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Mental health interventions in Italian prisons: are we ready for a new model? Suggestions from the Parma experience

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Summary. Mental health interventions for Italian prisoners with mental disorder remain a problematic issue, despite radical changes in psychiatric care and a 2008 major government reform transferring mental health care in prison to the National Health Service. Indeed, prison has increasingly become a place of severe psychological distress, where also serious mental illnesses sometimes occur. In this contribution, we commented on the recommendations recently proposed by the Emilia-Romagna Region on how structuring mental healthcare interventions in all regional jails. Moreover, starting from the findings reported in recent epidemiological studies examining the prevalence of mental disorders in Emilia-Romagna prisons, we proposed a new treatment model for mental health and pathological addictions in jail, which took into account the current incidence of inmates with severe mental illness, psychological distress due to incarceration, and substance use disorder. Perhaps, this new intervention model (specifically centered on clinical psychology and case management by intramural mental health professionals) requires a vision able to overcome the classical "medical-centered" approach, which still too often permeates many sectors of public mental healthcare services. In our opinion, if we decide to look at the moon, we shouldn't dwell too much on the finger pointing to it.

Key words. Forensic psychiatry, mental health intervention, offenders with mental disorder, prison, psychiatric services.

Interventi per la salute mentale nelle carceri italiane: siamo pronti per un nuovo modello? Riflessioni dall'esperienza parmigiana.

Riassunto. Gli interventi per la salute mentale nelle carceri italiane rimangono tuttora problematici, nonostante la riforma legislativa del 2008, che ha trasferito le responsabilità e le risorse per la cura della salute mentale dei detenuti al Servizio Sanitario Nazionale. Il carcere, infatti, è diventato sempre più un luogo di profondo disagio psicologico, dove talora esordiscono anche disturbi mentali gravi. In questo contributo si vuole anzitutto commentare le raccomandazioni redatte dalla Regione Emilia-Romagna su come le AUSL devono strutturare gli interventi per la salute mentale nelle carceri regionali. Successivamente, partendo dall'analisi dei risultati di ricerche epidemiologiche sulla prevalenza dei disturbi mentali negli istituti penitenziari dell'Emilia-Romagna, si vuole proporre un "nuovo modello" di cura per la salute mentale e per le dipendenze patologiche in carcere, che tenga conto della reale incidenza carceraria delle diagnosi di disturbo mentale grave, di disagio psicologico da incarcerazione e di disturbo da uso di sostanze. Questo nuovo modello organizzativo, specificatamente centrato sulla psicologia clinica e sul case management da parte degli operatori delle professioni sanitarie, probabilmente richiede una visione capace di superare il classico modello "medico-centrico" ("psichiatrico-centrico"), che ancor'oggi, troppo spesso, permea molti settori della salute mentale pubblica. A nostro avviso, infatti, se si decide di guardare finalmente la luna, non bisogna soffermarsi troppo sul dito che la indica.

Parole chiave. Carcere, pazienti autori di reato, psichiatria forense, servizi psichiatrici, trattamenti psichiatrici.

Introduction

In April 2008, the Italian government approved a crucial decree that transferred all resources and responsibilities for both primary and mental health care in prisons to the National Health System (NHS), delivered by regional healthcare systems according to their organization and funds[1]. In line with this decree, the Regional Council of the Emilia-Romagna Region recently diffused a resolution on "how" developing and implementing healthcare programs in all regional prisons. In this resolution (n. 2051/2019)[2], there were also specific indications on "what" specialized mental healthcare treatments should be offered to prisoners with mental disorder allocated into the regional penitentiary institutes. In particular, mental health interventions in prison should necessarily address the specificity of this harmful environment, which has progressively become the terminal of social problems that worsen together with the deprivation of freedom[3].

Moreover, it is necessary to carefully differentiate between "psychological distress" and "mental disorder", as this clinical misinterpretation does not help

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in identifying suitable intervention solutions[4]. Indeed, psychological distress is not strictly speaking a "psychiatric disorder" and would be more adequately addressed with other, often nonclinical interventions (i.e., environmental, social or interpersonal)[5,6].

