Acta Biomed 2021; Vol. 92, N. 3: e2021223 DOI: 10.23750/abm.v92i3.10663 © Mattioli 1885

Short paper

The Parma integrated model for intervention on pathological addictions in an Italian prison: process description and preliminary findings.

Lorenzo Pelizza, Amir Zaimovic, Bruno Veneri, Beatrice Urbani, Stefania Cutrino, Diana Gran Dall'Olio, Germana Verdoliva, Davide Maestri, Ursula Zambelli, Enrico Rossi, Ilaria De Amicis, Cecilia Paraggio, Adriana Adriani, Silvia Bertoli, Giuseppina Paulillo, Derna Palmisano, Emanuela Leuci, Pietro Pellegrini

Department of Mental Health and Pathological Addiction, Azienda USL di Parma, Parma, Italy.

Abstract. *Background*: Interventions for inmates with Pathological Addiction (PA) still remain a problematic issue in Italian prisons, despite a 1999 major government reform transferring PA care in prison to the National Health Service. Aim of this research was to describe the integrated intervention model implemented for prisoners with PA in the Parma Penitentiary Institutes from January 2020 to June 2020. This specific approach is based on "person-tailored" therapeutic-rehabilitation programs in line with local community PA services. *Methods*: All the procedures were first carefully illustrated, especially the service for newly admitted inmates and the specialized rehabilitation treatments provided. A process analysis on the first six months of clinical activity was then performed. *Results*: Since January 2020, 178 subjects entered the service for newly admitted inmates: 55 (30.9%) were taken in charge for a PA. *Conclusions*: Our results support the feasibility of an integrated intervention model for PA in Italian prisons, based on specialized psychiatric treatments planned and provided in collaboration with inmates and their community health and social services. (www.actabiomedica.it)

Key words: Pathological Addiction, Drug Abuse, Psychiatric Services, Rehabilitation, Prison, Italy.

Introduction

During the 1990s, there has been a steadily growing jail population in Italy (from 25 000 in 1989 to 60 000 in 2004) (1) with a consequent increase of serious mental health problems in prisoners (especially due to substance abuse/dependence). In this specific context, running a completely separate healthcare systems (Department of Prison Administration [DPA] vs National Health Service [NHS] – from the 1970s, the Italian DPA independently managed health care services in prisons, mainly consisting of facilities located in jail with directly employed medical and nursing staff) was leading to high-cost duplication of interventions, care inappropriateness and inequalities in basic health rights between free citizens and prisoners (2). Therefore, in June 1999, the Italian government approved an important decree (Decree n. 230/99) that passed all responsibilities and resources for drug addiction interventions in prison to the NHS (through its Regional health systems, in accordance with their funds and organizations) (3).

Starting to this background and following a recent resolution of the Regional Council of the

Emilia-Romagna Region n. 2051/2019 ("Regional health program in prisons") (4), the Parma Department of Mental Health and Pathological Addictions has decided to implement specialized, expertise-driven interventions on pathological addictions and substance misuse for male inmates allocated in the local penitentiary institutes, considering that this context is often the first one in which addiction disorders are diagnosed (5) and taking into account that jail has become overtime the terminal of social problems (worsening together with the freedom deprivation) (6). Similarly to what provided in the local Pathological Addiction Services (PAS), these treatments are offered using a multidisciplinary care aimed at formulating an Individualized Therapeutic-Rehabilitation Program (*ITRP*), elaborated together with the patient, his family members (if possible) and with the integration of his local health and social services including in the belonging community (7). However, it is crucial to specify that specialized treatments offered by the Pathological Addiction Service Team (PAST) in the Parma Penitentiary Institutes (PPI) necessarily represents specific "II level-interventions", to be offered in close collaboration (and not in replacement) with the general medical staff guaranteeing primary care in prison (4). Therefore, main goals of PAST interventions for PPI prisoners with pathological addictions are: a) to elaborate individualized, "person-centered" and "person-tailored" treatments aimed at quickly containing health damages and at promoting substantial changes with respect to substance misuse (using detention as preferential setting to start a therapeutic-rehabilitation pathway); and b) to encourage the establishment of a solid relationship between patient and his local health and social services, especially in anticipation of jail term.

