Therefore, the Local Health Authority should have the responsibility not only to provide necessary interventions, but also to "represent" the interests of the person, especially if the person is sick, before the judicial and penitentiary institutions. Only by making explicit the different needs and with full awareness of having to find solutions to an underlying contradiction, can we move forward on the path of affirmation of the right to health, by finding a satisfactory agreement between the different needs and different institutional levels. We must always remember that in prison the logic of custody is in itself preponderant: therefore achieving the objective of health can only be the result of conscious efforts, as is recognised by the Penitentiary Administration itself[26].

Knowledge of the barriers to health in prison and their communication to the general public are thus of particular importance and are a requirement for the "transparency" of prisons, as already mentioned: this is necessary to make the rights of detainees concretely receivable.

In many cases, some of the impediments have more to do with the logic and routine of the prison institution than with security itself.

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[25] C. Sarzotti, *I medici penitenziari tra istanze securitarie e paradigma del rischio: un'indagine sul campo,* in Esposito M. (ed.), *Malati in carcere*, Franco Angeli, Milan 2007. Half of health staff interviewed mentions the complaint of detainees for failure to respect your privacy.

[26] Ministry of Justice, *Planning Document of the Third Bureau, Health Service of the Department of Penitentiary Administration,* 2005: "The main challenge for the transformation of the pattern of health care in prisons is still the wide gap between the safety profile and the social/treatment profile including health. To bridge the gap between health and safety, intervention of a cultural nature should be taken into consideration even before regulations, which can not stop at the gates of the prison...".

We will point out some critical areas, usually motivated by security precautions:

- *Shortcomings and delays in care for prisoners subjected to medium and high security measures*[27]. Even when pathological states have been documented requiring continuity of care and assiduousness, in general, the Magistracy does not allow these prisoners external hospitalisation, but rather provides for admission to existing healthcare wards inside the prison. However, the lack in number of these wards and their uneven dislocation on national territory mean that they do not provide adequate care.

- *Non-recognition of the state of incompatibility with imprisonment of persons with serious illnesses and disabilities.* In many expert auditions, there have been reported dramatic cases of sick or disabled persons, who live in conditions at the limit of human tolerability. In these cases, time in prison is a denial of the right to dignity[28].

- *Denial of the right to die in dignity, as documented in the cases in the news*[29].

- *Delays in emergency cases* at times with fatal results have been reported by other news stories. It should be considered that during the night for those in cells there is only calling by voice of the guard, which, in itself leads to delays in alerting the emergency unit.

Other shortcomings appear without a solid reason, except for mere prison routine that has been mentioned. Quote:

- *The denial of the right to the choice of doctor.* This faculty, commonly exercised by the free citizen, often does not exist for prisoners because they are forced to see the general practitioner of the prison ward; or else an examination by the prisoner's own doctor is seen as a one-off concession. It also occurs, especially in large penitentiary institutions, that the detainee does not have the assurance that he will always be treated by the same ward doctor. For this reason there could at least be provision for the figure of "a section doctor", therefore ensuring that the detainee sees a doctor who has some historical memory of his medical situation as well as a recognised responsibility towards him[30].

- *The inadequacy of the information to the patient and his relatives.* Deficiencies regarding communication and the relationship between the health staff/patient also exist "outside the prison walls" however in prison they have greater repercussions and contribute to the perception of "abandonment" of the detainee, all the more serious when the individual is suffering from an illness. As for the difficulty of family to obtain news about their relatives, these can have dramatic outcomes. One indication of the lack of dialogue with the medical staff is the dissatisfaction expressed by many detainees faced with the so-called

[27] This complaint is also present in the expert consultations of the representatives of the permanent regional observatories by the Board of permanent consultation on prison health of the Joint Conference of Regions: the NBC was able to consult the report.

[28] Dramatic cases reported during the expert auditions held by the guarantor of the Campania region. The example is cited of a paraplegic prisoner, in a wheelchair, in a cell with three other paraplegics, with a single guard to take care of all of them, with regard to cleanliness etc. And another prisoner who after surgery for spinal cord tumor is forced to walk with sticks and wear a collar because he can not keep his neck straight. He needs hydrokinesitherapy, which of course not is feasible in prison.

[29] It is the case, for example, of a terminally ill Belgian prisoner, serving a sentence in Sassari: he had asked to be allowed to die at home but died in prison in April 2013.

