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Have prisons learnt from Covid-19?

How the world has reacted to the pandemic behind bars

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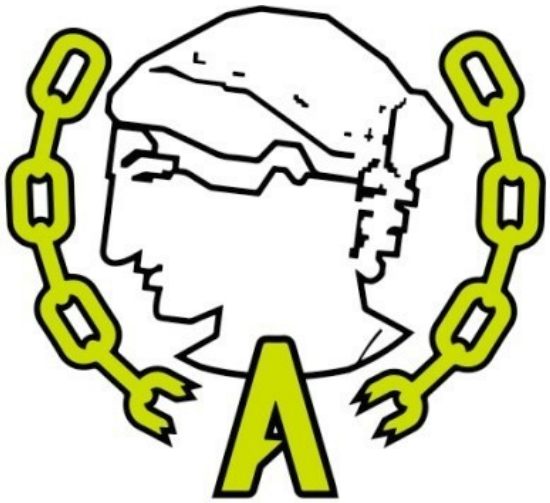

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N. 1/2020 HAVE PRISONS LEARNT FROM COVID-19? HOW THE WORLD HAS REACTED TO THE PANDEMIC BEHIND BARS

edited by Susanna Marietti and Alessio Scandurra

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Aldo Morrone[1]

1. The virus of inequalities

Covid-19 has revealed the deeply sympathetic character of the human being. At the same time, however, it has highlighted the inequalities, the social and gender disparities, and the infinite variations of differences among individuals, societies, nations and continents (A. Ambrosio, 2020).

One of the problems concerned the cuts in the health system and the different access to care: insufficient beds, masks, tests and ventilators. Our economic system must be changed at its foundation: we need to invest in welfare, education and health care.

In this emergency context, we find a National health service that was already collapsing when the pandemic hit. This can be seen through the numbers. On the one hand, there was almost no investment in research - only 0.2% - on the other, between 2012 and 2019, 759 hospital wards were closed down (minus 5.6%) and there are 2.3 beds per 1,000 inhabitants, compared to 2.4 in Spain, 3 in France and 5.5 in Germany. Regarding health personnel, in Italy, there are 5.6 nurses per 1,000 inhabitants, unlike Germany (12.6), France and the United Kingdom (7.9). The number of doctors has been absurdly decreasing for many years: 3.5 doctors per 1,000 inhabitants. Intensive care units, on the other hand, have availability of 2.6 beds per 1,000 inhabitants (while in Germany 6.0; France 3.1 and Spain 2.4). In our country, finally, there are 25.2 Mri and 30.6 Cat machines per million inhabitants; in France 110 Mri and 183 Cat scanners.

Meanwhile, the numbers of the pandemic continue to grow and the spread of the virus continues to accelerate. There are now more than 36 million infections in the world, while the number of deaths exceeds one million. It is no longer just a health crisis, but also an economic, social and in many countries even political crisis. The pandemic is developing at double speed and this also explains the difference in perception among citizens: in the countries that were first affected it has slowed down, but in the world, it is growing faster and in very populated areas.

The virus, in addition to highlighting the consequences of a social-health system reduced to its bare essential, has once again shed light on the issue of inequality also in terms of health. This issue must be brought back into the discussion at the end of the emergency if the constitutional right to enjoy good health is to be truly protected for all.

It is not true, in fact, that in the face of illness we are all equal. We have never been. It is not true that we all run the same risks and have the same opportunities to be treated. Particular social categories, more fragile than others, are and have been more at risk. Even deaths have not been the same. Elderly people with previous illnesses have been more at risk. Not all working classes have been able to benefit from remote working. Labourers, precarious workers, uncontracted workers, were at greater risk than those who had the comfort of a managerial role and became even more impoverished. But the current health emergency has discriminated against and penalised above all women who have been and still are in the front line, forced to work three times as hard at home. For them, there has been no distinction between personal and working life. They have suffered even more than before from male violence.

Among the social groups most at risk, prisoners occupy a prominent position. Prison facilities are epicentres for numerous infectious diseases (F. Dutheil, J. B. Bouillon-Minois, M. Clinchamps, 2020) due to three macroscopic factors:

1. inevitable close contact in structures that are often overcrowded, poorly ventilated and unhygienic;
2. poor access to the health service;
3. very rapid spread of pathogens among inmates, visitors and staff, inside and outside the prison community (internal-external communication).