The main *aim* of this manuscript was to illustrate the intervention model for PPI inmates with pathological addictions or substance misuse implemented by the Parma Department of Mental Health and Pathological Addictions since 1st January 2020. This approach is specifically structured on the following different time phases: Assessment, Detention and Release from prison (Figure 1).

Additionally, a preliminary process analysis on the first 6 months of the PAST clinical activity in the PPI was also performed.

Material and Methods

Participants and setting

Data were retrospectively collected within the PPI service for newly admitted inmates between 1st January 2020 and 30th June 2020. Informed consent was obtained from all subjects prior to their inclusion in the study. All procedures contributing to this research complied with the ethical standards of the Helsinki Declaration of 1975 (as revised in 2008) for experiments including humans. Relevant local ethical approvals were obtained for the study. The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to their containing information that could compromise the privacy of research participants.

For the purpose of this study, *inclusion criteria* were: age ≥ 18 years and enrollment within the PPI service for newly admitted prisoners. *Exclusion criteria* were known severe intellectual disability (Intelligence Quotient < 40), neurological disorders (e.g. head injury, dementia) or any other medical condition associated with an inability to express a valid consent to participate in the research.

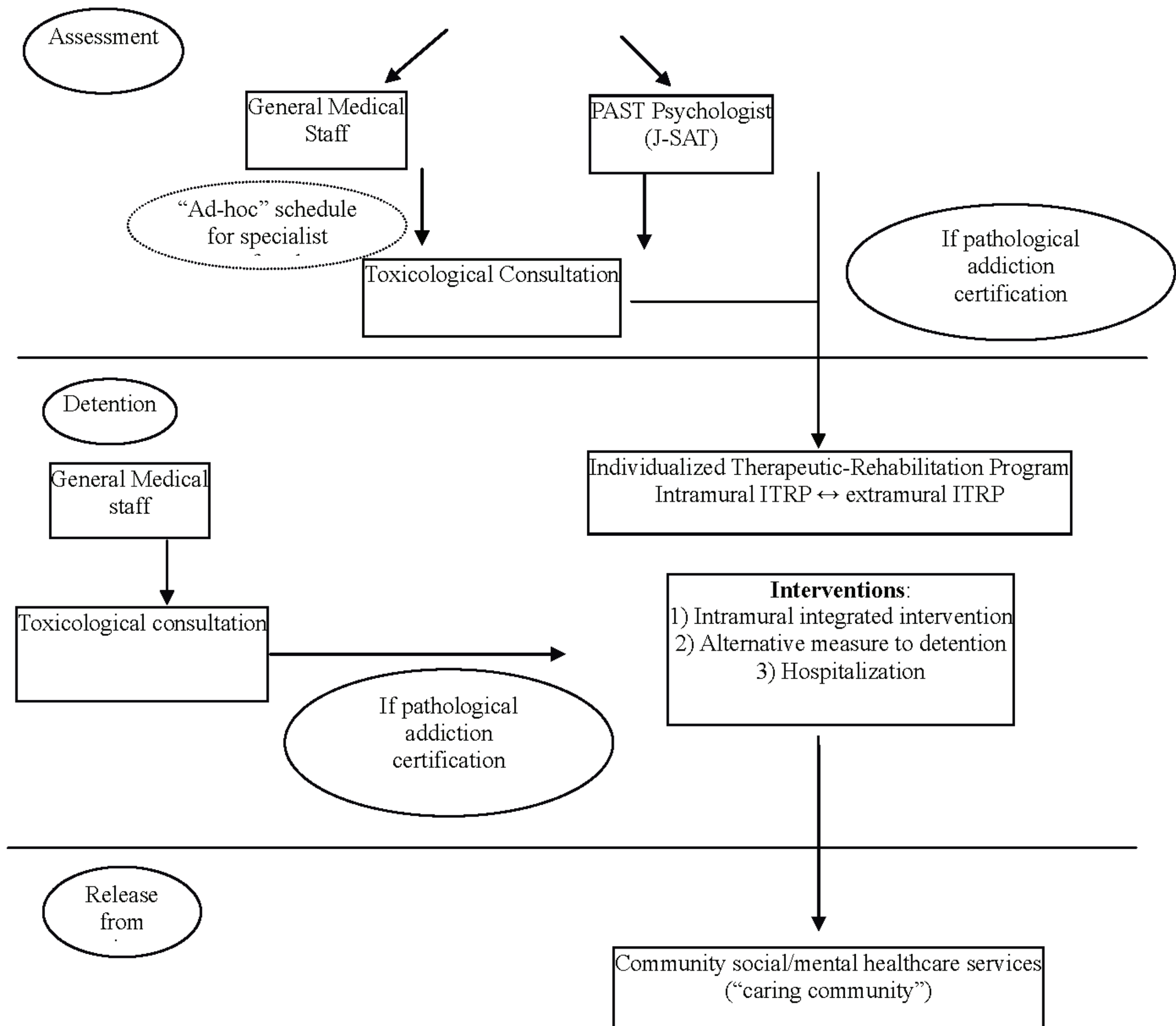
Process analysis

Preliminary process analysis of the new Parma integrated intervention model for prisoners with pathological addictions was performed after the first six months of clinical activity in the PPI. Data were collected and analyzed using the Statistical Package for Social Science (SPSS) for Windows – version 15.0 (8). Frequencies and percentages were used to describe categorical variables; mean ± standard deviation was calculated for representing continuous parameters.

Results

From 1st January 2020 to 30st June 2020, 178 male individuals (75 [42.1%] with non-Italian nationality; mean age = 41.40 ± 6.17 years; education level = 7.50

Figure 1. Flow-chart of pathological addiction interventions in the Parma Penitentiary Institutes.



Legend. PAST = Pathological Addiction Service Team; J-SAT = Jail Screening Assessment Tool; ITRP = Individualized Therapeutic-Rehabilitation Program.

