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FEASIBILITY STUDY ON THE TRANSFERABILITY OF THE CONSCIOUS MODEL TO OTHER CONTEXTS AT EUROPEAN LEVEL

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The research leading to these publication has received funding from the Rights, Equality and Citizenship Programme of the European Union (2014-2020) under the agreement n. 810588

This publication reflects only the author's view and the European Commission is not responsible for any use that may be made of the information it contains.

Foreword

The aim of this document is to propose a preliminary analysis before the feasibility study for the adaptation of the CONSCIOUS intervention model to other European contexts.

The partnership with WWP European Network, developed within the CONSCIOUS project, together with the European Forum for Restorative Justice, will be the network for the dissemination of the feasibility study to all institutional and non-institutional stakeholders.

The first part of this study aims to offer a rational reading of the legislative context, prison environment and best practices regarding the treatment of offenders in Europe, as indicated by specialised literature on the subject.

The second part analyses some considerable conditions necessary to the presentation of a model that can be replicated not only in Europe but also locally in other national contexts.

1) Analysis of Italian legislation on the treatment of sex offenders

In recent years, deviant conduct and behaviour involving sexual assault - especially when the victims are women and children - has aroused much interest in the scientific community (Reid, Dorr, Walker and Bonner, 1986).

The phenomenon of sex crimes forces us to carry out a multisectoral analysis, proceeding from the legislative scope to the prison and clinical-social context, allowing a reflection which offers global vision of the phenomenon (De Leo et al, 2011).

Italy has always been considered one of the most advanced countries in terms of protection against sex crimes, especially against minors. In recent years, we have witnessed not only the prediction of new types of crime but also the promotion of the protection of victims of crime. From a legislative point of view, supranational principles have imposed upon Italy a careful balance between the rights of victims and the need to handle offenders.

Law no. 172 of 1 October 2012 ratified the Lanzarote Convention on the Protection of Children from Sexual Exploitation and Sexual Abuse, adopted by the Committee of Ministers of the Council of Europe on 12 July 2007. The Lanzarote Convention is the first binding instrument, at European level, which requires States that have ratified it to prevent and criminalise every form of

sexual abuse and sexual exploitation of children, thus requiring amendments to the Criminal Code, the Code for Criminal Procedure and Prison Rules[1].

With Resolution of 5 April 2011, the European Parliament also reiterates, with regard to the fight against violence against women, the need to work with victims and aggressors alike, in order to make the latter responsible and help change stereotypes and beliefs rooted in society that help perpetuate the conditions that generate this type of violence and its acceptance.

The same direction is also taken by law no. 77 of 27 June 2013 which, ratifying the Istanbul Convention of the Council of Europe, specifically acknowledges in art. 16[2] the need to undertake and implement treatment programmes aimed at men.

It was then the intervention of the legislator, with the law no. 119 of 15 October 2013, that established the absolute urgency of promoting actions for the rehabilitation of perpetrators of violence. Article 282-quater, paragraph 1 of the Code of Criminal Procedure, so amended, states that when the accused submits positively to a violence prevention programme organised by the local social services, the person in charge of the service must notify the Public Prosecutor and the judge for the purposes of assessment pursuant to article 299, paragraph 2, for the replacement of the measure in a less severe form.

Shifting the focus to a soft law plan, in addition to these legislative interventions, it is worth mentioning the extraordinary action plans to combat sexual and gender-based violence 2015-2017 and 2017-2020. Their aim is to promote the development and establishment, throughout the country, of actions based on consolidated methodologies in keeping with the specific guidelines, aimed at rehabilitating and supporting perpetrators of violent behaviour within close relationships, in order to promote their rehabilitation and limit recidivism, imagining coordinated procedures between the network of support centres for women in their path and all treatment centres for men who behave violently.

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[1] The amendments to the Prison Rules regarded exclusion from the possibility of access to prison benefits for offenders under articles 600, 600 bis, paragraph one, 600 ter, paragraphs one and two, 601, 602, 609 octies and 630 of the Criminal Code.

[2] Article 16 entitled "Programmes of preventive action and treatment" states that
"1- The Parties shall take the necessary legislative and other measures to establish or support programmes aimed at perpetrators of domestic violence, to encourage them to adopt non-violent behaviour in interpersonal relationships, in order to prevent new violence and to change violent patterns of behaviour.
2- The Parties shall take the necessary legislative or other measures to establish or support treatment programmes to prevent recidivism, in particular for sexual offences.
3- When adopting the measures referred to in paragraphs 1 and 2, the Parties shall ensure that the safety, support and human rights of victims are a priority and that such programmes, where appropriate, are established and implemented in close coordination with specialised victim support services.

The 2017-2020 plan is of fundamental importance because it assumes the preparation of a national protocol of intervention and the identification of the most effective models of intramural treatment. It also insists on the training of the operators directly involved in their application, starting from the assumption that the strategy of the Plan must necessarily hinge on the principle of the full involvement of all significant stakeholders. This requires the Department for Equal Opportunities and all the public administrations involved to be fully accountable and synergistic, making a commitment that is not only financial but also - and above all - culturally oriented towards the construction of networks that operate as part of a system in the fight against violence against women.

2. Europe's prison systems

In analysing the conditions necessary or, rather, desirable for the transferability of the CONSCIOUS model to other European contexts, an in-depth analysis of the operation of the prison environment which includes a general description of the main European prison systems - i.e.: in Italy, France, the UK, Greece, Portugal, Poland, Spain, Germany and Austria - is of fundamental importance.

The activities of the CONSCIOUS model operate at an intramural level in the treatment of sex offenders and it is, therefore, necessary to identify the main features of Europe's prison systems in order to identify the limits and conditions of transferability of the model within the European context.

2.1. The Italian context

In the light of the legislative context described above, it is necessary to briefly explain how the Italian prison system works. It is regulated by law no. 354 of 1975, known as the Prison Order. This law has undergone various changes over the years, the last of which took place in 2018, and has affected some aspects including health care, daily life in prison and access to work for inmates.

The Prison Order is based on the concept that prison treatment is aimed at re-education. The scientific observation of the personality, by prison workers, aims to identify the best individual path to reinstate the prisoner into society. The sentence passed at trial can be reduced if the prisoner complies with the Prison Rules and Treatment. Treatment and security are two sides of the same coin and represent everyday prison life in our prisons: the correctional officers are in charge of both and

are employed by the Ministry of Justice. Prison educators[3] and social workers, on the other hand, are appointed to monitor treatment and they too are employed by the Ministry of Justice. Educators make up the pedagogical-treatment area and work inside the institutions, while social workers work outside and take care of the relationship between prisoners and their families and with the local community. Psychologists are, in some cases, employees of the Ministry of Justice, while in all other cases they are employed by the National Health Service. Teachers are employees of the Ministry of Education, while all other operators are occasional workers employed by cooperatives or local services.

The prison system is a single entity but is divided into regions and consists of 190 prisons throughout Italy.

The Italian Constitution states that punishment should aim to re-educate prisoners, but Italian prisons have different standards: the quality and quantity of activities organised in each individual institution depend on various factors such as the management imposed by the directors in charge, the dedication of the operators, the attitude of local institutions, and the presence of volunteers and cooperatives inside. There are, indeed, institutions which offer numerous, well-organised activities, while there are prisons where the inmates are forced to stay inside their cells or to walk inside the section because there are no educational or training activities.

Since 2008, medical services in prisons have been organised as part of the National Health Service. The institutional law is inspired by the principle according to which inmates shall be entitled to the same health treatment as the general public.

Unfortunately, it should be pointed out that medical, surgical and psychiatric services are insufficient; some institutions do not even have a doctor in attendance for all 24 hours of the day. The lack of prevention, diagnosis and therapy is one of the main critical points of healthcare in Italian institutions.

Some specialists (psychiatrists, psychologists, pulmonologists, dermatologists, infectious specialists) visit the prisons but the most severe cases are treated in the nearest hospitals.

2.2 The French prison system

The French prison system is governed by the Ministry of Justice and regulated by a law passed in 1987 and amended in November 2009. Before the reform, most of the provisions relating to inmates

[3] Now known as pedagogical legal officials

and the operation of prisons were regulated by lower-ranking laws. According to French legislation, the application of sentences should improve the integration or reintegration of inmates into society and prevent recidivism, while respecting the interests of society and the rights of victims. Generally speaking, the prison system should target reintegration. However, the control mission assigned to the prison administration still takes precedence over this.

There are 190 prisons on French territory, divided between the mainland and overseas territories. The institutions are divided into different categories:

- youth facilities for minors (6)
- pre-trial detention facilities (*maisons d'arrêt*), for people held on remand and sentenced to less than two years (98)
- high-security prisons (*maison centrales*), intended for long-term prisoners, serving sentences of over 10 years (6)
- detention centres (*centres de détention*), facilities for prisoners sentenced to medium sentences (25)
- day-release centres (*centres de semi-liberté*), facilities for those receiving an adjustment of their sentence (11)

Then there are *centres pénitentiaires* which comprise several categories: remand centres and detention centres and, where appropriate, high-security facilities and day-release centres (44).
This type of “hybrid” facility is growing significantly and practically all the most recently built prisons are of this type. Many of France's prisons were built in the 19th century. The most recent ones, built in the 1980s, fall under the joint management scheme: services such as laundry, catering, vocational training and employment are delegated to private companies. In recent years, many private companies have also managed the construction and maintenance of prison buildings: they own the buildings for a period of 27 years, during which time the government pays the rent.