Specifically, the Emilia-Romagna Region proposed an intramural, integrated mental health treatment model in prison. This model should be primarily reserved for people with mental disorder, and should be able to distinguish them from those prisoners with psychological distress due to imprisonment and from inmates with aggressive behaviors (often associated with specific socio-environmental and/or interpersonal triggers)[7]. Indeed, maintaining a correct clinical approach is crucial when treating emerging problematic behaviors, as the risk of "psychiatrization" is high, and it is necessary to avoid requests for psychiatric consultation that focus on managing aggression and "disturbing" prisoners rather than on the need of specialized mental healthcare interventions[8].

The integrated mental health treatment model in Emilia-Romagna prisons: structural aspects

The more innovative aspects of the mental health intervention model in Emilia-Romagna prisons are: 1) to have modeled a therapeutic approach on multiprofessional treatments usually offered in Italian adult community mental healthcare services; 2) to have built intramural multi-disciplinary Mental Healthcare Service Teams (MHSTs) that deal with mental health problems; 3) to spread a culture of work based on planning person-tailored therapeutic-rehabilitation interventions in close collaboration with prisoners, their family members and local social/mental healthcare services of their belonging communities (in order to ensure a continuity of care during the patient's "intramural-extramural" transition).

This intervention model should be accessible to all prisoners who need it. Indeed, it is specifically structured on the following different time phases of incarceration (figure 1): 1) assessment (with a specific service for newly admitted inmates); 2) detention; 3) release from prison.

Assessment phase

The reception phase in prison must offer a specific assessment service for newly-admitted prisoners, without distinguishing if they have come from liberty, other prisons or home. This service should include an in-depth clinical interview conducted by a MHST clinical psychologist within 2-3 days from