± 2.83 years) entered the service for newly admitted inmates in the PPI. Eighty-one (45.5%) of them were coming from liberty, while 97 (54.5%) from other prisons.

Fifty-five (30.9%) participants were taken in charge by the PAST for a primary pathological addiction (Table 1), all with an ITRP including integrated multi-professional interventions (including specialized treatments provided by a toxicologist, a clinical psychologist, a professional educator or a psychiatric rehabilitation therapist and a psychiatrist [if dual diagnosis was identified]). Most of these inmates with pathological addiction (n = 45; 81.8%) were multi-drug abusers. A large majority of them (n = 43 [78.2%]) was previously known or taken in charge within PASs in prison or in the local community.

Discussion

Main aim of the current study was to describe the innovative intervention model for PPI inmates with pathological addictions or substance misuse

Table 1. Sociodemographic and clinical characteristics of the PPI total sample (n = 178).

Variable	
Gender (♂)	178 (100%)
Nationality	
Italian	103 (57.9%)
Non-Italian	75 (42.1%)
Age	41.40 ± 6.17
Education (in years)	7.50 ± 2.83
Primary pathological addiction (prevalent)	55 (30.9%)
Cocaine	18
Opiates	17
Alcohol	10
Cannabis	10

Legend. PPI = Parma Penitentiary Institutes; Frequencies (and percentages) are reported.

implemented by the Parma Department of Mental Health and Pathological Addictions since 1st January 2020. As above mentioned, this approach is specifically structured on the following different time phases: (a) Assessment, (b) Detention and (c) Release from prison (Figure 1).

(a) Assessment

Service for newly admitted inmates

Reception phase in the PPI offers a specific service for newly admitted inmates, without distinguishing if they are coming from liberty, other prisons or home. As crucial part of this service, the *general medical staff* collects information on any current pathological addictions (Figure 1), completing an "ad-hoc" schedule in the pathological history section of the computerized medical record, with the aim of getting prisoners to declare their addiction behavior problems as soon as possible. In this respect, general medical staff plays a key role in motivating inmates to promptly carry out toxicological checks and diagnostic test for an early identification of any somatic illnesses due to substance misuse. General medical staff interventions in the immediate entry into the PP are also crucial in the symptomatic treatment of a withdrawal syndrome, following specific therapeutic strategies co-planned with the PAST and in accordance with current guidelines on the topic (9, 10).