For this reason, these *non-places* are an integral part of the public health response to Covid-19 (B.F. Henry, 2020; S.A. Kinner et al., 2020).

2. Health in prison before Covid-19

With the Decree of the President of the Council of Ministers of 1 April 2008, an attempt was made to implement the transfer of health competence from the Ministry of Justice to the National health system. The situation reported after ten years has proved to be complex. In 2019 there was only one general practitioner in each prison for every 315 prisoners, for a total of 1,000 general practitioners and on-call doctors in about 200 Italian penal institutions. Too few to guarantee adequate service. 70% of doctors are temporarily employed. Of course, the number varies from prison to prison depending on the capacity of the facility, but on average there is one doctor for every 315 prisoners. In some cases, there is not even a general practitioner (Ansa, 2019).

The experience of detention is in itself already a health risk, due to the degraded conditions of facilities, cells and communal areas, overcrowding and high turnover of prisoners and therefore the increased risk of contracting infectious diseases.

It should be borne in mind that living conditions in prisons, which are particularly inadequate to cope with a

pandemic of this magnitude, can act as highly stressful factors and aggravate an already critical situation due to forced isolation in an equally forced cohabitation context (A. Camposeragna, 2020).

Among prisoners, there is a higher:

1. prevalence of Hiv, Hcv, Hbv and tuberculosis compared to the free population, mainly due to the criminalisation of drug use and the detention of people who use drugs (the prevalence of Hiv infection among prisoners is 4.8%, compared to 0.2% of the general population; the incidence of tuberculosis is 23 times higher than that of the general population);
2. likelihood of contracting diseases even in healthy individuals.

The increase in risk concerns not only infections such as Hiv and Hcv, but also the possibility of becoming addicted to psychotropic substances or of developing mental disorders, to a greater extent than the incidence of the same pathologies in the general population. This is a matter of public health: sooner or later the majority of those deprived of their freedom are reintegrated into free society (P. Tozzo, G. D'Angiolella, L. Caenazzo, 2020). Their reintegration as healthy persons is a constitutional right and a civic duty.

In 2014, a multi-centre clinical trial was carried out in several penitentiary institutions in six central-northern regions: Tuscany, Veneto, Latium, Liguria, Umbria and the Salerno Health authority in Campania, showing the health conditions of about 16,000 detainees in 57 prison institutes (about 30% of penitentiaries). 70% of the sample was affected by some pathology, with differences in gender (men 67%, women 75% and transgender 95.7%) and age (18-29 years 58.4%, 30-39 years 63.9%, 40-49 years 70.9%, 50-59 years 76.7%, >60 years 82.6%). More than 40% of the patients recruited had a psychiatric pathology (anxiety, neurotic disorder or adaptation reactions, depression). Many were addicted to drugs (24% of the total sample, with cocaine being the most widely used substance). They were followed by diseases of the digestive system and, at 14.5%, diseases of the teeth and oral cavity.

There is a high concentration of infectious diseases (hepatitis C, hepatitis B and HIV), which affect 11.5% of the sample. Suicide attempts and self-harm acts are alarming: 5% had performed a self-harm act at least twice in the last year (Ars Toscana, 2015). Despite the high consumption of tobacco in the prison population (71% smokers compared with 22% of the general population in Italy), respiratory disorders are among the rarest in prison, as the average age of prisoners is relatively low. Therefore, prison health care is mainly geared towards the treatment of addictions and mental disorders, and frequent diseases in the prison population such as hepatitis, Hiv, tuberculosis and sexually transmitted diseases (S. Gainotti, C. Petrini, 2019, p. 138).