Since 2000, there has been a change in the regime of daily life in prisons reserved for prisoners serving medium and long-term sentences. The ordinary regime was an 'open door' regime, but has been replaced by a closed system which does not allow restricted inmates to leave their cell unless they are accompanied by prison staff and only to allow them to take part in a previously planned activity. The open system is reserved as reward, for prisoners who maintain good behaviour.
In France, like in Italy, only two prisons are reserved exclusively for women. In all other cases they are housed in specific units in male prisons (in about 50 institutions).

As far as treatment is concerned, the prison regime offers a programme of rehabilitation activities, organised on the basis of age, skills, disabilities and personal traits of the individual prisoner. Sports and cultural, educational and vocational activities are offered. However, not all prisons offer a wide range of activities. The offer of employment and training is limited, and the number of socio-cultural activities is far too limited in relation to the number of inmates.

With reference to health management, since 1994, the responsibility for providing healthcare in prisons has been managed by the Ministry of Health. Medical services are provided by healthcare workers assigned to the prison. In general, inmates should be able to benefit from the same healthcare as the rest of the population, but not all types of care are accessible within prisons. Medical units within prisons provide basic medical care (general medicine), addiction services, psychiatric follow-up, dental services and laboratory and radiology tests necessary for further diagnosis. In some cases - which vary from one institution to another - medical units also provide specialist consultations in the fields of dermatology, pneumology, cardiology, ophthalmology, etc. The specialists do not, however, intervene regularly; the current waiting times are long (up to several months). The waiting time also applies to psychiatric or psychological consultations (at least six months) and is particularly significant, as it reveals an insufficiency of personnel in relation to the number of inmates. When medical care cannot be provided in prison it is given in hospital, such as for specialist consultations, surgery and rehabilitation.

2.3 The Greek prison system

Prison institutions act as administrative units under the control of the Ministry of Justice, assisted by the Directorate for Prisons Operational Capability and Crisis, established in 2015, and the General Directorate for Crime and Penitentiary Policy.
Currently, all custody institutions are classified in the following general categories (25 institutions):

- therapeutic (3 institutions);
- special (7 institutions).

The general institutions are further divided between type A (short-term sentences and prisoners awaiting trial) and type B (long-term sentences). Special prisons include rural units, the central production unit (bakeries), youth institutes and day-release centres which are no longer operational.

Minors (aged between 15 and 18) are assigned to a specific establishment (a formally general, type A institution, which is actually a special institution for young offenders) and young adults (18-21 years old and, exceptionally, for educational reasons, up to the age of 25) are held in special institutions. Therapeutic institutions are psychiatric hospitals and drug rehabilitation centres.

Prison staff are civil servants and traditionally fall into two main categories: prison guards and administrative staff, supervising prisoners and keeping records, respectively. As of 2017, the Ministry of Justice, Transparency and Human Rights, has divided prison staff into prison guards, perimeter security officers, secretarial staff and financial service officials.

Seven institutions have social welfare departments, the four rural prisons have technical departments and the only therapeutic institution for drug addicts has a therapeutic programme department.

Social workers have been appointed to prison institutions since 1973 and, since then, 2000 other specialists (sociologists, psychologists, psychiatrists) have been appointed as part of the staff.

In total there are about 120 specialists out of a total of approximately 4500 staff members.

It is clear that specialists are lacking in many facilities. Consequently, a recent public tender for the selection of future employees also included specialists such as doctors, social workers, psychologists and nurses.

Many important decisions concerning the daily life of inmates in prison (work, time off, disciplinary control, social contacts) are made by the Prison Councils (Prison Council, Disciplinary Council, Labour Council), bodies consisting of three to five members and chaired by the director of the facility or a public prosecutor.

The problem of overcrowding on Greek territory has been complicated for several years. Despite the number of prisoners falling to just above maximum capacity, due to legislation introduced in the last year leading to the early release of several prisoners, many facilities are still overcrowded. The reasons for this include the lack of investment in infrastructure, especially during the country's recession, the occasional tightening of laws and sentencing practices and the high number of detainees held on remand, particularly foreigners and immigrants, who are more likely to be remanded into custody due to lack of residency.

Other chronic issues in the Greek prison system, which were reinforced during Greece's recession, include a lack of staff and inadequate training, which obviously undermines the quality of the prison system: not all facilities are able to offer the same amount of sustainable and durable programmes for prisoners. Despite legal obligations such as those imposed by the CPT, which have

been followed by a number of improvements in this sense, the lack of treatment remains one of the fundamental problems still facing prison facilities.

Prison medical services generally belong to the administrative structure of prisons and, historically, their standards (in some facilities) have been a cause for concern, as noted by both CPT and the decisions of the European Court of Human Rights. However, in accordance with the law, the General Hospital for Prisoners of the Korydallos facility has been integrated into the national health system (ΕΣΥ) and this integration is expected to be completed in the coming months, as should be the case for the Korydallos Psychiatric Hospital. As far as other cases are concerned, the prison facilities and the Ministry of Justice have signed cooperation agreements with hospitals and health services.

Despite the general principle that prisoners should have access to health services similar to those available to the general public, the European Court of Human Rights, the CPT, the Ombudsman and the prisoners themselves argue that this is not the case: in most Greek prisons, even central ones, there is no 24-hour coverage by medical staff. Health problems are usually dealt with by contract doctors and nursing duties are carried out by prison staff (security area). Inmates are often assigned the task of nursing other prisoners because of the lack of professional nurses.
Most institutions do not even have a general practitioner. Prisoners are examined by visiting doctors who usually offer their services for two hours a week, but they have the right to call a private doctor at their own expense. It is only recently that efforts have been made to cover the healthcare needs of prisoners with the help of doctors who work in the National Health Service and who have started visiting prisons on a daily basis.

2.4. The Polish prison system

The basic document that organises the operation of the Polish prison system with regard to the rights and duties of prisoners is the Executive Criminal Code (ustawa z dnia 6 czerwca 1997 r. Kodeks Karny Wykonawczy). However, the provisions governing the penitentiary structure are grouped together in the Prison Service Act of 9 April 2010 (ustawa z dnia 9 kwietnia 2010 r. O Służbie Więziennej). The elaboration and integration of the provisions of the Executive Criminal Code can be found in the Ordinance of the Minister of Justice on Organisational Rules for the Execution of Imprisonment and the Ordinance on Organisational Rules for Pre-trial Detention. More specific rules

on the conditions for serving a sentence are issued by the directors of prison units in special internal provisions (known as 'Porządki wewnętrzne Zakładu Karnego').

The Polish prison system is governed by the Minister of Justice, who is also responsible for the Prison Service - a military formation - governed by the Director General of the Prison Service (Dyrektor Generalny Służby Więziennej). The Director General of the Prison Service heads a Central Prison Service Council and is also responsible for 15 Prison Service circuit inspectors who are responsible for the Prison Units within their jurisdiction. Prison units are managed by administrators appointed by the Director General of the Prison Service at the request of the Director of the competent circuit.

There are 156 prisons in Poland. The largest has 1,620 places (Areszt Śledczy Warszawa - Białołęka), the smallest has 56 (Areszt Śledczy in inowinoujście).

Most of the prison buildings were built in the 19th and 20th centuries. The last prison unit was established in 2009 (Opole Lubelskie). This is a closed unit for first-time and young offenders, with two separate divisions for prisoners held on remand.

Prisoners in Poland are divided into different prison units depending on whether they are:

1) young adults
2) first-time offenders
3) repeat offenders

These units can be divided into:

1) closed units;
2) partially open units;
3) open units

The most important differences between these units are the level of security, the level of isolation of inmates and their rights and duties related to their mobility opportunities inside and outside the Unit. These matters are governed by a criminal enforcement code.

According to the Executive Criminal Code, prisoners should receive various treatment activities, such as employment, education, socio-cultural activities and family bonding activities. In actual fact, prisoners rarely have the opportunity to participate in such activities. Moreover, there is no single standard under Polish law. The internal rules of each institution determine the time allowed for cultural and sporting activities.

Healthcare in Polish prisons is organised differently from public healthcare and is controlled by the Ministry of Justice. Medical services for prisoners are mainly provided by the prison health system which has 57 outpatient clinics and 17 hospitals. Public health facilities cooperate with prison

units in providing medical services, particularly in cases where the life or health of the offender is endangered. They conduct specialist examinations, treatment and rehabilitation and also provide healthcare services for prisoners who are temporarily discharged or on temporary release. Prisoners are provided with healthcare free of charge.

2.5 The Portuguese prison system

Portugal has a total of 51 prisons of varying types: 15 "central prisons", which are usually larger, for prisoners sentenced to more than six months; 31 "regional prisons", for prisoners sentenced to less than six months; and five "special prisons", for prisoners who require special attention, such as women, youths, former members of the armed forces and the sick.