As an alternative, the PPI service for newly admitted inmates also consists in an in-depth clinical interview by a *PAST psychologist* within 3 days from the prison entry (Figure 1), specifically aimed at carefully assessing the adjustment reaction to the imprisonment, a relevant "life-event" that all prisoners must necessarily face and inevitably goes to impact with a more or less heavy preexisting load of psychological distress (11). During the interview, a detailed assessment of the inmate's current mental state and information on his clinical and life history (including pathological addiction behaviors) are collected, also through the administration of the "Jail Screening Assessment Tool" (*J-SAT*) (12). In this initial in-depth evaluation, it is also important to accurately assess the *risk of suicide*, in integration with information collected at entry by the general medical staff (13). In presence of an impending suicidal risk, the PAST psychologist directly activate the "Local Prevention Unit for Suicide" to promptly start a careful clinical monitoring, together with the prison officers. In this crucial preventive framework, the psychologist's activation is considered as a "first level" intervention and not only subordinate to a general medical staff request (14). The ultimate goal of this initial psychological evaluation on newly admitted inmates is to formulate a first mental functioning hypothesis within 2-4 weeks, in order to select prisoners with marked psychological distress, mental disorders or pathological addictions, for which, on a case-by-case basis, psychologist can further request the activation of a psychiatrist, a toxicologist and/or other professionals of the multidisciplinary PAST. Indeed, Indeed, *psychodiagnosis* (also using specific psychometric instruments [such as structured clinical interviews or self-report questionnaires]) is crucial to formulate the most appropriate ITRP and its effectiveness must be thus maximized (15).

All prisoners declaring problems with pathological addictions (e.g. alcohol, drugs, gambling) at prison entry, are referred by general medical staff or PAST psychologist to the PAST for a specialist toxicological evaluation. All information on pathological addictions collected by others professionals working in the PPI (e.g. social workers, educators, volunteers, nurses, prison

officers) must be preliminarily evaluated by the general medical staff before referring to the PAST toxicologist.

Toxicological consultation

A specialist toxicological consultation is provided by the *PAST toxicologist* within 48 hours from the request of the general medical staff or the clinical psychologist (Figure 1). This allows to quickly plan any further necessary diagnostic examination and therapeutic interventions (including pharmacotherapy in case of withdrawal syndrome), and to provide timely information on the usefulness (in legal terms) of carrying out toxicological checks (e.g. screening tests for alcohol abuse, toxicological urine test) aimed at "certifying" a drug addiction, given the short time duration of some substance catabolites in the urine (16). In case of inmates from other prisons or already taken in charge in local PAS, all the most suitable procedures should be put in place to guarantee pharmacological maintenance treatment (especially if substitution therapy has already been set) (17). In this respect, the ownership of substitution treatments exclusively belongs to the PAST toxicologist, who must guarantee a maintenance therapy within 48 hours from jail entry (4). During the baseline toxicological assessment, an electrocardiogram (with QTc measurement) and a cardiology consultation at least for those prisoners taking a methadone equivalent dose of 80 mg/day or/and antipsychotic medications should always be prescribed (17).

If pathological addiction criteria are met in accordance with the Italian Ministerial Decree n. 186/90 (18), the PAST toxicologist draws up a drug *addiction certificate*, which must also be reported in the ITRP. After the initial assessment, in case of pathological addiction certification, the prisoner is officially taken in charge by the multi-professional PAST, regardless of hypothesized alternative measures to detention. If pathological addiction criteria are not met after baseline evaluation (e.g. negative toxicological checks) but clinical features highly indicative of pathological addiction persist, the PAST may plan an in-depth psychopathological assessment involving a clinical psychologist and a professional educator or a psychiatric rehabilitation therapist within a defined period of observation and diagnosis lasting up to 45 days. This prolonged period should be useful for a best diagnostic framework (also aimed to certify a drug addiction), for motivating inmates to start specialized substance abuse/dependence treatments, and for offering specific interventions to support initial adjustment to imprisonment.

(b) Detention phase

Toxicological consultation

During detention, later behavioral problems specifically due to pathological addictions in prisoners not known to the PAST (and thus not previously treated for substance use disorders) may also arise. In this case, it should be preliminarily necessary an inmate's careful evaluation by the general medical staff before referral to the *PAST toxicologist* (as for any other specialist consultation) (Figure 1). Additionally, also PAST psychologist and psychiatrist involved in the assessment and treatment of the psychological distress and mental disorders in prison may directly refer prisoners for a toxicological consultation.