More recent studies, which photograph the entire national situation, indicate a very high percentage of hepatitis C patients, the infection most present in the prison population in Italy, also due to the high presence of drug users. Between 25% and 35% of Italian prisoners suffer from hepatitis C (between 25,000 and 35,000 prisoners a year). To these must be added 6,500 active carriers of the hepatitis B

virus. There are about 5,000 Hiv carriers, declining in comparison to 15 years ago thanks to the use of antiretroviral medications. Their prevalence has fallen from 8.1% in 2003 to 1.9% today (Ekuo News, 2020). The figure is certainly positive in terms of health, including psychological health. In fact, the fear of Hiv and Aids and the social stigma associated with seropositivity (or the suspicion of infection) have negative effects on individuals and undermine the success of responses to the same pathologies, discouraging prisoners from voluntarily accessing the Hiv test or those positive from requesting health care services. In combating stigma and discrimination related to Hiv and Aids in prison, it is therefore important to protect the rights of inmates living with Hiv and to increase the effectiveness of services, as well as to reduce risk behaviour through effective internal awareness-raising and training campaigns among inmates (R. Lines, 2007, pp. 26-27; G. Ciccarese et al., 2020, p. 390).

As far as the elderly Italian prison population is concerned, a 2017 study on the prisons of Bari, Taranto, Foggia, Lecce, Bergamo, Cremona and Mantua found that 64% of the sample was not in optimal health. Among the most frequent pathologies, 23.4% suffered from cardiac pathologies, 12.8% from dysmetabolic pathologies (diabetes), and 9.6% from pathologies requiring surgery (C.A. Romano,*et al.*, 2020).

3. Prison and Covid-19

Is prison pathogenic? Can a place in itself make someone sick? Is it possible to be mentally healthy in prison? These are socio-cultural questions that anthropologists and scholars have long tried to answer. Often it is the effects of the environment that fatally affect individual inmates. Victor Serge wrote that a prisoner, even after the first hour in prison, is a mentally deranged person (V. Serge, 1980). The Who also confirms psychic disorder as the most frequent pathology in prison, while from a strictly national point of view we find more than one prisoner out of 4 in psychiatric therapy, with an average of 27.6%. In some prison establishments almost all prisoners are in psychiatric therapy, according to data reported in Antigone's XVI report. A picture of Italian prisons before Covid-19. These are worrying elements: in the Spoleto prison, 97% of inmates were in therapy, in Lucca 90% and Vercelli 86%. The presence of psychiatrists in these prisons was guaranteed for an average of 7.4 hours per week for every 100 prisoners, while psychologists were present for an average of 11.8 hours per week for every 100 prisoners. In 19 of the institutes visited by Antigone, there was a mental health ward (Antigone, 2020b).

The Covid-19 health emergency started in a precarious context, where numbers are not encouraging. The possibility of complying with one of the most important safety regulations, social distancing, clashes with the very serious and atavistic problem of overcrowding. According to Antigone's reports, the pandemic began with a prison population rate of 130.4%, in some cases even 12 prisoners per cell while in others there was a violation of the criterion of 3 square metres per prisoner (Antigone, 2020b). A situation that has been persisting for years, since in 2013 the Strasbourg Court condemned Italy for inhuman and degrading treatment

precisely because of its dramatically overcrowded facilities. One last figure: at the outbreak of the new coronavirus, there were 61,230 prisoners compared to a prison capacity of 50,931. The prisons of Taranto, Larino and Latina were the prisons with the highest risk of infection.

In a panorama like this it is useful to remember the four articles of our Constitution which are absolutely relevant in the experience of Italian prisons (here in official translation of the Italian Senate):

article 3: "All citizens have equal social dignity and are equal before the law, without distinction of sex, race, language, religion, political opinion, personal and social conditions. It is the duty of the Republic to remove those obstacles of an economic or social nature which constrain the freedom and equality of citizens, thereby impeding the full development of the human person and the effective participation of all workers in the political, economic and social organisation of the country";

article 13: "Personal liberty is inviolable. No one may be detained, inspected, or searched nor otherwise subjected to any restriction of personal liberty except by order of the Judiciary stating a reason and only in such cases and in such manner as provided by the law. In exceptional circumstances and under such conditions of necessity and urgency as shall conclusively be defined by the law, the police may take provisional measures that shall be referred within 48 hours to the Judiciary for validation and which, in default of such validation in the following 48 hours, shall be revoked and considered null and void";

article 27: "Criminal responsibility is personal. A defendant shall be considered not guilty until a final sentence has been passed. Punishments may not be inhuman and shall aim at re-educating the convicted. Death penalty is prohibited";

article 32: "The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent".