The first type of prison has high-security sections to provide tighter isolation for difficult inmates in specific disciplinary cases. In general, the system is divided into three types of general security regime: medium, high and special.

Since the 1980s, the Portuguese prison system has been characterised by the growing political influence of the union of prison officers. The problems then continue with difficulties in cooperation between the Ministry and the Director General, between the Director General and the prison officers and between directors and prison officers. Disconnected from the Ministry, the General Directorate is often left alone to draw up not only prison policies but also to provide public accountability for what goes on inside the country's prisons.

The fact that each prison has its own locally defined rules and that no form of standardisation is adopted at administrative or legislative means seems to result in a system where respect for the law is not ensured by jurisdictional entities, courts or police forces.

The Prison Statute envisages the possibility for the administration to determine treatment programmes (both in group and individual activities) as part of its rehabilitation programme. In practice, however, these coincide with sports activities such as the gym, time spent out in the yards and television, while very few activities are organised. Occasionally programmes related to isolated activities are offered, particularly by civil volunteers.

Portuguese law states that an inmate has the right to access national health services in identical conditions to those guaranteed to the general public. A process of integration of prison health services into the national health service was launched in 2007. This was the result of a complex process, the practical results of which are still hard to define due to the lack of official reports on the state of the

art. The trend in recent years has been towards outsourcing, with healthcare being outsourced to private procurement. The Ministry of Justice has completed the process of outsourcing a substantial part of the provision of healthcare services to a private company. Some medical staff are still employed by the Ministry of Justice, but an increasing number are supplied by the private contractor. While outsourcing has brought some improvements in terms of costs, it has also led to high levels of staff turnover within prisons, with a negative impact on the sharing of information and staff-patient relationships.

2.6 The Spanish prison system

The Spanish prison system is governed by a law passed in 1979, the first law after the Constitution, together with a Decree issued in 1981. The law and the decree are based on the concept of prison treatment aimed at re-education. Each prisoner's personality should be observed in order to identify the best individual path to reintegrate them into society. The Spanish prison system is made up of two different prison administrations: the Catalan administration - which depends on the Catalan Department of Justice - and the Spanish administration, which has been dependent on the Ministry of the Interior since 1992. Consequently, there is only one prison code on Spanish territory, but there are two different independent administrations.

There are 68 Spanish prisons and 14 Catalan prisons. The prison system is divided into four different grades each of which has a different day-to-day detention regime:

- closed regime (level one),
- partially open regime (level two: inmates receive some prison benefits),
- open regime (level three: inmates return to the institution to sleep).
- *parole*

With the reform of the Criminal Code in 2015, the "*prisión permanente revisable*" was introduced, for a whole series of extremely serious crimes. It has been criticised by many jurists due to the presumption that it represents a concealed form of life imprisonment.

The economic crisis has had a severe impact on the Spanish prison system: there has been (and continues to be) a sharp reduction in legal assistance and defence for prisoners in some of Spain's Autonomous Communities. Moreover, some health services (such as new treatments for hepatitis C) have been discontinued and treatment programmes have been cut back in several prisons in Catalonia.

According to the Spanish Prison Order (articles 110 and 118), the prison administration plans training and activities to develop prisoners' skills, enrich their knowledge, improve their techniques or vocational skills and make up for their shortcomings. Psychosocial programmes and techniques are used to improve prisoners' ability to deal with specific issues that may have influenced their previous criminal behaviour. Educational, training, cultural and sports activities are determined by the Management, considering the action plans of the Management Centre, starting from the individual programmes developed by the treatment committee. The law states that foreign inmates are entitled to full access to both training and education. Prisoners held on remand are not allowed to participate in the activities and inmates generally complain about the absence of treatment programmes.

In 2003, a law was passed stating that health services that depended on the prison administration should be integrated into the healthcare services of each of the Autonomous Communities. In the case of Catalonia, this transfer has been effective since 2006 and there is no difference between inmates and people outside of prison as far as access to public healthcare is concerned.

An important problem of the Spanish and Catalan prison system is the growing number of prisoners with psychiatric problems. The prison administration has psychiatric hospitals and programmes and modules for this type of prisoner, but they are completely inadequate. The administration itself has publicly acknowledged that over 40% of prisoners in Spain suffer from some form of mental disorder and 4% of them suffer from severe mental illness.

2.7 The British prison system

Different prison systems operate in the three jurisdictions that make up the United Kingdom: England and Wales, Scotland and Northern Ireland. Each jurisdiction has its own prison service, inspectorate and ombudsman. There are currently 130 prisons in England and Wales, 16 in Scotland and three in Northern Ireland. Every prison is run by a warden, with a staff comprising prison guards, doctors and treatment workers. Prisons can be publicly owned and run, publicly owned but run

privately or, in some cases, both built and run privately. The prison guards are not militarised but are unionised.

In England and Wales, adult male prisoners are assigned to a security category based on a combination of the type of offence committed, the length of sentence, the likelihood of escape and the social danger in the event of escape. Prisons are classified as "closed" or "open", depending on the inmates detained. The prisoners are divided into the following categories:

- Category A: those whose escape is considered highly dangerous for public or national security.
- Category B: those who do not require maximum security but for whom escape must be made very difficult.
- Category C: those who cannot be trusted in open conditions but who are unlikely to try to escape.
- Category D: those who can be reasonably trusted because there is no danger of escape have the privilege of access to an open prison, where limited interaction with the public is permitted, such as release to visit family or hold down a job.

Facilities holding Category A-C prisoners are regarded as "closed" institutions. Category A prisoners are further subdivided by level of risk, based on the probability of escape. Those held on remand are usually held under category B conditions.

Adult prisoners are classified into four categories and detained accordingly:

- Restricted status (similar to category A for men)
- Closed: women for whom there is a danger of escape
- Partially open: those who are unlikely to try to escape
- Open: those for whom there is no danger of escape

Young adults (under 21 years of age and of both sexes) can be sent to different types of institutions comparable to those for minors.

Prisoners in Scotland are assigned to one of three categories:

- High supervision: people for whom all activities and movements must be authorised, supervised and monitored by prison staff;
- Medium supervision: where activities and movements are subject to limited supervision and restrictions;

- Low supervision: where activities and movements are subject to minimum supervision and restrictions. Inmates under low supervision may be entitled to temporary release to carry out unsupervised activities in the community.

The Prison Service in Northern Ireland has recently tried to switch from a system mainly designed to deal with political prisoners to a more mainstream system.

Recent trends in the UK have been characterised by an increasing prison population, combined with declining resources to manage it. These trends have a number of effects, not only on the services that prisons are able to provide (rehabilitation, drug treatment, mental healthcare, etc.) but also on prison conditions (overcrowding, reduction of time spent outside cells, increased violence and self-harm, etc.).

The prison population is characterised by large numbers of inmates with drug or alcohol problems and a need for mental healthcare. People over the age of 60 are the fastest growing group and the system is not well equipped to cope with an ageing population. The number of women in prison has also increased significantly from the mid-1990s to the present day. Although they account for only 5% of the total prison population in England and Wales, female prisoners account for one third of all cases of self-harm. Despite the decline in the number of children in detention, those who remain in custody are the most problematic and vulnerable. A high percentage experience a significant incidence of self-harm and poor relations with staff.

With reference to treatment activities, inmates must engage in a range of activities during their period of detention in order to facilitate "order and control, rehabilitation and reintegration". These activities include learning certain skills, using the gym, criminal behaviour programmes, rehabilitation services, job activities.

The rules in Scotland state that an institution must provide a range of activities which, as far as reasonably possible, take the interests and needs of prisoners into consideration. The Scottish rules state that the prison must make a report about each prisoner's particular needs and wishes in relation to work and education immediately after their arrival at the institution. After receiving this report, the warden must set up a work, education and counselling programme for each prisoner to improve their chances of successful reintegration into the community. Unless justified for health or other reasons, prisoners in Scotland are required to do a maximum of 40 hours of work, education or counselling per week. However, the movement of prisoners often affects the provision of treatment activities in

the UK in general: cases of inmates being locked in their cells for long periods of time and a lack of treatment activities are numerous.

Inmates are entitled to the same healthcare services as those provided by the National Health Service (NHS), including mental health services. Qualified doctors, dentists, pharmacists and nurses provide healthcare in prison. If there are medical problems that cannot be dealt with by medical staff inside the prison, an outside specialist may be brought in. The prisoner can be transferred to another prison where different facilities are available or transferred to a local NHS hospital.

In general, the high prevalence of mental health problems and self-harm among prisoners makes it difficult for services to reach those who are most in need. In England and Wales, prisoners with more complex mental health problems have had access to specific services for mental health problems through mental health professionals. In some prisons, however, therapeutic support services and access to counselling are limited.

2.8 The German prison system

Germany is structured according to a federal system. There are 16 Länder (federal states), which have their own administration for the prison system. The public prosecutors are further subdivided: 16 Länder, so consequently 16 Ministries of Justice, are responsible for a prison population of over 62,000 people, and 16 Ministries of Public Health house over 11,000 people in criminal institutions.
An essential aspect of the German prison system is the "double-track system" of sanctions.
On one hand, imprisonment is considered primarily as a punishment, while on the other, there are security measures that can deprive a person of his or her liberty on the basis of the commission of a crime:

- Treatment in psychiatric institutions (art. 63 Criminal Code)
- Treatment for drugs and alcohol (art. 64 Criminal Code)
- Preventive detention (art. 66 et seq. Criminal Code)

The latter is especially controversial because it allows restraint of the prisoner even after the end of the actual prison sentence and despite being defined as a preventive measure, it is perceived as a punishment. Preventive detention can be ordered if an offender is considered to be at high risk of re-offending.