[30] This is a proposal made by the prisoners of the correctional facility of Padua.

prescription of generic drugs, which means that no time was given to provide the patient/detainee with sufficient information on the drug therapy. In other cases, there are complaints about no feedback to the patient as regards the results of clinical tests.

Lastly, the emergency of overcrowding should once again be reiterated: despite international indications and the guidelines of the healthcare reform in prisons recommending taking charge of the environmental and social aspects of health, the reform has so far failed to have a significant impact on these aspects. *Overcrowding, with the highly harmful hygienic and psychological consequences, along with prison regimes (especially when held in custody) which compel to be in the prison cell for more than twenty hours per day, exacerbated by difficulties in accessing work and training activities constitute an emergency* which has grown into a situation of dramatic normality in our country. On these aspects, so detrimental to the right to health, little has been heard from the voice of the competent health authorities.

6) Healthcare personnel: specific ethical aspects

Another aspect of the healthcare reform in prison is the administrative placement of healthcare personnel employed by the NHS and no longer by the Prison Administration. This step is a guarantee for the autonomy of the healthcare personnel. Autonomy is particularly valuable to doctors and the reform emphasises, even symbolically, the first duty of the physician to stand in defense of the well-being of the patient, fully independent from the prison administration. This passage, from "prison doctor" to "doctor tout court", however, calls for cultural maturity, in order that doctors may consider themselves truly autonomous and at the service of the individual, without being improperly responsible for other requirements and viewpoints that they are not called on to represent; and which in fact they are called on to counteract "on the part of the patient". This process of autonomy of the doctor is not totally complete. During the consultations of experts, it was repeatedly emphasised that the younger doctors who have experience of the NHS "outside the prison walls", better interpret their mandate; whereas a part of the doctors from the old prison health system are more likely to maintain the old role.

An indicator of insufficient acquisition of the spirit of the reform is the fact that doctors are often called upon to play two very different roles: their own as a therapist, and the one of the expert called on to judge the health of the detainee, in relation to the measures to be taken by the competent judicial or prison authority (see deferment of sentence for early release or incompatibility with imprisonment due to health conditions). It would be more appropriate for this judgment to be left to a doctor different from the actual doctor on the ward, so as to avoid adversely affecting the doctor-patient relationship[31]. Moreover, this is the indication at international level. The intent of preserving the fiduciary mandate of the doctor towards the patient clearly emerges also in other measures recommended by the WHO. In particular:

- in the case of special detention schemes (in Italy, Art.41bis, for example) and particular conditions of detention such as isolation, in which the administration wants to limit contact with the prisoner as far as possible, it is

[31] S. Antinarelli et al., *I rapporti tra sanità penitenziaria e Autorità giudiziaria*, in “Salute e Territorio”, September-October 2012.

recommended that the healthcare personnel should always be able to visit prisoners, *and they should claim this right if it is denied.*

- again in the name of the ethical principle that the doctor is called to pursue the well-being of the patient, it is recommended that doctors should not lend themselves in any way to certifying that a prisoner is able to sustain isolation or any other form of punishment. In particular, isolation for disciplinary reasons, according to the WHO which has evidence related to the damage that this causes to health, so much so that the United Nations has called for its elimination[32]. From the harmful results of isolation recorded on the health of prisoners, there has been identified a specific syndrome denominated (*Secure Housing Unit Syndrome*)[33].

7) Specific areas of intervention

Health data, computerised medical records and telemedicine

Computerised medical records are a decisive step forward for the practicability and timeliness of information regarding the health of all its citizens. This applies even more to those who are imprisoned, subject to transfers from one prison to another and from one region to another. At the moment, computerised medical records for prisoners exist only in Emilia Romagna and, on an experimental basis, in Tuscany. The remainder still relies on paper documentation, which accompanies the detainee in his transfers, often with great delay. Moreover, once again, there is the problem of reconciling organisation of the healthcare system on a regional basis, with the need to have data at national level. The regional medical record is inadequate for prison: instead, there needs to be a national healthcare dossier for the prisoner which collects from the computerised operational folders in use in the regions the essential information in order to reconstruct the clinical history of the detainee. The national medical file should therefore be constructed and managed by the Administrative Penitentiary Department on the basis of information obtained from the Regions and the Local health authorities. There has been reported a disconnection in this area between the tools of the APD, and the Health Service: the AFIS database (Automated Fingerprint Identification System) in use at the Administrative Penitentiary Department, which allows in every prison: quick reference to information about detainees, it already contains a "clinical diary," which however is not utilised by healthcare personnel.