The principle of equivalence of care is a concept present in numerous national and international declarations on the rights of prisoners and is, as has been pointed out recently, inherent in the idea of the right to health as an inalienable right of every person, regardless of their condition of freedom or detention, as it is enshrined in article 32 of the Constitutional charter (S. Gainotti, C. Petrini, 2019).

No one can be obliged to a certain health treatment except by order of law. Under no circumstances may the law violate the limits imposed by respect for the human person.

The Basic principles for the treatment of prisoners, adopted by the General assembly of the United nations with resolution 45/111 of 14 December 1990, recall that: "All prisoners shall be treated with the respect due to their inherent dignity and value as human beings. 2. There shall be no discrimination on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".

4. Women and foreigners in prison. Some data and some criticalities

Female imprisonment has always been much lower than male imprisonment. According to data published by the

Department of prison administration, as of 30 September 2020 there were 2,279 women detained in prisons in Italy out of a total of 54,277, just over 4% of the prison population. Such a small percentage can be attributed to the decrease in entries following the measures taken to contain coronavirus infection in prisons, which have affected women more than the average number of prisoners. In fact, there were 2,702 female prisoners out of a total of 61,230 on 29 February 2020 (4.41%), but in two months their number fell by 478, marking an all-time low and a reversal of the growing trend since 2015. Only four institutions in Italy are exclusively for women, while there are 44 female sections in male prisons: 519 female prisoners in the former, 1,705 in the latter (Antigone, 2020a). In addition, women are often locked up in old wards that previously hosted male detainees. There is a lack of space dedicated to women's activities and gender issues, also specifically related to health. Not only from an Italian perspective, most women are imprisoned for drug-related crimes, so they serve short sentences. In terms of management, there is a strong turnover that creates problems linked to the fact that prisoners awaiting trial have reduced opportunities to access work programmes, to maintain contact with their families and also with other prisoners. All these aspects should be rethought in terms of services and reshaped.

A minority in the minority is represented by women over 50, a category that requires special treatment for a number of causes ranging from menopause to other factors, mainly health-related. There is still no systematic plan to discuss these issues and identify effective and efficient strategies.

One of the most widespread categories of detainees is that of foreigners, who play a fundamental role in the correctional systems of the countries of the European Union. On average, more than 30% of women locked up in European institutions are foreign nationals and most are serving drug-related sentences.

As far as foreigners held in Italian prisons are concerned, according to the data of the Ministry of Justice, as of 30 September 2020 there are around 17,600. In 2016 in Italy 33.8% of prisoners were foreigners, compared to a European average of 22.6% (F. Fabi, C. Rossi, 2019). As has been pointed out, the phenomenon is closely linked to the considerable increase in migration flows and the inevitable repercussions on criminality, as well as to the method used by the Italian legislator in dealing with immigration in negative and emergency terms (G. Caputo, D. Di Mase, 2013). Crimes are mostly related to drugs. The latest Antigone report illustrates a European reality in which only Cyprus (43.5%) and Estonia (36%) had higher percentages of foreigners in the total detained population. France and Spain had 23% and 28% respectively (Antigone 2020a).

The problems of a managerial and organisational nature are directly proportional to the multiplicity inherent in the very concept of *foreigner*, which does not take into account the thousands of nationalities and cultures that today inhabit prisons all over the world. It means to face, in an era of globalisation and strong mobility like the one we are living in, different customs and habits, different communication systems, verbal

and non-verbal, substantial lack of emotional and civil reference points. One element that is perhaps underestimated is the training of the prison police itself: is it really directed towards a multicultural approach as befits a system, such as the increasingly international and multi-ethnic prison system?

The differences highlighted are elements that certainly make integration dynamics within penitentiary institutions problematic, and in constructive rehabilitation terms make the implementation of programmes aimed at reintegration and social integration more difficult. (G. Caputo, D. Di Mase, 2013). Add to this the high percentage of irregular immigrants who often receive their first care in prison. This poses practical problems in terms of therapy: it means starting to treat socially important pathologies, such as HIV infection, without knowing whether or not the therapeutic process can actually continue at the time of release.

