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Integrating Prison Staff Perspectives on Mental Health in Prison

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Introduction

In 2019, the Italian Constitutional Court decided to abolish the distinction between mental and physical health care for prisoners. Health is a fundamental right 'of the individual and in the interest of the community' in the Italian Republic, as described and guaranteed by Article of the Constitution. In the Italian penal system, the concept of health increasingly includes both physical and mental health, as defined by the World Health Organization as "a state of complete physical, mental, and social well-being." Beginning with these thoughts on mental health, which are meant to be broad concepts encompassing many aspects of life, the following paragraphs will provide an overview of the conditions of the Italian prison system and its population (prisoners and staff), as well as the effects on their mental health [1].

Description

Psychosis, dissociation, affective disorders, anxiety disorders, personality disorders, substance abuse disorders, and comorbidities are the most common mental disorders among Italian prisoners. Suicide is much more common in prison settings than in the general population, and one out of every ten prisoners in Italian prisons engages in self-harming behaviour. Environmental conditions, such as dilapidated facilities, few hours outside, insufficient training and work activities, limited personal space due to overcrowding, high temperatures, and so on, all contribute to the onset of mental distress among prisoners. Some of these conditions prompted the European Court of Human Rights to issue a preliminary ruling condemning Italy's inhumane prison conditions in 2013. The problem becomes more complicated, however, when we consider that many of those who [2].

Those who end up in the penitentiary system have already suffered from psychophysical conditions. Given that prison's structural elements promote the emergence of psychiatric pathologies, it stands to reason that prison strengthens pre-existing links between social marginalisation and psychiatric pathologies [3]. However, since the closure of Judicial Psychiatric Hospitals in 2015, offenders with mental illnesses have congregated within increasingly overcrowded prisons, altering the baseline epidemiological situation and contributing to a highly complex environment. Today, 25% of Italian prisons have an FPU, but physicians and psychologists work only 7.4 and 11.7 hours per week per 100 prisoners, respectively. Penitentiary police officers, who have been required to participate in prisoners' treatment and rehabilitation programmes since the passage of Law 395 in 1990, must now assist prisoners with mental illnesses despite lacking the necessary psychological competence. The adoption of dynamic security and open-cell regimes has added new challenges, particularly for PPOs. Finally, in 2010, the replacement of penitentiary educators with legal-educational professionals resulted in additional structural change and role ambiguity.

Organizational challenges, role ambiguity, and environmental conditions endanger not only the mental health of prisoners, but also the mental health of prison staff. Prison staff face the difficult task of performing afflictive, re-educational, and recovery-oriented functions mandated by 1975 reforms, resulting in role ambiguity and distress. Indeed, prison appears to be a high-risk work environment in terms of mental health. Correctional nurses have been found to have high levels of depersonalisation, which is one aspect of burnout, as well as moral distress. Carnevale and colleagues discovered that structural, organisational, and relational aspects of the work environment were unfavourable, leading to a lack of job satisfaction after conducting focus groups with Italian correctional nurses.

The literature reports numerous role conflicts for correctional nurses, PPOs, and JEPs, as well as how the professional's mental health is inextricably linked to that of the user and vice versa. Nonetheless, few Italian studies to date have focused on multidisciplinary collaboration or attempted to integrate different perspectives on mental health among prison staff. Furthermore, no Italian studies have examined the perspectives of prison directors, PPO heads, or FPU heads to date.

A PTSI does not develop in everyone who is exposed to a PPTE. A PTSI refers to a group of problems that include, but are not limited to, mental disorders such as PTSD and mental health conditions that do not meet the Diagnostic and Statistical Manual of Mental Disorders or International Classification of Diseases criteria for PTSD but still interfere with daily functioning in social, work, or family activities. Pre-existing conditions, concurrent or post-PPTE mental and physical injuries can all increase the likelihood of a PTSI. Prior history of unresolved PPTE exposures are examples, as are perceived helplessness during the PPTE, perceived uncertainty during the PPTE, and perceived social support post-PPTE [4,5].

Conclusion

Overall, the goal of this article was to operationalize investigation and trauma using Canadian cases, and then to investigate the relationship between mental health and investigation and testimony experiences for PSP. Finally, we discuss how PSP can be better supported during such processes in order to positively inform their mental health and well-being. Testimony is difficult, mentally draining, and difficult (with many unintended consequences); thus, society should ensure that PSP are supported during such processes and that efforts are made to make these experiences more tenable.

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