If a medical record is the perfect tool to ensure the continuity of the therapeutic relationship, it constitutes only the first step towards realising those forms of telemedicine which enable monitoring and specialist consultation at a distance through electronic submission of tests, images and data to centres of excellence, without having to face all the problems, with their associated costs

[32] *Basic Principles for the Treatment of Prisoners*, Resolution 45/111 adopted by the General Assembly on 14 December 1990.

[33] In December 2007, a Group of 24 international experts promoted the Istanbul Declaration on the *Use and Effects of isolation in prison,* asking states to limit the isolation to truly exceptional cases and for very brief periods making recourse to it only as a last option. For a review of the literature on the effects on health of disciplinary isolation, see Sharon Shalev, the centre of Criminology at the University of Oxford (presentation at the *Network Meeting on Prison and Health* cit.).

and delays, transportation of prisoners or of doctors. There are, for example, the highly significant cases of Porto Azzurro and Regina Coeli. In the former case an agreement with the Department of Dermatology, of the Hospital of Livorno allows the transmission of high-resolution images of melanomas or other infections or skin lesions, as well as the related examinations and medical history reports, providing rapid and highly qualified therapeutic assistance. In the second case telemonitoring and specialistic teleconsultation concerns cardiological care and it is achieved through a Convention with San Giovanni Hospital in Rome.

Telemedicine therefore offers undeniable advantages in terms of efficiency of service, increased safety and, once fully in operation, reduction of costs. Its implementation requires all the necessary investments to modernise facilities, from the introduction of broadband to the acquisition of appropriate equipment for the acquisition and transmission of data. It presupposes, in short, as has been pointed out several times in the course of this document, this change in mentality that compels the consideration of the prison sentence as an aspect, albeit dramatic and controversial, of the effort to adapt to the increase in civility of a technologically advanced society and not the ancestral remainder of an approximate management of suffering and marginalisation.

As it is now sadly only an abstract concern , it must be affirmed, even in the face of all the advantages offered by distance care through telemedicine, the right of every patient[34], and therefore of every prisoner, to a direct and personal relationship with the doctor. Telemedicine should be seen as the best possible accomplishment of this and not as an alternative model or its substitute.

Mental health

The area of mental health should be a priority in health planning in prisons,, both because, as we have seen, it is one of the areas with a greater prevalence of disorders[35]; and because the very condition of imprisonment itself is in a high mental risk index. This analysis is supported at international level in nine million people, detained all over the world, at least half of these suffer from personality disorders, while one million suffer from serious mental disorders such as psychosis and depression. Almost all the prisoners have experienced depression and stress symptoms[36].

The network of territorial services needs to take charge of people with mental health problems, following the principles of the healthcare reform itself: by targeting intervention to individual care projects, involving all the support resources available inside and outside prison; and with projects to assist social reintegration upon release. This requires not only a good provision of specialised personnel (bridging the shortage of psychologists mentioned above), but also taking on an approach to promote mental health, with an active control on the general conditions of life in prison. As pointed out by the WHO, "the presence of healthcare personnel does not in itself guarantee health," let alone mental health. Again, the importance of ensuring acceptable environmental conditions, treatment according to the principles of humanity,

[34] "Ethics, health and new information technologies", 21 April 2006.
[35] The abovementioned research of the Tuscany Regional Health Agency (2009) shows that 29% of prisoners have been diagnosed with a mental illness.
[36] WHO, 2007 cit., pp.133-144.

respect for human rights is reiterated. The WHO gives an account of the most significant factors for the promotion of mental health, as is clear from research: firstly, assistance and services that facilitate self-promotion and guarantee respect for other people; secondly, satisfaction of the need to be appreciated and to be the object of care; thirdly, the opportunity to engage in activities and to have distractions[37]. These outcomes also indicate general and simple measures to improve the prison regime: such as the opportunity to receive regular visits from family and friends or to have access to work or study activities. It is important, however, that these and other measures should be considered for their importance as protective factors for mental health, and be fully included in health programming in an active inter-institutional dialogue between the health authorities and the prison administration.