5. In prisons during Covid-19

In Italian prisons, there were no epidemic outbreaks. On the contrary, the data pictured a number of infections in line, if not lower, than in other European countries.

According to the National guarantor of the rights of persons detained or deprived of liberty, as of 1 May 2020, 159 cases of Covid-19 had been recorded among Italian prisoners and 215 among prison staff. It must be said, however, that there is a problem of lack of public data on the number of tests carried out on prisoners.

The strategies implemented to preserve penitentiary facilities - potentially *epidemic bombs* (M. Cingolani, L. Caraceni, N. Cannovo, P. Fedeli, 2020) - run along the*in and out* dichotomy: regulation of sociality (already precarious) inside and limitation of contact (also very delicate) with the outside.

Structural and contingent reasons have made it almost impossible to comply with traditional containment measures: physical distancing, voluntary quarantine for suspicious cases, health isolation for those found positive. Add to this, the almost total lack of protective material: masks, disinfectants, gloves, etc. (T. Burki, 2020; M. Cingolani, L. Caraceni, N. Cannovo, P. Fedeli, 2020). Extraordinary measures have been implemented, both for prison staff and inmates, which, while on the one hand, have further limited the rights of citizens housed in prisons, on the other, have undermined the particular balance of the entire national penitentiary system. The protests that broke out throughout Italy in the middle of the Corvid-19 pandemic are in everyone's memory. Despite internal regulations of the Department of Prison Administration, life in prison has not yet resumed, family visits have been greatly reduced and are conducted with a glass partition and intercom as in the 41-bis regime.

In this context, the condition of psychiatric and drug-user prisoners, who have considerable difficulties in receiving treatment even if they are seriously ill, should be highlighted. These people would need to be elsewhere in order to have access to the most comprehensive treatment. Instead, they are unable to have diagnostic and therapeutic continuity with psychologists, psychiatrists and social workers. Surveillance Judges too must always respect the health protection of

prisoners, regardless of their sentences.

Unfortunately, we are witnessing more and more suicides both by inmates and prison officers, as in the case of the episode that occurred on 4 August when an officer took his own life: he was on duty in the Latina prison, one of the most overcrowded in Italy, and is the fourth suicide among prison officers. The suspension of visits by relatives and family members, as well as of all external and recreational activities, proved to be an obligatory measure of collective protection, creating, if we are willing to find a positive point in this context, also a *technological challenge*, with the purchase of mobile devices and the activation of videoconferencing channels with which inmates were able to get in touch with their families and their lawyers in a controlled manner. Since 8 March, visits have been replaced by telephone calls and video calls on various digital platforms. The introduction of these technological tools has not been uniform. In some facilities, smartphones purchased on purpose have been used. This is a sign: no one had ever posed the problem of Internet in prisons. As Ornella Favero, director of *Ristretti orizzonti*, explained, "video calls were a beautiful thing because there were people who didn't have family visits even before [the pandemic]. So, they were able to see distant relatives again: some saw their mother after years, maybe because she lives in another part of Italy or more often abroad" (Il Post, 2020). The hope is that this novelty, born in a moment of crisis, will allow the rethinking of the critical issues within prison facilities and will be the driving force behind a digital renewal that will bring these institutions up to date with the times, even when we are out of the pandemic.

In the medical field, this does not mean that telemedicine should be permanently used: technology cannot replace contact between doctor and patient. The risk is always abuse (J. Gunn, 2020). However, the use of technological platforms such as telemedicine can be a good way to follow the evolution of a pathology after the first visit has been performed live with direct contact with the sick person.

Government initiatives have not led to a suitable solution to resolve problems. One possibility would be to focus more strongly on a decarceration plan that releases those prisoners serving short sentences for non-violent offences, those near the end of their sentence and those in poor health. These measures could achieve the goal of reducing the prison population by around 9,000/10,000 prisoners, thereby improving the situation in prisons. This would be fair both for those who work there and for prisoners. Action should be taken as soon as possible as the alternative will be unrest in prisons and an increase of sick prisoners. Only in this way could there be a restart inside prisons, offering dignity and health to all.

6. Conclusions: what to do?

Fyodor Dostoevsky said that the degree of civilisation of a nation is measured by entering its prisons (P. Tozzo, G. D'Angiolella, L. Caenazzo, 2020).