Various activities are offered both by prison staff and by outside organisations and volunteers. The offer covers a wide range of activities that are mostly entertainment, such as sports and board

games. Prisoners are entitled to spend some of their leisure time together. The amount of leisure time allowed is set out in the rules of each prison.

According to art. 98 LandesR, healthcare must be provided by employees who hold a permit under the Nursing Act. Nursing staff may also be employed without necessarily having completed their training; paramedics, medical assistants, doctors, technical assistants and physiotherapists, however, must have completed their training.

In Bavaria, Lower Saxony, Saxony-Anhalt and Schleswig-Holstein, the police are obliged to guarantee medical care by doctors: prisons often use part-time or on-call doctors. In general, the same services available in the community are available inside prisons or in a prison hospital, the prisoner can be transferred to an outside hospital to receive further assistance if necessary.

2.9 The Austrian prison system

The main legal basis for the criminal justice system in Austria is the Criminal Services Act 1969. Responsibility for the prison system lies with the Ministry of Justice, as the highest authority, and is supported by the Generaldirektion für den Strafvollzug und den Vollzug freiheitsbeschränkender Maßnahmen (Generaldirektion für den Strafvollzug und den Vollzug freiheitsbeschränkender Maßnahmen).

There are currently 28 prisons (Justizanstalten) with 12 additional branches and an average of 8,800 inmates in Austria. They are divided into seven prisons for men serving sentences of more than 18 months, one juvenile prison, one women's prison, three forensic placement institutions (Massnahmenvollzug) and 15 judicial prisons on the sites of the regional courts responsible for criminal proceedings. The material and security conditions of Austria's prisons in general do meet modern standards. The two newest institutions were built in 2015 and 2012 and the older ones are being continuously renovated and expanded. The Austrian legal system distinguishes between three types of detention:

- Custody on remand;
- Criminal service;
- Precautionary measures.

The main legal requirement for the prison system is written in §20 of the Criminal Services Act

(Strafvollzugsgesetz, StVG): imprisonment must support the inmate to such an extent that they can live according to the needs of society and with a view to preventing further deviant behaviour. The main aim is, therefore, rehabilitation, which can only be achieved through personalised treatment and care. This is also reflected in the understanding of the role of prison staff, who are responsible for both security and care.

As far as prison treatment is concerned, when they are not working, inmates are allowed to do other activities, such as painting or drawing, reading and writing. Then, at least once every three months, an educational, artistic or entertainment event must be provided. Prison staff are encouraged to motivate prisoners to use their free time in a useful way. The regime for prisoners held on remand in some prisons is extremely poor in terms of treatment. Only some of them have the opportunity to work and even sports and leisure activities are limited compared to those available to the rest of the prison population.

The medical service in prisons follows equivalence and equal treatment procedures, which means that the services are similar to those provided outside prisons. The medical supervisor regularly checks the compliance of hygiene standards in the cells and ensures that prisoners are examined by a doctor at least once a year. The main critical points include a lack of privacy in the doctor-patient relationship due to the presence of prison officers, and a lack of access to qualified interpreters for non-German speaking prisoners.

If the necessary medical treatment cannot be provided by the doctor within the institution, the doctor is responsible for ensuring that the prisoner receives said necessary medical care, including specialist treatment. If the service cannot be provided within the institution, the prisoner will be taken to a suitable institution, which may be a hospital or psychiatric unit.

One of the critical issues affecting Austrian healthcare is the lack of availability of psychiatric specialists. Psychiatric care is available only for a very limited number of hours per week and psychological treatment is also insufficient.

3) Prisons in Europe: overview and trends in health services

With a view to providing an overview of the elements collected, it should be specified that they were collected using the Council of Europe Prison Rule as the main reference. Prison Rules (Council of Europe. Recommendation Rec (2006) 2, adopted on 11 January 2006), and through the valuable contribution of the European Prison Observatory, which collects information from the countries monitored in relation to prison conditions, describing each national prison system and focusing in particular on its compliance with European Prison Rules.

With regard to the organisation of prison healthcare, the European Prison Rules state that "*medical services in prison shall be organised in close relationship with the general health administration of the community or nation"*(40.1) and "*health policy in prison shall be integrated into, and compatible with, national health policy*"(40.2).

It is clear that most prisoners will eventually return to free society, which means that their state of health is, to all intents and purposes, to be understood as a public health issue and that any illnesses contracted - or exacerbated within prisons - also have an impact on the outside world, as does the management of psychological disorders.

This concept is at the basis of most legal reforms in Western countries that have led to the transfer of responsibility for prison healthcare from prison administrations to the authorities responsible for public health services.

In Italy, this was implemented by Legislative Decree no. 230 of 22 June 1999 and the subsequent Prime Ministerial Decree of 1 April 2008. With these reforms, governments agreed to transfer the matter of prison healthcare to the bodies responsible for planning and administering the health service in all other spheres of social life, thus overcoming the anomaly of exclusion of the prison context (Coyle, 2004).

The importance of management that is as co-integrated as possible between inside and outside is also stressed by the World Health Organization, which strongly recommends establishing stable links between prison and public health care (Hayton, Gatherer and Fraser, 2010). The common goal is to make health and healthcare in prisons as similar as possible to those outside, as governed by article 40.3 of the European Prison Rules, and access to care must be guaranteed outside for any prisoner regardless of their legal situation ("*Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation*"), as reiterated by the Health 2020 programme (Kickbusch and Behrendt, 2013; WHO, 2013).

Reviewing the reports of the European Prison Observatory we see that, from a legal point of view, the responsibility for providing healthcare in prison is handled by the Ministry of Health only in France, the UK, Greece and Italy.

In other countries, medical services in prisons are the direct responsibility of the prison administration. In these countries, however, some exceptions can be found in relation to specific topics (e.g.: in Latvia, the Ministry of Health covers the costs of tuberculosis and HIV/AIDS drugs, as well as laboratory tests for HIV/AIDS patients, while in Poland, public health facilities cooperate with prison units in providing medical services, especially in the most critical cases, where the inmate's life is at risk). In Portugal, for example, the relationship between the two systems is often poorly structured or even non-existent. Despite the launch of a process of integration of prison health services into national health services within prisons, in practice this integration is still a complex process.

In the Italian context, although the transfer of responsibilities has, to all intents and purposes, formally taken place, there is still resistance from a factual - and cultural - point of view. This underestimates the need to consider the health of prisoners as a public health issue or a failure to share this assumption. This only complicates the link between internal and external services, the end result being that it is not always guaranteed or adequately structured.

Although medical services in prison belong to the National Health Service, doctors, and particularly specialists such as psychiatrists, are often insufficient, and there is also a lack of prevention, diagnosis and treatment. Some prisons in the UK have good arrangements, but it is generally difficult to effectively reach those in need, particularly those suffering from mental health problems and self-harm. In Italy and France, the distance between theory and practice causes longer waiting times than outside and creates significant difficulties in organising escorts for the transfer of prisoners to outside hospitals.

The gap between theory (what applies at legislative level) and practice is a common problem. In Portugal, specialised medical services are available in theory, but in practice sick prisons find it extremely difficult to access the services, given the administrative and security obstacles that arise. On a more general note, almost everywhere, medical units are insufficiently equipped. As a result, not all penitentiary institutions have a doctor available all day and specialists cannot intervene regularly. In Greece, nursing duties are carried out by non-specialised members of prison staff, often assisted by inmates assigned to care work, due to a lack of professional nurses. In Poland, prisons often shunt responsibility for caring for disabled inmates to their cell mates. Therefore, we can state

that rule 40.5 of the European Prison Rules ("*All necessary medical, surgical and psychiatric services including those available in the community shall be provided to the prisoner for that purpose*") is largely ignored in the European prison systems observed by the European Observatory on Detention Conditions.

Another principle of fundamental importance concerns the equivalence of care. The principle of public health and the approach to human rights converge in a recommendation of the Prison Rules, further elaborated by the Committee of Ministers of the Council of Europe - in paragraphs 10-12 of its 1997 Recommendation - concerning the ethical and organisational aspects of healthcare in prison, also introducing the notion of integration:

> *10. Health policy in custody should be integrated into, and compatible with, national health policy. A prison health care service should be able to provide medical, psychiatric and dental treatment and to implement programmes of hygiene and preventive medicine in conditions comparable to those enjoyed by the general public.*
> *11. The prison health care service should have a sufficient number of qualified medical, nursing and technical staff, as well as appropriate premises, installations and equipment of a quality comparable, if not identical, to those which exist in the outside environment.*
> *12. The role of the ministry responsible for health should be strengthened in the domain of quality assessment of hygiene, health care and organisation of health services in custody, in accordance with national legislation. A clear division of responsibilities and authority should be established between the ministry responsible for health or other competent ministries, which should co-operate in implementing an integrated health policy in prison.*

The inmate, as mentioned above, must have access to care equivalent to that available to those in the outside environment.