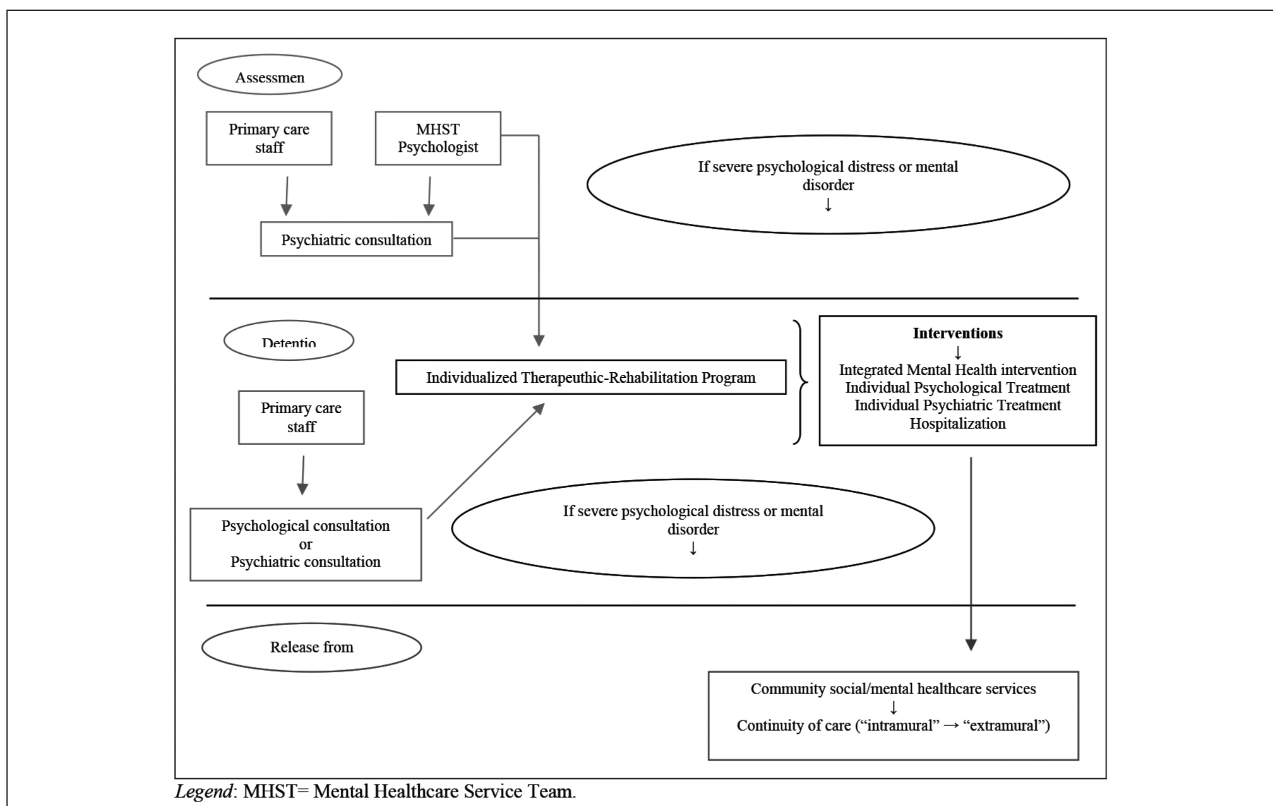

Figure 1. Flowchart of mental healthcare interventions in Emilia-Romagna prisons (recommendations form regional resolution n. 2051/2019)[2].

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entry. This is mainly aimed at carefully evaluating the adjustment reaction to imprisonment (a relevant "life-event") that all prisoners must necessarily face and that impacts with a more or less heavy pre-existing load of psychological distress[9]. During the interview, a detailed assessment of the prisoner's current mental state and information on her/his clinical and life history must be collected, also using screening instruments (such as the Jail Screening Assessment Tool - JSAT)[10]. In particular, it is important to identify past traumatic/critical events (such as self-harm behaviors, mental disorder, substance abuse, unresolved mourning, failed migration project), as well as to map the patient's cognitive, affective and interpersonal resources (commonly considered as useful protective factors in structuring resilience to the prison experience)[11]. Finally, it is also crucial to accurately assess the risk of suicide[12]. In case of impending suicidal risk, the MHST psychologist must activate the Local Prevention Unit for Suicide, as to organize careful clinical and environmental monitoring (together with the prison officers)[13].

The crucial purpose of the psychological assessment for newly-admitted inmates is to select prisoners with marked psychological distress, mental disorder or substance misuse. On a case-by-case basis, the clinical psychologist may also activate other mental health professionals of the multi-disciplinary MHST (e.g. psychiatrist, toxicologist, educator, social worker) and may administer specific psychometric instruments for an in-depth case formulation (e.g., structured clinical interviews, self-report questionnaires). Indeed, psychodiagnosis is crucial to formulate the most appropriate Individualized Therapeutic-Rehabilitation Program (ITRP) and to maximize its effectiveness.

During the assessment phase, a first psychiatric consultation can also be requested directly from both primary care medical staff and MHST psychologist evaluating newly admitted inmates. Specifically, the primary care staff should identify prisoners to be referred to the MHST psychiatrist by completing an *ad hoc* schedule (Table 1).

Table 1. Example of *ad hoc* schedule for appropriately referring inmates to MHST psychiatric consultation (to be completed by primary care medical staff) currently used in the Parma Penitentiary Institutes.

History
1. The inmate (or her/his family members) have had a previous contact with psychiatric services and/or have taken psychotropic drugs: No (0) Yes *If "yes", please proceed with the following 5 questions*: a) She/he has relatives affected by mental disorders → Yes (1) No (0) b) Emergency room access for psychiatric symptoms → Yes (2) No (0) c) Admission to psychiatric ward → Yes (3) No (0) d) She/he previously took antidepressants or antipsychotics → Yes (3) No (0) e) She/he was being treated by a psychiatrist/psychologist → Yes (6) No (0)
2. She/he previously intended to commit suicide → Yes (2) No (0)
3. She/he previously attempted suicide → Yes (6) No (0)
Objectively detected signs/symptoms
4. She/he is inhibited, mutacic and/or abnormally slowed → Yes (8) No (0)
5. She/he is excited, talkative and/or abnormally agitated → Yes (4) No (0)
6. She/he shows conceptual disorganization (i.e., she/he is confused and/or incoherent) → Yes (4) No (0)
7. She/he refers delusions and/or hallucinations → Yes (8) No (0)
Subjective symptoms
8. She/he feels distressed → Yes (3) No (0)
9. She/he feels hopeless → Yes (4) No (0)
10. She/he feels guilty → Yes (3) No (0)
11. She/he feels disheartened → Yes (1) No (0)
If the total score is above 4, send to psychiatric consultation.