Besides solving the ancient problems of the Italian prison system, starting from a new idea of *space*, it is necessary to return to the relationship between doctor and patient and rethink it in the light of the relational dynamics of listening and welcoming. Narrative medicine can play

an important role in this sense, not only in the field of *treatment* in the most *material* sense of the term. Reception and dialogue can in fact, under certain and favourable conditions, provide fundamental support, especially where very frequent problems such as those of a psychological nature arise.

Healthcare staff should never lose sight of the overall health of the detained person: the first duty towards every element of the prison is of a clinical nature. The 1979 Oath of Athens of the International council of prison medical services makes this clear: "We, the health professionals who are working in prison settings, meeting in Athens on September 10, 1979, hereby pledge, in keeping with the spirit of the Oath of Hippocrates, that we shall endeavour to provide the best possible health care for those who are incarcerated in prisons for whatever reasons, without prejudice and within our respective professional ethics".

In operational terms, the protection of the health of those incarcerated or deprived of their liberty must obviously pass through a greater availability of specific treatments: a vaccination campaign should be followed by a critical-epidemiological study of the individual penitentiary realities. At the same time, the investment must be of a socio-cultural nature. Investing in the person, in the strengthening of his/her identity and in his/her training in a perspective that must abolish paternalism and be placed in the perspective of listening and sharing, to achieve a global growth that includes the enrichment of skills. Overall, it is true that the number of prison graduates has progressively increased over the years: in 2005 the number of prison graduates was 565, compared to 705 in 2019; but it is also true that the total number of illiterate prisoners has increased, from 852 in 2005 to 1,054 in 2019.

Investing in the training of the person within the prison and insisting on a renewed culture of legality also, given the times, within schools, with specific awareness campaigns: preventive measures that therefore include the provision of information, education, screening campaigns and against behaviours considered at risk (G. Niveau 2007; S. Gainotti, C. Petrini, 2019). Moreover, a transcultural rather than multicultural perspective must be adopted in the training of prison staff, who are increasingly in contact with inmates from all over the world.

There is the need for a view that goes beyond the present moment, that is projected into the future. It is often forgotten that most prisons host men and women who, after serving their sentences, will return to civil society. Institutions should ensure that all prisoners have access to adequately paid work and to literacy, educational courses, language courses for foreigners and vocational training tailored to the needs of the labour market. It would be important for prisoners to maintain links with the outside world, for example through the press and media, or by following particular artistic or cultural activities, so as to encourage positive reintegration.

From a strictly operational point of view, the pandemic experience has shown the potential of technology also used for alternative purposes. On a socio-economic level, the exploitation of these opportunities can operate in the positive

direction of overcoming that digital divide often referred to as political discrimination between rich and poor.

Being healthy is not only a question of having normal haematological or laboratory parameters. Health is a much more complex reality and prison is the least healthy place in the broadest sense of the term.

Ensuring the protection of everyone's health is a duty and the effectiveness of the next vaccination campaign for Covid-19 will also depend on its universality, as we read in the manifesto letter that Muhammad Yunus - Nobel peace prize winner in 2006 - addressed to world leaders months ago.

Perhaps the coronavirus has torn Maya's veil and is now the mirror that reflects our inability to respect all living things, to pay attention to everything around us. We have ultimately lost that mystical sense in the face of the infinite beauty of the planet. We know that this pandemic will not be the last. There are over 1.6 million unknown viral species in mammals and birds, 700,000 of which would have the potential to trigger a new zoonosis, a new leap of species ready to bring us to our knees again. We are not yet able to take care of the whole of *creation*. We consider people, animals and forests raw materials for our survival. Humanity is struggling to realise that the attention to the planet must be the same as we doctors have for the human body, which is the same for everyone. We lack the solicitude and tenderness of a free embrace. If we want to guarantee the health of a country, we must start from the most marginal, the most fragile, because they are the most at risk. It is not just a question of solidarity or civilisation: it is a scientific choice, a clinical idea, an epidemiology idea and an idea of health policy because a country where people are sick is destined to economic underdevelopment, as well as aridity of the soul.

Notes

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