Recently, the prevention of SIB and suicide risk has become a specific and priority objective, by way of several acts: from the APD newsletter dated 25 November 2011 to promote reception and support staff at the time of entry into prison, to the State Regions agreement of 19 January 2012 "Guidelines for reducing the risk of self-harm and suicide of prisoners, internees and minors subjected to criminal detention measures," to the three-year interregional project, supported by the Ministry of Health, for the testing of an operational model for prevention[38].

The NBC takes note of the efforts made at various levels of government to reduce the dramatic emergency and, in the wake of the information already provided in its Opinion of June 2010 (*Suicide in prison. Bioethical guidelines*) it recommends an approach that does not focus only on individual psychiatric risk factors, but it takes due account of the situational factors that can aggravate the stress of imprisonment, and, more generally, the risk involved in a prison environment that is not adequate or even that fails to respect the dignity and rights of individuals: as we have just seen, the WHO stands firm on this aspect.

This permits avoidance of "psychiatrisation" of the problem of suicide in prison, as well as the stigmatisation of people attempting to take their lives: with the risk of resorting to counterproductive measures, such as isolation of individuals and their exclusion from activities that take place in the penitentiary.

Along these lines, of active promotion of mental health, it is important that efforts to give greater attention to the moment of reception of newcomers should also be extended later on: essential services, such as early and continuous information about one's legal situation, the connection with family and significant others outside prison, easy access to talks with psychologists, and in general to basic health services, are important protective factors; as well as a positive relational climate, where the detained person has the opportunity to have a supportive relationship with all the personnel that the prisoner comes into daily contact with. There are interesting pilot projects (for example, in Bollate-Milan-Florence and Sollicciano), creation of health desks in which health information to prisoners and the relationship with health services are managed by the detainees themselves, who have a significant operative role. These programs should be made more widespread.

[37] WHO, 2007, cit., p.138.

[38] Collaboration Agreement of 29 August 2012 for the implementation of the project *the health status of the detainees in the penitentiary institutions of six Italian regions: an experimental model for monitoring of health status and the prevention of suicide attempts* (Veneto, Liguria, Umbria, Lazio, Campania and Tuscany as lead partner).

As regards Judicial Psychiatric Hospitals, their being brought to an end is now at an advanced stage as started by the Prime Minister's Decree of the 1st of April 2008, although the date for the final closure of JPHs was extended for one year in February 2013. In summary, the institution of acquittal for those considered not imputable on account of mental illness remains unchanged, so that they are subjected to security measures (or provisional security measures when they have not yet been judged): with the reform, those who have been acquitted, but declared dangerous (and therefore subjected to a security measure) will be taken charge of in therapeutic projects within the territory arranged by special divisions of the Departments of Mental Health; or in the new psychiatric residential facilities, which should meet, in terms of size and functionality, the therapeutic purposes (but with external police control). Although the closure of JPHs is a positive innovation, important issues remain to be solved, such as the reference criteria, currently lacking, for the proper assignment of persons to the two types of taking in charge described above: the risk is that the majority of the acquitted may be simply destined to the new structures. Suitable thought should be given to these psychiatric residencies which the Regions are currently preparing to avoid the pressure for economies of scale leading to over-sized structures that are likely to recreate the typical conditions of the mental asylum, with a concentration of its population and distancing from services and context belonging.

Female detainees

In 2009, the WHO Europe and the UNODC published a document whose title contains in itself a line of action: "*Declaration on* women's health in prison*:* correcting *gender inequity in* prison *health*". In first place in the final recommendations is the creation of a criminal justice system that is gender-sensitive, that is, which takes into account the specific needs and circumstances of life of the female gender: for example, that considers the types of crime committed by women. Women are often convicted of petty crimes, in relation to which imprisonment has a disproportionate impact on their health (and that of their children, if they are mothers).

Coming to detention, there is a paradox: the greatly reduced numbers of females compared to males in detention (2,800 women out of 66 568)[39], that does not appear to benefit women. Very often they are locked up in women's sections of male prisons, organised for the needs of men, while there are few women's prisons[40]. Although the problem of overcrowding for women prisoners does not exist, in general, in male prisons there is less attention to the functioning of the women's sections and there are fewer treatment services.