Legend: MHST= Mental Healthcare Service Team.

Detention phase

Similarly to mental health interventions offered by Emilia-Romagna Community Mental Healthcare Centers (CMHCs), prisoners with mental health needs should be provided with one of the following specialized, person-tailored therapeutic-rehabilitation interventions during their detention: psychological consultation, psychiatric consultation and specialist engagement in the multidisciplinary MHST (figure 1).

Psychological and psychiatric consultation. During the detention phase, a careful evaluation of the prisoner by the primary care medical staff should always be made before activating a psychological and/or psychiatric consultation. Indeed, it is crucial that MHST psychologists and psychiatrists provide specific treatments that have not to be conditioned by secondary benefits for the inmate (such as single cell allocation, opening of the incarceration armored door, increasing pharmacotherapy dosage, elimination of bunk bed). In particular, a psychological consultation should be first requested in case of onset of a severe mental illness or severe psychological distress and maladjustment to prison life in inmates not engaged in MHST services. As "an expert in the therapeutic relationship"[2], the MHST psychologist may reduce inappropriate requests for psychiatric consultation, as well as decrease the risk of "medicalizing" adjustment difficulties and the abuse of psy-

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chotropic drugs, too often prescribed to manage negative emotions and disturbing behaviors[14]. Moreover, the MHST psychologist involved in the treatment of severe mental disorder may also refer the prisoner to the MHST psychiatrist for advice and the need of pharmacotherapy.

Engagement in the MHST services. The prisoner's engagement by the MHST should be always based on an ITRP, co-planned and co-signed with the inmate. ITRP personalization and specificity are guaranteed by the integrated multi-professional composition of the MHST, combining different mental health professionals (i.e. psychiatrist, toxicologist, clinical psychologist, psychiatric nurse, professional educator, psychiatric rehabilitation therapist, social worker). All these professionals should collaborate to plan the ITRP, together with the active participation of prisoners, their family members (when possible) and their community social/healthcare services.

A personalized and co-planned care pathway requires the provision of one of the following person-tailored mental health interventions: 1) individual psychiatric treatment; 2) integrated mental health intervention; 3) individual psychological treatment; 4) hospitalization (figure 1).

1) *Individual psychiatric treatment*. This is a simple form of MHST engagement, including an individual outpatient intervention aimed at monitoring the prisoner's clinical status and pointing out psychopharmacological therapy.

2) *Integrated mental health intervention*. This is jointly defined by all MHST professionals after the prisoner's first psychiatric/psychological consultation. It is the most articulated form of MHST engagement and is based on the integrated competence of the multi-disciplinary team. Indeed, this multi-disciplinarity allows a more effective management of the most severe mental disorders. For each case, the specific "micro-team" may vary in composition (i.e., it may potentially include a different combination of psychiatrist, clinical psychologist, toxicologist, educator, psychiatric rehabilitation therapist, psychiatric nurse, and social worker), in accordance with prisoner's mental health needs and her/his specific ITRP goals. In this respect, most effective intervention planning (especially in the long-term) should include a shared integration of goals with the community CMHCs, family members and local social services.

According to the inmate's ITRP, MHST educators or psychiatric rehabilitation therapists may offer both individual interventions (e.g., psychoeducational sessions aimed at supporting basic autonomies and daily functioning, specialized treatments aimed at rehabilitating specific residual socio-cognitive skills), and/or group interventions (e.g., psychoeducational groups focused on specific rehabilitation issues, mutual self-help groups, also using the "peer-support")[15].