4. Internal circuits in the Italian context

Another of the fundamental aspects involved in conceiving a feasibility study concerns the circuits into which prisoners are inserted. In Italy, DAP Circular no. 3359/5808 of 21 April 1993 introduced a plethora of administrative interventions that led to the creation of differential circuits within the prison institution.

The circuits were structured in consideration of the need for security and custody and the level of danger posed by the inmates involved. The circular had divided the circuits into three types: high security, medium security and soft custody. In 2009, with circular no. 3619/6069 a further change was made, dividing high security into a further three circuits: High Security 1 (H.S. 1) dedicated to the detention of prisoners and inmates involved in Mafia-type organised crime, with respect to whom the decree of application of the regime referred to in article 41 bis of O.P. paragraph 1 of article 4 bis O.P. has ceased to apply; High Security 2 (H.S.2), which automatically includes those accused or convicted of crimes committed for the purposes of terrorism, also at international level, or subversion of the democratic order through the perpetration of acts of violence (crimes referred to in articles 270, 210-bis, 270ter, 270quater, 270quinquies, 280, 280-bis, 289-bis, 306 of the Italian Criminal Code); and lastly, High Security 3 (H.S. 3) reserved for inmates who have played a leading role in the criminal organisations dedicated to drug trafficking (pursuant to art. 4-bis par. 1, subject to the exceptions set forth in Dap circular no. 20 of 19 January 2007).

Alongside the formal circuits there are also those "informal" circuits (Santorso, 2018) considered necessary in order to prevent episodes of aggression or oppression against specific categories of inmates, as established by paragraph three of article 32 of the Executive Rules of 2000. These "protected" categories include sex offenders, transgender inmates and former members of the police force. Prisoners convicted of sexual offences live in conditions of reduced access to the fundamental rights of prisoners. The need for greater defence of sex offenders suggests that they should be placed in protected sections, which, however, only add isolation to the distress of reclusion, reducing rights and increasing the stigma linked to the type of crime committed by them.

The criminal approach to gender-based violence does not recognise the subjective and relational complexity of gender-based crimes, and ends up standardising all forms of violence of common crimes, envisaging, at most, aggravating factors linked to familiarity with the victim "*according to an emergency and punitive rationale, and thereby generating particularly serious distortions significant of the criminal legal culture. Only sexual violence is considered as a "sexual" crime, while all other forms of gender-based violence are classified as common crimes within the articles of the Criminal Code"* (Frenza, Peroni, Poli, 2017).

This approach cannot avoid having material implications within prisons, forcing the administration to separate the perpetrators from ordinary prisoners, because they are considered at risk, and forcing them to spend the period of detention not only with a double stigmatisation but also with effects on the effectiveness of rehabilitation (Tewksbury, 2012).

5. The treatment of offenders

The treatment of sex offenders is a process that does not exclusively address the victim's system, but also confronts the offender via a specific and targeted level of expertise (Cuzzocrea, Lepri, 2010).

There are no regulations in our system that refer to the implementation of prevention and treatment programmes aimed at the professionals operating within the prison context. There are, however, some Recommendations (no. (87) and no. (92)16) on the European Prison Rules with the aim of encouraging prison staff to adopt an attitude in line with the moral and social importance of their work and to create conditions in which they can perform their services in the best possible way for the benefit of society in general, the inmates entrusted to them, and the satisfaction of their professional vocation. And of course, the staff must receive adequate training and information to enable them to have a realistic perception of their field of work, their specific activities and the ethical requirements of their work. Professional skills should be improved and developed on a regular basis through further training, analysis and work assessments.

For 20 years now, literature on the subject (Farrenkopf, 1992; Hatcher, Noakes, 2010; Clarke, 2011) has focused on the negative psychological impact suffered by those involved in the treatment of sex offenders.

The treatment efforts that are being implemented today are the result of a long process in which the Prison Administration has understood the importance of having to update in order to provide effective re-educational treatment for sex offenders (Napolitano, 2012).

At the moment, the most important project promoted by the Ministry of Justice, in agreement with the Prison Administration, has been WOLF (Working on Lessening Fear) and the subsequent FOR-WOLF (Training for WOLF). The first WOLF project (co-financed using European funds) was launched in 1998 and 1999 following a proposal by the Department of Penitentiary Administration in cooperation with Belgium and the Netherlands and the University of Siena. The fact-finding survey

carried out on 71 prisons led to the drafting of two basic documents on "Treatment of sex offenders" and "Training requirements of operators involved in the treatment of convicted offenders" (Various Authors, 1999).

The project proved to be of particular importance as it acknowledged the innovative management introduced in the institutes of Biella and Lodi, where sex offenders were included in specific programmes managed by the multidisciplinary team and illustrated the experience of other countries, where the participation of territorial networks is much more active.

WOLF was followed by the FOR-WOLF project, based on research, training of operators and international exchange of work methodologies and contents related to the training of prison and social workers who work with sex offenders, also through a study involving the UK, Belgium and Spain. The comparison between different models has highlighted the inability of criminal law alone to provide tangible answers to the phenomenon and the absolute need to initiate intervention strategies that are activated from an intersystemic and multidimensional point of view (Cuzzocrea, Lepri, 2010).

Alongside these two important projects, others have been carried out at national level, in institutions that held this type of inmate, such as Bollate, Biella, Prato, Pesaro and Castrovillari, but also experiences conducted at European level such as the S.O.Cr.A.Te.S. project and STALKING, as well as the study group SOGIS (Sex Offender Special Interest) set up within the European Confederation for Probation (CEP) with the aim of providing an overview of risk assessment and management tools.

The latest projects carried out within Europris and the Confederation of European Probation have developed an overview of programmes relating to perpetrators of domestic violence in prisons with the ultimate aim of identifying the most appropriate approaches to treatment.

The study of some of the good practices conducted in Europe is the result of the first meeting of the Expert Group on Domestic Violence during 2019. It is undeniable that there is a clear need for many EU countries to develop methods to address the problems of domestic violence and the treatment of its perpetrators. The purpose of this mapping is to encourage further development and cooperation in this important area, with the aim of fostering innovation and analysis among potential users and beneficiaries.

One of the most important programmes for the treatment of perpetrators of domestic violence is the **Domestic Violence Formative Program (VIDO)** which focuses on female offenders, conducted in institutions in Catalonia (Spain). The Association for Community Rehabilitation (ARC) has developed this pioneering project to implement training programmes and treatment of violence during

Probation. The project offers training programmes with specialised content based on the crimes committed and their needs: gender-based violence and domestic violence, hate crimes, sexual crimes and other violent crimes. The implementation of PF-VIDO was launched back in 2007, but since 2014 it has become a specific programme focused on female offenders.

As far as the content of the programme is concerned, it is conducted by psychologists and therapists and covers three main areas of intervention aimed at separating the psychological points that motivate violence and build a non-violent relationship model through respect and affection:

- cognitive aspect
- behavioural aspect
- emotional aspect

The programme is developed in three phases:

- Assessment and diagnostic phase (individual sessions)
- Development and monitoring phase (group sessions)
- Final phase (individual sessions).

The theory used is that of the cognitive-behavioural model and psycho-educational model, according to which the cognitive component is the central axis of change. This is chosen because it intervenes on the main risk factors (erroneous thought, personal values, irrational ideas linked to the act of violence), applying cognition techniques restructured in order to avoid the act of violence (Pérez, Martínez, 2009).

The behavioural component helps reduce violent behaviour and develop relational skills, conflict resolution and self-control.

The psycho-educational component is oriented towards the self-recognition of emotion and its consequences, in order to readjust them.

In England and Scotland, the **Becoming New Me Plus (BNM+)** programme, together with **Building Better Relationships**, builds on the success of previous programmes, like CDVP and IDAP. They focus on the acquisition of certain core competencies, with the aim of providing participants with a range of cognitive and behavioural skills and tools to support non-violence.

The main theoretical background behind the programmes is the bio-psycho-social model (Walton, Ramsay, Cunningham and Henfrey, 2017), the main approach of the programme is cognitive behaviour therapy.

In addition to these two, there is another programme called **Kaisen**, which is future-oriented and responds to the criminal needs of each individual participant rather than focusing on the needs related

to a specific crime. As such, it is similar to individual treatment within a group setting and can accommodate offenders with convictions for intimate violence against partners, sexual offences and general violence.

In Ireland, a programme called **Choices perpetrator programme** has been active since 2017, assisting men who undertake the learning of the programme and helping them develop an awareness of how their use of violence/abuse is a learned behaviour that is supported and maintained by their distorted way of thinking. The programme addresses this distorted thinking by assessing events and emotional regulation and helps participants understand why they are violent towards their partners and the impact that it has on their partners, children, themselves and others. It supports participants in taking responsibility for their behaviour and helps them learn behavioural strategies to prevent violence and abuse.

This programme, in addition to those in use in England, is voluntary. Only in some cases - where established by the Court - can it be compulsory.