Imprisonment appears to have a greater impact on the suffering of women, not only because the stigma of imprisonment is still heavier; but also because the control of time and especially of space in daily life is an important dimension to the well-being of women, so this loss is felt by women more dramatically.

The treatment of women is linked to the concept of female transgression: crime tends to be seen as a "mistake" even before an offense: hence the shift

[39] APD, data on the number of prisoners, to 30 September 2012.

[40] Women's prisons are present only in Trani, Pozzuoli, Empoli, Rome Rebbibia Pontedecimo Genoa, Venezia Giudecca, while there are 64 women's sections of male prisons. There is only one Clinical Centre for Women in Pisa.

towards educational/correctional paternalism. Women are seen as "weak" in a manner not dissimilar from minors: less (intentional) "hardness" but with the risk of greater arbitrariness and fewer rights: the logic of the reformatory rather than of the prison, which however may lead to greater suffering and feelings of *helplessness*[41].

The female network of emotional relationships, usually richer than that of males, may constitute a factor for protection and support. Often, however, it turns into the very opposite, because women suffer separation more acutely: and because little is done in prison to facilitate the maintenance and the assiduity of contacts with the outside.

In addition, one should not overlook the presence of children under three years old who live in prison with their mothers. Currently in Italy there are about 50 children locked up. The law provides for house arrest for mothers with children that are under three years of age. This, however, is not applicable when the female prisoners have no residency or are repeat offenders. Most of the children detained are the children of nomads. The risks and harmful effects are serious: illness, psychological trauma, poor language skills, etc.

In theory, the imprisonment of children should end by virtue of the Law of 21.04.2011, No. 62 (Provisions relating to detained mothers), which provides for mitigated custody in ICAMs (Institutes for the mitigated custody of detained mothers), more liveable penitentiary institutions, or in secure shelter homes. Under this legislation by January 2014, all mothers of children aged three to six years should be transferred. However, it is easy to predict that this is not likely to happen because there are at present only two ICAMs, one in Milan and one in Genoa and another is being built in the Lazio Region. However, there are also influential opinions that are contrary to the ICAMs on the assumption that no child should enter the door of a prison. Hence, the desire for an alternative solution as represented by shelter homes, where it would be possible to house the children until the age of six and to reconstruct the family network with the siblings.

Addiction to illegal substances

Despite the declared intention of legislators from 1990 onwards to avoid imprisonment for drug addicts, the percentage of people addicted to illegal substances of the total prison population still remains high. In recent years, this is even on the rise. This applies to admissions to prison over the whole year (28.6% in 2005, compared to 32.4% in 2012), but also for the attendance calculated on any given day of the year (37, 31/12/2006 5%, compared to 38.4% 31/12/2012)[42].

The area of drug addiction passed under the National Health Service in 2002, in advance of the passage of general responsibilities, as an experimental area of the healthcare reform in prisons. This has led to improvements in some critical phases of the management of drug addiction in prison: for example, the treatment of the crises that may be suffered by opiate users is now a common intervention of care. These interventions are important, since the admission procedures may involve even lengthy periods (arrest, validation of the arrest,

[41] Cf. E. Campelli, F. Faccioli, V. Giordano, T. Pitch, *Donne in carcere*, Feltrinelli, Milan 1992.

[42] The source is the APD, Office of development and management of automated information system-Statistics Section. Most of the people with addictions are in prison for violating the anti-drug legislation itself, or for drug related offenses.

transfer to prison, registration)[43]. The presence of the SERT should also be designed to prepare treatment plans to facilitate the access of people with addictions towards alternative measures, such as special custody for drug addicts.

Nevertheless, there remain critical issues, as reported also at an international level. The European Monitoring Centre for Drugs and Drug Addiction complains about the delay in adaptation in prison to the treatment standards of the services outside prison (a difference of about 8/9 years). A recent review of 21 studies of programs with methadone maintenance in prison reported benefits similar to those seen in the programs in the country's territory, such as: the ability to attract people in treatment, reduction of the use of illicit opiates, the reduction of risk behaviors (especially the promiscuous use of material for injection). Most importantly, it reduces the (high) risk of a drug overdose in the period immediately following release[44]. It also points out the importance of continuity of treatment in services on national territory, after release.

The European Observatory examines in various European countries, the coverage of methadone programs in prison, i.e. the percentage of people receiving treatment over the total number of those estimated to need it: Italy is placed in the category "limited coverage" estimating that the number of those treated with methadone corresponds to less than half of the people who could benefit from it[45].