The MHST psychologist may also be involved in reaching the ITRP goals and may offer both individual treatments (e.g., specific support interventions in response to defined prisoner needs and to promote resilience, focal psychotherapy [i.e., more structured psychotherapeutic interventions on specific goals agreed with the prisoner]), and/or group treatments (e.g. psychoeducational group sessions specifically oriented to improve compliance with therapy or the acquisition of specific socio-cognitive skills, psychotherapeutic groups aimed at increasing a reflective functioning and at favoring a more mature emotional expressiveness). In particular, *group interventions* within the Emilia-Romagna prisons are considered as extremely useful, because of both offering effective peer support on common areas of psychological distress and optimizing existing mental health professional resources.

3) *Individual psychological treatment*. Defined by the clinical psychologist after the first psychological consultation, it is a simple form of MHST engagement, based on an individual outpatient intervention aimed at reducing the context-specific distress (often inducing various problematic behaviors [e.g., self-harm, drug abuse, protests, social isolation]) and at encouraging the patients' compliance with care pathways, paying special attention to relevant stressful life events (e.g., bereavement, judicial notification, new illness diagnosis, separation/divorce, anniversaries)[16]. In this respect, the MHST psychologist may provide individual psychological support interventions, psychoeducational sessions on specific needs/goals, and/or focal psychotherapy.

4) *Hospitalization*. When necessary, hospitalization should be requested in accordance with specific procedures agreed with the emergency network of the local Department of Mental Health (DMH). As an alternative, a transfer request to special prison sections for psychiatric observation and treatment may also be proposed (i.e., the ATSM ["Articolazioni Tutela Salute Mentale"] sections). In these special sections, psychiatric diagnosis and/or specialized interventions are enforced without transferring inmates outside prison. Furthermore, prisoners requiring a compulsory inpatient treatment must be transferred out of the prison, in a secure psychiatric ward allocated in community general hospitals. This is still often a critical issue in Emilia-Romagna prisons. Indeed, specific hospitalization procedures are lacking in several DMHs and many psychiatric wards "maldigest" hospital admissions of prisoners and the need of their guarding, warried about their possible escape or aggressiveness.

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In most Emilia-Romagna prisons, engagement in MHST does not include retention in care for substance use disorder, which remains the prerogative of another, separate service (i.e., pathological addiction service). There are only few experiences (such as in the Parma Penitentiary Institutes) of mixed (but unified) professional teams combining expertise in the treatment of both mental disorder and pathological addictions[8].

Release from prison

The release from prison may be a very difficult step. Indeed, it leads prisoners to consider economic, housing, employment, and/or interpersonal difficulties that remain "outstanding," as well as coping with an external reality often very different from that hypothesized during the detention. Close to inmate's discharge from prison, the following mental health interventions should be planned:

- In case of severe psychological distress due to release from prison, MHST members (i.e., clinical psychologist, educator, psychiatric rehabilitation therapist, social worker) may implement specific individual and/or group psychoeducational sessions to inform prisoners about the local social and healthcare services that are present in their belonging community and how to access them. This is aimed to reduce fear and anxiety related to the extramural reality return. In patients requiring mental healthcare continuity, the activation of the local CMHCs should be encouraged, as well as a direct contact with local social agencies.
- In case of prisoners with mental disorder and/or previously engaged in CMHCs, the MHST should activate specific network interventions for the continuity of care, working in close collaboration with social and mental health professionals operating in the caring community.

The integrated mental health treatment model in Emilia-Romagna prisons: data from the real world and weaknesses

Data collected in 2018 on health condition in Emilia-Romagna prisoners[17] showed that the most common diagnosis was represented by psychic and behavioral disorders (including substance use disorders), concerning 37% of the total number of inmates (i.e., 3482 diagnoses on 8678 prisoners). Considering only inmates with psychic and behavioral disorders (regardless of illness severity and excluding substance use disorder), this percentage decreased to 14.8% (i.e., 1282 primary psychiatric diagnoses on 8678 inmates). Anxiety disorders (lasting for at least 6 months) were the most frequent diagnosis (i.e., 12% of the total number of inmates in Emilia-Romagna prisons), followed by personality disorders (4.3%), major depressive disorder (1.8%) and schizophrenia or other functional psychoses (1.7%). More specifically, anxiety disorders had a 76.6% prevalence rate among all psychic and behavioral disorders affecting Emilia-Romagna prisoners, followed by personality disorders (27.6%). However, about 1 out of 5 Emilia-Romagna inmates (19.9%) received at least one prescription of antipsychotic medication. Similar prescription rates were also observed for antidepressant drugs (20.3%). As for anxiolytic medications, prescriptions were definitely more frequent (63.1% [i.e., approximately 2/3] of Emilia-Romagna prisoners). Moreover, 1 out of 3 Emilia-Romagna inmates (33.4%) underwent at least one psychiatric consultation during their detention, with an average of 1.4 visits per prisoner per year. Psychiatric consultation was also the most common specialist healthcare service provided in Emilia-Romagna prisons in 2018. Compared to the 15% of primary psychiatric diagnoses (especially anxiety disorders with or without personality disorder in comorbidity) among all Emilia-Romagna prisoners, 33% of regional inmates requested a specialist psychiatric intervention in 2018. These results substantially replicated national data, within an overall increase of prevalence rates for all mental disorders over time[19].