The **IDAP** project in Sweden (Haggård, et al. 2017) works in the same way. IDAP involves men who embark on the programme, learning new perceptions and behaviours and awareness of how their violence is a learned behaviour, supported and made possible by their perceptions. The goals of the programme label distorted thoughts, both in terms of event assessment and emotional labelling. The IDAP model of change teaches skills through observation, role-playing, empowerment, Socratic dialogue, discussion, critical thinking and non-violent problem-solving exercises. In addition to IDAP, the **Relational Violence Programme (RVP)** is also conducted. The RVP targets people convicted of domestic violence against one or more people referred to as "significant others" who include current or former partners, in heterosexual or same-sex relationships, as well as parents, children and siblings. The programme is gender inclusive and RVP is developed primarily for offenders in correctional settings with a high risk of re-offending. The programme is individual and based on cognitive-behavioural therapy (CBT) and Duluth. RVP is structured around three main themes: 1) Emotional stability, 2) Relationship patterns and 3) Attitude. In all three themes and phases, special attention to substance abuse is possible, where applicable. The three themes, together with substance abuse, aim to address some of the most criminogenic needs of domestic violence: antisocial cognition, poor self-regulation, jealousy, lack of self-control, poor communication and capacity for conflict/problem solving.

6) Limits and prospects of the treatment of offenders within the prison context

The treatment of offenders within the context of a total institution such as a prison has limits that are not only legislative, structural and organisational, but also cultural (Goffman, 2001).

Day-to-day material imprisonment often radically contradicts the inspiration behind the treatment of punishment (Torrente, 2019) and this is why it is important to differentiate between the regime and the treatment. The latter is represented by the activities of the treatment and multidisciplinary team and is individual - an individualised and voluntary program that is applicable - in almost all European systems - only to convicted prisoners with a final sentence.

The prison system, on the other hand, represents all the rules and provisions to be applied to those who find themselves with restricted personal freedom, whether they are awaiting trial or have been convicted with a final sentence or imprisoned.

Security and treatment are two sides of the same coin and they have to exist side by side because they are the very cornerstones of detention. Reconciling the rules of daily life in prisons with the treatment requirements is the challenge that the prison institution is called to face.

It is undeniable that there is a two-way relationship between treatment and security requirements: the greater the training, work, cultural and recreational activities, the less aggressive the behaviour of the inmate, but this relationship presents tensions between two different cultural matrices. These differences are custodial and related to treatment in a place like the prison, created to punish and also required to play an educational role.

Cooperation between institutional players is essential. The maternal culture of the treatment area must necessarily coexist with that defined as paternal (Sarzotti, 1999) typical of the prison corps. What often happens within the penitentiary institution is that we see an uncooperative attitude in some operators, often among prison officers, which can be traced back to a demand for additional work with respect to that envisaged by the institutional mandate of maintaining security.

This demand, considered an "extra", and the sometimes obstructive attitude, can be correlated to a lack of involvement of prison officers in the promotion of projects; a problem that can be overcome by imagining training on specific cultural issues and requiring the participation of officers in projects concerning the treatment of offenders, with the hope that they will show a willingness that is not only organisational, but also cultural, with a view to raising awareness of the projects.

Another criticality of the treatment within the prison setting regards the type of prison in which the treatment is being carried out. Although the rules of the prison system proclaim the principle of equality in criminal justice, being in one prison instead of another can make a difference. Some prisons are defined as "treatment facilities", where the managerial staff is more far-sighted, the attitude of the administration aiming to experiment with excellent treatment projects rather than being punitive. Others are defined as "punitive prisons" and often house inmates with negative behaviour. The staff in these facilities, starting from the top management, tends not to be very collaborative (Torrente, 2018).

Then there are some technical-organisational problems, such as the limited number of hours available to the treatment team, with each individual operator in charge of the treatment of hundreds of inmates, in a strongly unbalanced relationship that is not very functional in terms of rehabilitation.

The aim of the prison administration should be to build a synergistic network that allows a certain continuity of treatment that can help to overcome the temporary nature of the projects related to individual funding, removing not only the uncertainty regarding the continuation of the project, but also the discontinuity in time, with long periods between the implementation of one project and the start of the next.

The complexity of the prison context is also expressed in the relations between the various players involved not only in educational and security areas but also - and above all - the inmate population and the medical area. The reform of prison healthcare, as has been said, has laid the foundations for the separation of responsibilities within penitentiary institutions, entrusting the Ministry of Health with those relating to healthcare and the Ministry of Justice with those relating to security (Ronco, 2018; Libianchi, 2008).

Medical and health workers are required to comply with the rules envisaged by the Prison Regulations, the implementing regulations and the internal rules of each prison, and consequently have limited autonomy. Although the mutual distrust between administrations and organisational-management difficulties emphasise the irreformability of the institution as a whole, it is undeniable that the transfer of health management from the Ministry of Justice to the Ministry of Health has influenced and led the penitentiary institution to a reshaping that is counterbalanced by the "outside", the external dynamics of civil society, and has helped improve the health protection service offered.

7) Analysis of the feasibility and transferability of the CONSCIOUS project

In the light of the cognitive framework outlined above, it is now necessary to focus on the transferability of the CONSCIOUS project to other contexts.

Feasibility assessments are an integral part of the development of the project. The general aim of this assessment is to establish the feasibility, practicability and applicability of the CONSCIOUS model in a permanent and replicable way in other contexts - detention centres and others - within regional and national territories.

We know that developing new interventions, especially in the field of criminal justice, and moving from an idea to full operation, has always been a great challenge.

This feasibility assessment revealed that the CONSCIOUS model is robust and implementable within other national contexts.

Looking specifically at the elements considered most suitable for transferral to European countries, the following should be noted:

- **Operational Protocols 1-2-3 (D 2.4, D 2.5, D 2.6)**

The CONSCIOUS Project succeeded in creating an effective partnership and bringing together a number of significant stakeholders in order to create a team with the skills and scope to implement this approach.

Operational Protocol 1 (D 2.4) involves the Local Health Authority of Frosinone, the Lawyers' Associations of Frosinone and Cassino, the Regional Superintendent of the Penitentiary Administration of Lazio, Abruzzo and Molise, the Guarantor of persons subject to measures restricting personal freedom in Lazio and the National Centre for Studies and Research on Family and Juvenile Law. All the representatives of the aforementioned institutions took part in training and capacity building and mutual learning activities.

The Operational Protocol was the element used to promote a permanent confrontation, in a systemic logic, on strategies to combat domestic violence, gender violence or violence against minors.

The specific goal was - from a preventive point of view - to contrast the violent behaviour of individuals who voluntarily submit to specialised treatment, also favouring the constitution of an intersystemic network among the signatory Institutions for an agile sharing of information (with respect for privacy) and the specific needs of the investigative phases. Alongside these, it promoted

the exchange of expertise between the parties involved and mutual learning activities. Each signatory subject undertook - to the extent of its competence - to promote the specialist treatment promoted by CONSCIOUS. Upon completion of the preliminary investigations that confirmed the allegations of a crime, conflict or violence, the individual concerned was asked to give their formal consent (**Treatment Agreement - D. 3.3**) to the transmission of these behaviours (methods and contingencies of violent behaviour, specific individual characteristics) by the lawyers and/or the police to the specialist treatment services of the Local Health Authority that took charge of the individual.

Operational Protocol 2 (D 2.5) moved in the same direction and defined the following programmed specialist treatments: the IMPULSIVE BEHAVIOUR THERAPY DESK (T.C.I.) - for individuals in a state of freedom - aimed at individuals with a recent history of impulsive/violent acts or mistreatment within the family, without associated psychopathological and organic disorders; and the VIOLENT IMPULSE TREATMENT LISTENING GROUP (GATIV) - for individuals who have performed impulsive/violent acts or mistreatment towards women, relatives or minors within the family - also with possible association of the use of substances and/or psychopathologies that do not affect self-reflexive and relational abilities. Both treatments are voluntary, weekly group treatments. All the activities are monitored, and the results obtained are assessed.

Different European societies respond differently to sexual offences, as the level of awareness, attitudes and support for the rehabilitation of sex offenders vary significantly from one country to another. These national differences are hard to explain and are probably caused by a multitude of factors. The various national policies and laws governing the management of sex offenders in the community differ too.

One of the most important cultural factors that influence sex offenders and their treatment is the degree of awareness of the extent and impact of sexual victimisation in each country. This awareness in itself marked the start of a joining of cultural forces, particularly feminist forces and the movement for the protection of children. In countries where these movements are strong, such as the countries of North-western Europe, the focus on preventing sexual violence against women and children is greater than in countries where these movements are less prominent, such as the countries of Southern Europe. And they are almost absent in the former communist countries. However, in the wake of the recent victim support movement, the treatment of sex offenders seems set to take root strongly throughout Europe.

For these reasons, Operational Protocols 1-2 (D 2.4 and D 2.5) are applicable in European countries, in the wake of the attention paid to the creation of inter-institutional networks in order to make prevention paths more effective.

A different consideration should be paid to **Operational Protocol 3 (D 2.6)**, which includes the Prison Departments of Cassino and Frosinone among the signatory institutions, with the ultimate aim of overcoming the organisational-structural and cultural obstacles of the penitentiary setting. In this sense, the Protocol envisages a specific treatment for sex offenders and one for abusers - both group and individual - promoting the frequency of treatment activities and encouraging the development of the social-family network.