Communicable diseases: the HIV virus

As previously reported, the HIV virus is one of the transmissible infections that cause most concern, both because the prevalence is highest among the prison population, and for the risk of stigmatisation faced by people with this infection. International organisations insist on both prevention and treatment so much so that a document signed by all relevant UN agencies (UNODC, ILO, UNDP, WHO, UNAIDS) was recently published[46]. In the text, after having complained that only a few countries in the world provide appropriate programs, it recommends a comprehensive package of 15 key interventions: 1) information and education on HIV, hepatitis, and sexually transmitted diseases; 2) availability of condoms to prisoners (discretely); 3) Prevention of sexual violence (in particular protecting the vulnerable such as people with a different sexual orientation and young people; 4) Treatment of drug addiction including opioid replacement therapy; 5) Availability in a confidential manner of sterile material for injection to drug users; 6) Prevention of transmission that can occur through infected dental and medical supplies; 7) Prevention of transmission

[43] Cf. S. Libianchi et al., La tossicodipendenza e il carcere, in “Salute e Territorio”, No. 194, 2012, p. 287 et seq.

[44] D. Hedrich et al., *The effectiveness of opioid maintenance treatment in prison settings: a systematic review*, in “Addiction”, 107 (3), 2012, p. 501 et seq.

[45] EMCDDA, *Prisons and drugs in Europe: the problem and responses*, Selected Issue, 2012, pp. 22-23.

[46] United Nations Office on Drugs and Crime, the International Labour Organization, United Nations Development Programme, World Health Organization, UNAIDS, *HIV prevention, treatment and care in prisons and other closed settings in: a comprehensive package of interventions, 2012*. Urgency for HIV/AIDS is also confirmed in other documents. See WHO, 2007 cit., p.51; UNODC, UNAIDS, WHO, 2006 *HIV/AIDS prevention, care, treatment and support in prison settings: a framework for an effective national response*.

that can occur through tattooing; 8) Post Exposure Prophylaxis in situations of possible contagion; 9) Easy access to voluntary HIV testing and counselling; 10) Treatment for HIV including anteretroviral therapy; 11) Prevention, diagnosis and treatment of tuberculosis (considered the high percentage of HIV-TB co-morbidity; 12) Prevention of mother-to-child transmission; 13) Prevention and treatment of sexually transmitted infections; 14) Vaccination, diagnosis and treatment of viral hepatitis (including hepatitis B vaccination for all, for hepatitis A for those at risk, and prevention/treatment for hepatitis B and C); 15) Protection of personnel (which should receive information, education and training from healthcare personnel, in order to carry out their work tasks safely).

8) Migrants and Centres for Identification and Expulsion

Foreigners account for a substantial proportion of the prison population, about 36%. There are various nationalities, among which people from Africa and Eastern Europe stand out. Many do not possess identification documents and this leads to several critical problems, including the difficulty in establishing the age of those who run into the law, and of importance for the protection of minors.

Detention entails for both the male and female foreigner, especially those without a residence permit and valid identification document, many additional problems and suffering, including[47]:

- A more difficult communication with the personnel working in institutions, due to language problems but also because of cultural barriers impeding the full understanding of different roles;
- The lack of family ties or relationships in the territory and the difficulty in maintaining relationships at a distance: phone calls to the family are often hampered by the economic hardship of the detainee and the difficulty of inspection on telephone subscriptions in foreign countries;
- The internal work is not very accessible due to lack of documents and tax code number;
- Education and professional courses are designed to address the needs of Italians;
- Frequent homelessness and social ties within the territory narrows the possibility of obtaining benefits and take advantage of alternative measures to prison. In addition, cultural differences involve a different idea of the body, of its care, as well as the very concept of health.

To ensure that foreigners are able to exercise the same rights, the constant and not sporadic presence in prisons of a cultural mediation service is a priority. The cultural mediation project "Health without flags", launched at the end of 2012, to promote the healthcare integration of detained foreigners through full and informed access to the NHS, even during the period of detention. The project involves nine institutes with a greater presence of foreigners, including Rome-Rebibbia and Milan-Opera.

Foreigners without documents who have not been identified during the period of imprisonment are interned in the Centres for Identification and Expulsion.