Furthermore, in line with these findings, data collected across 12 months within the service for newly-admitted prisoners in the Parma Penitentiary Institutes[7] showed that 167 (55.1%) out of a total of 303 adult male inmates were affected by a current substance use disorder (especially cannabis [n=116], alcohol [n=44] and cocaine [n=34]), and 30 (9.9%) had a current primary mental disorder. Specifically, the most common primary psychiatric diagnosis was depressive/anxiety disorder (n=25 [83.3% of all mental disorders in Parma newly-received inmates]), followed by psychosis (n=3 [10%]) and personality disorders (n=2 [6.7%]). Finally, 151 (49.8%) PPI newly admitted inmates were retained in care within the PPI intramural mental healthcare service: 128 (84.7%) with an integrated multi-professional treatment and 21 (13.9%) with an individual psychological intervention. No exclusive individual psychiatric treatment was specifically provided.

The results of these regional investigations suggested that most of prisoners' mental healthcare needs underlie a substance use disorder or a common mental disorder (i.e., anxious-depressive disorder). Severe mental illness (such as psychosis and bipolar disorder) is relegated to a minority of inmates. Nonetheless, the need of increasing the number of weekly visits and hours per day of psychiatrist in prison has been invoked from many quarters. Even recently, the National Guarantor for the rights of persons deprived of their liberty has loudly shouted about the need

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to have a psychiatrist available in prison 24 hours a day[19]. Why this high-sounding proclamation? Is there truly a need for more psychiatry in Italian prisons? Even if evidence reported that mental health and detention are two closely related aspects (i.e., mental disorders are more frequent among prisoners than in the general population)[20] and that psychological distress (which has progressively increased in Italian prison in the last decade) is exacerbated by the deprivation of personal freedom[21], are we sure that the most effective clinical response is to intensify the psychiatrist's working time in jail?

Psychological suffering in prison is often due to imprisonment context and several anxious-depressive symptoms and aggressive behaviors are reactive and related to specific socio-environmental and/or interpersonal triggers. Therefore: could it be more appropriate to provide psychological, social and interpersonal interventions as first-line choice? Indeed, the intervention/consultation offered by the psychiatrist only often runs the risk of increasing psychoactive substance prescriptions, further raising the already high consumption of psychopharmacological therapy in prisoners[22]. Perhaps, we need to better consider the difference between "psychological distress" and "mental disorder", as well as between "clinical psychiatry" and "mental health". Indeed, in accordance with current international classification systems[23], mental disorders are syndromes that are a "dysfunction in the individual" (i.e., some psychological processes are unable to function appropriately). Without question, stressful social arrangements can cause internal psychological dysfunctions and mental disorders (such as in wartime combatants, Holocaust survivors, chronic poverty without solution)[24]. However, the more typical outcomes of stressful social arrangements are mental responses that non-disordered people make to stressful conditions, do not produce internal psychological dysfunction, and can be positively processed/overcame and/or naturally diminish with the passage of time (such as in many cases of imprisonment condition)[25]. Therefore, it is necessary to give greater importance to intramural psychological, social/interpersonal and occupational/educational interventions for prisoners, relegating the psychiatrist to a more specifically consultative role able to effectively support the clinical psychologist in identifying and treating inmates with severe mental illness (especially when there're pharmacological needs and in planning extramural alternative mental healthcare pathways).