Public opinion varies in certain countries and can be more or less favourable to treatment within the framework of detention. In the UK, Belgium, Germany and the Netherlands, for example, public support for treatment seems to have declined in recent years, focusing on the management of the offender rather than his treatment and considering sex offenders as criminals who should simply be imprisoned and punished. Every case of recidivism seems to increase media attention to the problem and provoke a stronger judicial response. Nevertheless, it is true that, with the exception of some countries, the dominant and consolidated approach in almost all of continental Europe tends to focus on the treatment rather than the incapacitation of the offender. Throughout Europe, a plethora of comprehensive treatment programmes for sex offenders has developed both within the community and in the prison setting. Most of these programmes are prison-based (e.g. Sweden, Spain, Finland, France, Italy, Austria, Poland and Ireland), and in some cases treatment is usually imposed by the courts. These can vary, for example, from treatment in specialised departments within penitentiary institutions in Germany (Pfäfflin, 1999), Denmark, Norway, Belgium and the Netherlands (Frenken et al., 1999) for sex offenders who are criminally liable, to outpatient facilities in Belgium (Cosyns, 1999), the Czech Republic (Weiss, 1999) and Switzerland.

The lack of adequate communication between those performing the treatment and the judicial authorities in European countries with regard to the goals, methods and effects of the treatment often also hinders the flow of users to treatment. It is in these countries that the above-mentioned Operational Protocols are of the utmost importance also in order to create an exchange of good practice, through the

- **Networking Agreement (D 2.10)**

approved by the Local Health Authority of Frosinone, the Centre for Studies and Research on Family and Juvenile Law, the Lazio Region and the European Network for the Work with Perpetrators of Domestic Violence (WWP).

The aim of the network agreement is the exchange of information and good practices between the signatory partners to ensure the protection of victims by building a social system to respond to perpetrators of domestic and sexual violence that is capable of providing psycho-social treatment to prevent the recurrence of (gender-based) domestic violence against women and children.

The Networking Agreement can be transferred to the countries of the European Union because, in recent years, government support and funding of projects to assist victims generally seems to be encouraged by feminist movements and child protection groups.

In addition to this, it is important, in order to establish the continuous training of the operators involved in the treatment administered, to note the

- **Training Course (D 2.8)**

an event organised in three meetings dedicated to the operators of the penitentiary administration, the Department of external criminal execution (UEPE), Addiction and Psychopathology operators in the penitentiary circuit, the Women's Mental Health Unit and Third Sector Volunteers. The topics discussed in the first and second meetings concerned the intramural treatment of sexual assailants with reference to the legislative situation in Italy, the general principles of intervention of sex and violent offenders, networking in the surveillance court, UEPE and social services and presentation of clinical cases. The third meeting addressed the issue of communication and building alliances with sex offenders, emotion management and counter-transferral of operators. Another accredited training event for Continuing Medical Education was organised into six modules for the operators of the Local Health Authority Frosinone who work at Cassino Prison, Frosinone Prison and in the external treatment service for abusers. The six modules were organised over three days for a total of 24 hours of training in a single block. Operators from the Dependencies and Psychopathologies Unit in the prison circuit, from the Women's Mental Health Unit and the Psychiatric Diagnosis and Care Service (SPDC) of the Local Health Authority of Frosinone for the professional figures of Psychologist and Psychiatrist took part.

The training contents (clinical model, practical implications, management of critical cases, assessment of results, coordination with the penitentiary system) were in line with the needs of the

operators, whose professional skills improved both from a theoretical point of view and in clinical practice. The contents transmitted and the organisation of the training activities were in line with the project's aims; the teachers positively assessed the transfer of know-how to all learners.

The Training Course tool (D 2.8) appears to be applicable more widely in all European countries due to the need for continuous training of the operators who come into contact with the users who voluntarily undergo treatment. Given the specific nature of the topic, it is more appropriate than ever to insist on the training of the operators directly involved in their application, based on the principle of all significant stakeholders and requiring their full commitment and synergy.

The last training module was also attended by volunteers, who showed considerable interest in the subsequent work of the circles aimed at social inclusion, with a view to restorative justice (RJ), which is the conceptual framework for the treatment. Restorative justice offers a vision capable of recovering people - in their roles of victim and offender -, the damage, as a consequence of the crime committed, which not only affects the victim, but also the community, due to the resulting sense of fear and insecurity, as well as the person responsible for the damage, due to the effects of the custodial response involving family members and other significant relationships (Patrizi, 2019).

- **Social reintegration plan (D 4.4)**

This plan assumes the community as a unit of analysis in the restorative vision. This mainly restorative programme is created using the Co.Re. Community of Restorative Relationships theoretical model (Patrizi, 2019) based on the generation/regeneration of social connections via the search for consensus, sharing and security of the community.

The cases treated within the CONSCIOUS Project are, evidently, endowed with peculiarities (crime method, victim-perpetrator relationship, child victims, perpetrator awareness and outcomes of the treatment, current conditions of the victim, etc.) that prevent the construction of typologies. It is, however, possible to identify certain criteria that allow the identification of the methods used within the reintegration plan and, in the case of the restorative justice programme, the choice of that best suited to the individual situation.

The plan is developed in an area characterised by judicial constraints (role responsibility: the role of the individual in the criminal system) and works on the psychological variables of responsibility (responsibility - capability), with the aim of supporting the perpetrator's path towards

the development of their potential for the definition of a better life and the containment of the risks of further harmful behaviours (fight against recidivism), in accordance with social expectations (ecological level of the CO.RE. model: reciprocity and obligations, responsibility). The development of resources and potential leads back to the individual and group level of the CO.RE. model, where each variable is clearly considered in an interpersonal and social light.

The reintegration plan is easily transferable to those contexts that want to involve communities, the public and society in an informed exchange. The debate on child sexual abuse to increase their understanding and commitment (McCartan et al., 2015), should focus on correcting misconceptions about recidivism rates of sex offenders who have undergone treatment and provide evidence of distancing processes in sex offenders, in order to address the widespread myth that sex offenders are "incurable monsters".

Models like CONSCIOUS offer unique opportunities to provide the general public with more accurate information about sex offenders in the community, their risk of re-offending and the possibility of bridging that divide with the community.

In those countries like the UK, France and Belgium, where there has always been, for historical reasons, a strong focus on Restorative Justice, the social reintegration plan is feasible without particular cultural resistance. The Central and Eastern European countries - which began to become interested in the expansion of Restorative Justice late, just before the fall of the Berlin Wall - adapted to European Directive 2012/29/EU, which envisaged the right of victims to recourse to criminal mediation as one of their rights.

Besides the legislation, however, it should be noted that in many other European countries, such as Poland, Hungary and Germany, a culturally generalised attempt, closely linked to the existence of a national political strategy (or at least a macrosystem) capable of supporting initiatives such as the reintegration plan of the CONSCIOUS model, has been made.

- **Mapping Report (D 4.3)**

The study on best practices carried out in the Mapping Report (D 4.3) only confirms that there is a widespread homogeneity of treatment modalities on several levels within the European context. About two thirds of treatment programmes apply group work together with other types of intervention. Individual counselling is also frequent, but group work is the prevailing mode of intervention. Other approaches, such as couple counselling or mediation, are less frequent. As regards

the quantification of treatment, it should be noted that there are numerous variations between programmes, with most programmes in ranging from 14 to 52 sessions over a duration of 14 to 52 weeks. With regard to the operational approach of the programmes for their practical work with offenders, most of the programmes cover Cognitive Behavioural Therapy (CBT) and a psycho-educational approach or an approach similar to that of Duluth. In the European case, a variety of approaches are always applied, sometimes combining elements of different approaches (Canales, Geldschläger, Nax and Ponce, 2015).

What no programme can do without are the fundamental guiding principles in the treatment of offenders, including:

1) the safety of women and children who are victims of male violence;
2) violence is the responsibility of the perpetrator and PPS must challenge perpetrators to take responsibility for their abusive behaviour;
3) attention to gender sensitivity;
4) multi-agency cooperation to work effectively (links with other non-governmental organisations working with survivors and perpetrators of violence, health service providers, probation services, the police and other local authorities, help develop a better environment to address the issue);
5) Zero tolerance to VAW, violence against women.

Other guiding principles include:

- the fight against violence of any kind (not only that of men against women);
- minimising the negative effects of war and building peace;
- the neutrality of advisers;
- mutual respect;
- a client-centred approach, paying particular attention to the client's individual needs and rights;
- partnership between women and men in addressing MVAW;
- non-discrimination and mutual respect between consultant and client;
- minimum standards for programmes aimed at offenders;
- integrated approach with counselling, advocacy and decision-making processes on hand for survivors of violence;
- psychotherapeutic approach;

- prevention of DV, domestic violence.

In order for treatment for sexual offences to occur, treatment providers must cooperate with the justice system. In European countries, justice systems are often limited in their attitude towards treatment in conjunction with prison sentences. The only exception to this is in the countries of North-western Europe, and this stems from concern for young victims and their families. However, things are gradually changing for the better in the countries of South-western Europe.