[47] S. Libianchi, *La detenzione dello straniero*, in “Salute e territorio”, 194, 2012, p. 293 et seq.

In these centres the right to health of the internees is subject to such limitations as to question the use of the term "right".

In the first place the centres are located in inappropriate containers strongly lacking in terms of hygiene. There is a concentration of subjects of different and heterogeneous origin, many of them being particularly vulnerable: such as persons seeking refugee status and the victims of trafficking, who are likely to be locked up along with their enforcers. Assistance in the centres is not the responsibility of the NHS, instead it is provided by the managing body of the Centre. In most cases, it is basic healthcare calibrated on the previous legislation which allowed detention for not over thirty days. After extension of this period to six months, healthcare has become completely inadequate and there are serious cases recorded of persons not treated properly. In addition, there are great problems in obtaining the clinical documentation in the passage from prison to the CIE.

To these difficulties, there must be added the adverse psychological aspects: internees see this period as an additional punishment to the one already served, and moreover with fewer guarantees (they do not know how long they will remain in the Centre) and with fewer opportunities to carry out some activities.

Prompt action is necessary, with a number of urgent and immediate measures:

- The CIE should be closed or at least brought back to their original function as an exceptional measure, as required by the EU Directive, restoring as an ordinary measure assisted voluntary return (financed by a special European fund)[48];

- The NHS must take charge of the CIE or at least there should be immediate activation of agreements and conventions in this regard. Not only should adequate services be provided, there should also be a check on the state of premises, the adaptation of services and hygienic conditions, adaptation of lifestyle to the requirements which respect the dignity of persons;

- identification must take place during the period of detention;

- vulnerable groups must be protected, including the victims of trafficking, their regularisation should take place for humanitarian reasons.

9) Recommendations

- The NBC recommends to the competent institutions that the right to health of prisoners is to be understood in the full sense, in order to achieve an effective rebalancing in the levels of health inside and outside the prison walls, way beyond the guarantee of equality of access to healthcare services.

- The NBC reminds that the foundation of the health of the prisoner is the being treated with dignity and respect, in full observance of fundamental human rights. These include the right to receive treatment outside prison when detention exacerbates the suffering of infirmity to intolerable limits.

- The Committee points out that healthcare reform is not limited to the transfer of authority from the prison administration to the health administration. In keeping with a comprehensive approach to health, the health authorities

[48] A. Barbieri et al., *Arcipelago CIE. Indagine sui centri di identificazione ed espulsione italiani,* Medici per i Diritti Umani, May 2013. The MEDU survey was conducted in centers of Bari, Bologna, Caltanissetta, Crotone, Gorizia, Lamezia Terme, Modena, Rome, Turin, Trapani Milo.

must take full charge of control of the hygienic conditions of the institutions, the state of the cells and services, the living conditions of prisoners, tolerability of the prison regime. The ruling of the European Court of Human Rights on January 8, 2013, which judged life in overcrowded Italian cells as "inhuman and degrading treatment" indicates that the reform is still far from achieving its objectives.

- The NBC noted that some aspects of the healthcare system provided on a regional basis should be modified, if one wants to offer detainees equal opportunities in healthcare services. In particular, penitentiary administrations and the Regions need to work to *launch national computerised medical records* as soon as possible, which can follow the prisoner in real time when transferred from region to region; to ensure continuity of care when passing from one prison to another, even in the presence of varying levels of care from region to region.

- The NBC calls for the immediate application of measures for those aspects in which the most serious inequalities persist or where equal opportunities in accessing services are not met: insufficient promptness in emergency intervention, delays in specialist consultations and in the planning of interventions in outside hospitals, inadequate services to meet the specific needs of the prison population.

- The NBC recommends key areas of intervention, particularly with regard to mental health and the prevention of suicide and self harming, the prevention of HIV and other communicable diseases. More attention should be paid to the rights and needs of women prisoners, as part of a gender-sensitive criminal justice system.

- The NBC invites the NHS in its subdivisions within the different regions to immediately take charge of the serious health situation and living conditions in the Centres for Identification and Expulsion, pending more far-reaching measures to decide the fate of these structures and solve the spectrum of problems related to persons without a passport.

- The NBC also recommends great attention to ensure that an area as delicate as prison, which requires every effort to reach an acceptable standard of living, does not, on the contrary, have to suffer from the reduction in resources.