Finally, another question remains unanswered: given the high comorbidity, does it make sense to divide intervention for mental disorders and pathological addictions into two different intramural teams, neglecting the uniqueness of the individual and her/his history?

Conclusion: are we ready for a new mental health intervention model in prison?

In this anachronistic context, we propose a new organizational model for mental healthcare intervention in Italian prisons, specifically based on the valuable clinical expertise of MHST psychologists and other healthcare professionals (i.e. educators, psychiatric rehabilitation therapists, psychiatric nurses and social workers): i.e., a new operational approach that instead of seeing the centrality of the psychiatrist, sees that of a multi-disciplinary service, so as to confines the medical role (i.e., psychiatrist and toxicologist) to a more peripheral position in the organizational structure of the intramural MHST (figure 2).

Within the same mental health treatment options offered by the intramural MHST (i.e., integrated mental health intervention, individual psychological treatment, group therapy, psychological consultation, psychiatric consultation), we propose a single multi-professional team with two main areas of intervention: one dedicated to clinical psychology and one to pathological addictions. Indeed, this single multi-disciplinary MHST dealing with both mental healthcare and substance abuse may truly allow us to erase the rigid organizational barriers between mental healthcare and pathological addiction services, which too often bounce the retention in care of patients without them belonging to any service[8]. Indeed, the bipartition between these services currently present in most Italian prisons fragments the retention in care among multiple professionals, removes responsibility from each team, and does not capture the uniqueness of the individual (frequently splitting in single comorbidities such as those inmates with co-occurring substance use disorder and personality disorder). In this sense, a single multi-professional team returns the patient to the multi-faced nature of her/his ITRP and individuality.

The clinical psychology area should mainly deal with: 1) screening for newly-admitted inmates (especially for early detection of severe mental illness, severe psychological maladjustment and substance use disorder); 2) psychodiagnosis of mental disorder and pathological addiction (in collaboration with other MHST professionals) also using structured clinical interview (such as the SCID-5)[26]; 3) individual psychological treatment (especially aimed at reducing severe psychological distress due to imprisonment or during the detention phase); 4) group psychotherapy. The screening for mental disorders is a particularly crucial procedure. In this respect, imprisonment and health services in jail sometimes constitute the points of first contact of the prisoner's mental healthcare needs with specialist teams. In this detection activity, the psychiatrist must support clinical psychologists'

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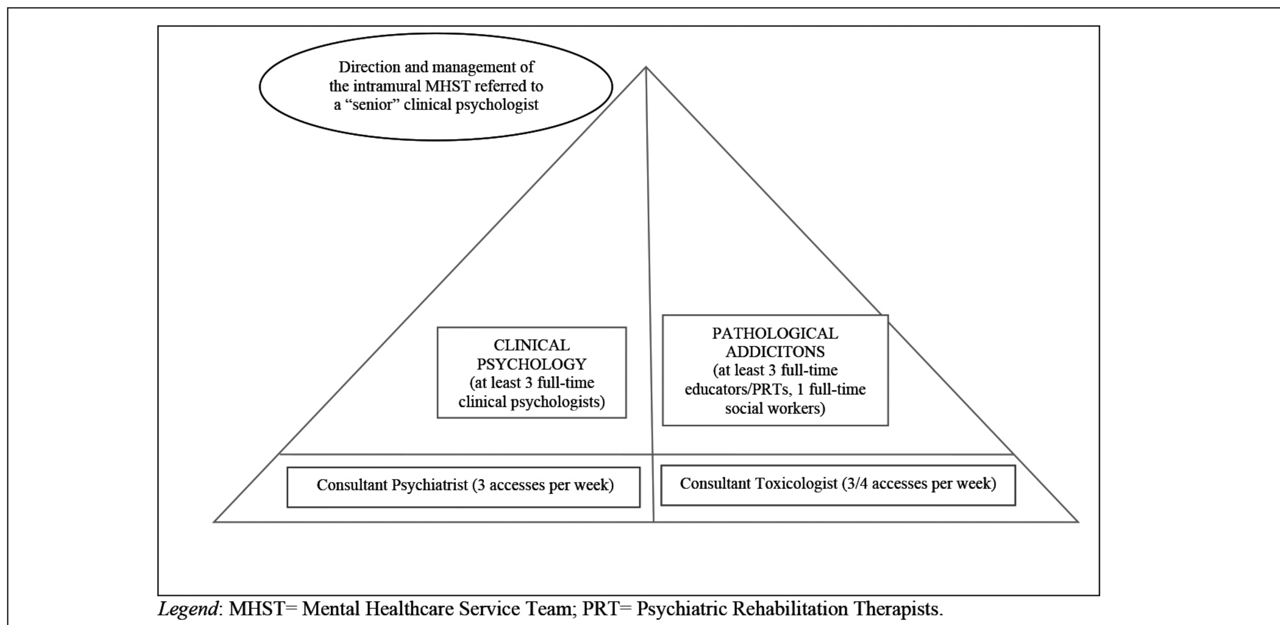