- **Perpetrators Evaluation Toolkit (D 4.2)**

CONSCIOUS has created a toolkit consisting of questionnaires designed and intended to be used both with men who have joined a programme and with women whose (former) partners are participating in a programme to help them end domestic violence and abuse.
The main tools are three questionnaires:
1- Questionnaire on the content and context of the programme, providing information on the context of the programme on issues such as the number of men referred to, who participated and who completed the programme, the number of partners contacted and helped; number of sessions carried out and other characteristics of the programme.
2- Questionnaire on the impact of the user and (former) partner (separate questionnaires for man and (former) partner). This questionnaire collects information on the impact of the intervention on the abusive behaviour of men and the safety of women. The programmes try to find appropriate, safe and ethical ways to contact partners and significant former partners in order to assess their safety and their need for support and protection.
3 - Tracking users and (former) partners. This questionnaire helps the programmes keep track of the users and (former) partners who responded to the previous questionnaire.
The questionnaire is administered at five different times during the processing programme, both for the offender and the (former) partner, broken down as follows:
T0 User/Partner - Self-assessment form at the beginning of the intervention (first contact)
T1 User/Partner - Self-assessment form at the beginning of the intervention
T2 User/Partner - Self-assessment form half way through the intervention
T3 User/Partner - Self-assessment form at the end of the intervention
T4 User/Partner - Self-assessment form six months after completion of the programme.

Ideally, a programme is looking to reduce the frequency, severity and types of physical and emotional violence/abuse, increase the security of the (former) partner and their general impression of possible changes, reduce feelings of fear on the part of (former) partners and children; trigger an improvement in the (former) partner's parenting and co-parenting skills.

The first version of the Impact Toolkit was delivered and assessed by the operators of the Local Health Authorities involved in the treatment programme. Then a webinar was organised to explain how to use the toolkit. Subsequently, the Italian version of the Impact Toolkit was considered appropriate and suitable for use with perpetrators receiving treatment as free citizens (GATIV and TCI). For perpetrators in prison, it was decided that a further adaptation process would be necessary. A pilot test was carried out to identify the Impact Toolkit questions that were not relevant to the prison environment. The test results showed that most of the Impact Toolkit questions are also suitable for the prison environment.

The Toolkit proved to be an excellent tool for the assessment of re-offending risk. An agile tool, it has been designed in English to allow more extensive use, and is applicable within regional, national and European contexts.

Although in some areas its practical implementation can be considered less coherent than in others, its transferability is undeniable. It should be noted here that the use of Toolkit in prisons, and its administration over time, appear to be more easily practicable in those national contexts where healthcare is commissioned by the state, such as France, the United Kingdom, Greece and Italy.

The training of operators (psychiatrists, psychologists, etc.) as well as their independence from the prison administration is an extremely important element in the treatment of offenders. The commissioning of health services run by of the Ministry of Health also facilitates contacts with external territorial services. At the end of the sentence, connecting with the person outside, when they are released from detention, seems to be a priority in order to contain re-offending.

Another essential element for the applicability and transferability of the CONSCIOUS Toolkit concerns treatment. It has emerged that the best projects take place not only in those penitentiary contexts defined as having a high-level treatment vocation (as in the case of France, the UK and Germany, for example) where various cultural, recreational and training activities are carried out, but also where prison operators seem to work actively to ensure their success.

- **Report of the Model Impact Assessment on economy and society (D 4.1)**

This report defined that, in the case of the CONSCIOUS project, the pathways in support of those who take part in the project take advantage of the fact that they are in contact with the services and the analysis phase of their re-entry into society could complement the support provided by the operators. These pathways are analysed within the framework of continuous supervision and will result in a specific report, shared between therapists and supervisors.

The use of these assessment tools should not be considered with a view to a complete assessment of the paths of intervention on perpetrators of crimes within the family. From this point of view, the number of individuals involved and the specific characteristics of the crime committed and the interventions carried out make it particularly desirable for an assessment process to be based on the analysis of individual paths, rather than on a mere statistical analysis of re-offending. Thanks to this form of monitoring, it will also be possible to assess in the long term the suitability of interventions capable of preventing the perpetration of new crimes.

The approach to costs divides the analysis into two phases. The first considers a time t0, in which the average rate of re-offending considered standard in literature and, more specifically, in the reference territory, is estimated as the average rate in the absence of CONSCIOUS treatment (estimating the standard number of victims of re-offending expected and comparing it with hypotheses presented in literature, research and previous experiences). and the re-offending rate after CONSCIOUS treatment. The second looks at a time t1 (5 years), in which it is necessary to verify the re-offending rate observed in the CONSCIOUS intervention group, along with the deviation between expected and observed rates.

Conclusions

In the light of the legislative analysis, the best practices examined, the European penitentiary contexts and the transferability of some instruments conducted so far, we can conclude that the CONSCIOUS model offers excellent possibilities in the treatment of perpetrators. It also provides the general public with accurate information on sex offenders, heals the breach with the community and deploys its effects in reducing the risk of re-offending.

The CONSCIOUS model is a valuable decision-making support tool for regional and national policy makers and this is highlighted by the advantage of using feasibility assessments to guide decision making in reducing re-offending by sex offenders.

Given the current national and European legislative landscape, the practical obstacles to the development of a transferability of the effectiveness of the approach used by CONSCIOUS appear to be few and far between. The model has the potential to provide an additional tool to ensure public safety by making a valuable contribution to established methods for the treatment of sex offenders and limiting re-offending.

To ensure the functional transferability of the CONSCIOUS model to other national contexts at European level, it is essential to start from the basic guidelines for the treatment of offenders. For the aim of the administrative - and penitentiary - action to be that of participating in the construction of a support network that takes charge of vulnerable individuals in order to identify the best rehabilitative and therapeutic path for them, these elements can be summarised as follows:

- Individual and group treatment based on cognitive-behavioural therapy;
- Involvement of a multidisciplinary team;
- National health service commission;
- Creation of global actions and an intersystemic area in which institutions work together;
- Use of the tools created by CONSCIOUS, described above, and specifically the CONSCIOUS Guidelines (D 4.5).

Synergy must take place at all levels, not only at treatment level but also and, above all, at legislative, judicial and penitentiary level (Cuzzocrea, Lepri, 2010).

In order to achieve the general aim, actions have been implemented in the CONSCIOUS model to give continuity to the treatment programme that has already been started with sexual offenders in prisons. This is aimed at influencing the assumption of responsibility by prisoners, as well as supplying them with tools to read the consequences of their behaviour on victims, identifying strategies for non-abusive relationships. CONSCIOUS then gave continuity to their progress outside prison by consolidating the network of territorial services. It is essential to ensure that the prison system operates in close correlation with the other stakeholders involved, the institutions and territorial services, in order to build a single welfare system that guarantees continuity both in and outside prison, both preventively and ex-post.

The aim is not only to improve the quality of intramural or external treatment, but to build a welfare system that addresses vulnerable individuals globally, including those serving prison

sentences. in the case of the CONSCIOUS project, the pathways in support of those who take part in the project take advantage of the fact that they are in contact with the services, and the analysis phase of their re-entry into society complements the support provided by the operators.

It is necessary to analyse how much of the difficulty existing in their life before imprisonment and how much is an adaptive reaction to the prison environment (Clemmer, 1997; Goffman, 2001). Prison is a pathogenic factor in its own right, or at least an amplifier of disorders that existed prior to imprisonment and a container for the surplus (De Giorgi, 2002). It has an effect on all those individuals who already live in social contexts characterised by severe poverty, social marginality and occupational exclusion and for whom the prison context also represents a first access and contact with health services, in the first instance, and with territorial services in the second instance.

To this end, the establishment of operational protocols between the various parties involved in treatment and outside prisons, working in synergy with the institutions and territorial services, also in order to prepare for the subsequent taking charge once the detention period is over, has been a good practice.

CONSCIOUS and its tools for individuals on the outside (GATIV and TCI) show how the reduction of re-offending allows the reduction of the general costs related to victims of violence, and more besides. The costs of prevention are significantly lower than those of ex post treatment, proving that greater investment in prevention produces more lasting and effective results, not only at individual level but also for society as a whole and the public services involved.

There is a need and urgency to create cultural interventions like CONSCIOUS as an indispensable premise for the implementation of activities to generate awareness and prevent violent crimes. It is only by implementing global and systemic actions on a broader spectrum that we can hope to counteract that specific risk of re-offending, although there does not yet seem to be an unambiguous view on the extent of that risk in the light of the investigations carried out (Carabellese et al., 2012).

Moving on from the legislative level via the investment of resources in research, the training of the operators involved in the treatment, the provision of funding to avoid interruption of treatment projects, it is possible to start thinking in terms of real protection of society and prevention of crimes of violence, abuse and sexual exploitation. (Patrizi, 2019). There is a widespread desire and expressed at various levels (social, cultural, government policies) to proceed with the specific treatment of sex offenders, with the ultimate aim of being able to protect their right to health, i.e.: the right to a more

adequate sexual and behavioural life, while respecting the essential legal and security needs of the community (Carabellese et al., 2012).

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