Figure 2. A new organizational model for mental healthcare interventions in Italian prisons (professionals counted out of an average prison population of approximately 800 prisoners).

work (both in early identification and early intervention in offenders with severe mental illness), with the founding treatment principle that severe mental disorder should mainly be treated outside prisons, through extramural person-centered ITRPs shared with patients, their family members and social/mental healthcare services of their native community. Indeed, prison cannot be considered as the right place of treatment and care, especially for the most severe mental disorders (which, as previously suggested, affect a minority of Emilia-Romagna inmates). Moreover, the psychiatrist may also assume the relevant role of supporter of other MHST professional figures, especially in planning the care continuity with existing DMH structures.

The pathological addiction area should mainly deal with: 1) individual intervention aimed at enhancing motivation to treatment (i.e., detoxification, substance withdrawal); 2) intramural planning of person-tailored ITRPs, also aimed at the continuity of care within the external community (both at the end of incarceration and through alternative treatments to detention); 3) collaboration in the formulation of a psychodiagnosis related to substance use disorder; 4) group psychoeducational sessions, mainly aimed at supporting psychological distress due to imprisonment in inmates with pathological addictions, at preventing relapse close to release from jail, and/or at favoring mutual self-help support for substance misuse (also including "peer supporters"). In these clinical activities, it is helpful to structure a work model centered on a case management by mental healthcare professionals (i.e., educators, psychiatric rehabilitation therapists and social workers), similarly to what happens in the Emilia-Romagna community pathological addiction services. Furthermore, it is also crucial to keep the focus of MHST clinical activities on favoring extra-mural treatment programs, especially as alternative measures to detention (indeed, prison cannot be considered an adequate care place also for treating drug abuse). About this, it is important to identify prisoners motivated to do so and not exclusively adhering to the therapeutic program for secondary benefits (such as a quick way out of prison). Given the relevance of clinical psychology in this new organizational model, we proposed that the direction and management of the MHST should be entrusted to a clinical psychologist with high experience in mental health clinical practice.

However, possible limits if this new model should also be acknowledged. A first concern is related to screening approach and psychodiagnosis that could not easily delegated to a clinical psychologist. Indeed, according to the common clinical practice (also outside the prison) and a potential, strict interpretation of Italian jurisdiction, screening procedure is often considered a medical diagnosis. In our opinion, this is a too restrictive vision on diagnostic process in mental health.

Moreover, some issues still remain open: 1) drawing up clear operational procedures for the hospitalization of prisoners with severe mental disorder (including compulsory inpatient treatment) in all Italian jails; 2) drawing up procedures for the mental health

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treatments of migrant inmates without regular residency documents; 3) drawing up reliable intramural procedures for the distribution of methadone or buprenorphine (in order to reduce the risk of overdose), for monitoring the correct administration of drug therapy, and for the use of long-acting medications.

Perhaps, this new organizational model requires a vision able to overcome the classical "medical-centered" ("psychiatrist-centered") model, which too often, still today, permeates many sectors of the public mental healthcare service. Indeed, in our opinion, if we decide to look at the moon, we shouldn't dwell too much on the finger pointing to it.

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