If there are clinical features highly indicative of behavioral problems related to pathological addictions, the PAST toxicologist may plan an in-depth psychopathological assessment, lasting up 45 days and involving a clinical psychologist and a professional educator or a psychiatric rehabilitation therapist. If in this defined period of observation and diagnosis pathological addiction criteria are met in accordance with the Italian Ministerial Decree n. 186/90 (18), the PAST toxicologist draws up a *pathological addiction certificate*, which must also be reported in the ITRP. After this evaluation period, in case of pathological addiction certification, the prisoner is officially taken in charge by the multi-professional PAST, regardless of hypothesized alternative measures to detention.

Taking in charge

Similarly to PASs of the Parma Department of Mental Health and Pathological Addictions, PPI inmates' taking charge of PAST is based on the *ITRP*, co-planned and co-signed with the patient (Figure 2). ITRP specificity and personalization are first guaranteed by the multi-professional composition of the

PAST, combining different integrated mental health professionals (i.e. toxicologist, psychiatrist, clinical psychologist, nurse, professional educator, psychiatric rehabilitation therapist and social worker). All these professionals proactively collaborate to plan the ITRP, also with the active participation of the prisoner, his family members (if possible) and his community social and healthcare services.

Specifically, this multi-professional team is engaged in both a clinical-diagnostic assessment of the prisoner with pathological addiction (also using psychometric instruments [such as clinical interviews and/or self report questionnaires]) and planning an *intramural ITRP*, which subsequently (i.e. at the time of release from prison) must be connected with an *extramural IRTP*, so as to prepare an intervention process that starts during detention and continues into the belonging community, with the transition of his taking charge to local healthcare and social services for a full social reintegration (Figure 1). In this regard, an effective intervention planning in the long term should necessarily include a shared integration of goals with the local community PAS team, at which the inmate inevitably returns at the time of discharge from prison, together with his past and current family, health and social problems. Therefore, during the detention phase, scheduled micro-team meetings are regularly planned in order to verify the ITRP effectiveness and the achievement of the set goals.

Furthermore, the multi-disciplinary nature of the PAST also allows an effective management of the most complex cases and a circularity of useful clinical information for an appropriate taking in charge of the inmate as a whole (19). For each case, the defined PAST

Figure 2. The "Individualized Therapeutic-Rehabilitation Project" (ITRP).

Name and surname: ____________________ **Date**: ____________________	**Project typology**: a) Simple b) Integrated
General and specific goals: ____________________ ____________________ ____________________	
Methodology and instruments: ____________________ ____________________ ____________________	
PAST members involved (name and degree): ____________________ ____________________ ____________________ ____________________ ____________________	
Scheduled verification **Date**: ____________ **Outcome**: ____________________ ____________________ ____________________	
Signatures: ____________________ ____________________ ____________________ ____________________	

Legend. PAST = Pathological Addiciton Service Team in the Parma Penitentiary Institutes.

micro-team may vary in composition in accordance with individual unmet needs and specific therapeutic-rehabilitation goals (*"variable structure" micro-team*).

For PPI prisoners with a pathological addiction certification, project formulations on alternative therapeutic-rehabilitation measures to imprisonment should always be considered over the course of the detention, in accordance with the Decree n. 309/1990 of the President of the Italian Republic (18) and in close collaboration with local PASs. In this respect, one of the most important aim of the PAST during the formulation of an ITRP for an inmate with a pathological addiction certification is to encourage an extra-mural project involving an *alternative measures to detention* (e.g. in specialized facilities for drug addiction or at home within a PAS territorial program) (Figure 1).

During detention, for an effective formulation of a personalized and co-planned care pathway, a person-tailored and person-centered *integrated intervention* is provided for all PPI prisoners taking in charge by the PAST (Figure 1). This intervention is jointly defined by the PAST after the inmate's assessment phase (and his subsequent diagnostic and clinical framework). It is the most manifold and articulated form of taking charge, based on the integrated expertise of the multi-dimensional and multi-professional PAST, together with the patient, his family members and the social and health services of his belonging community.

Within this integrated intervention, the PAST *toxicologist* remains the primary responsible for the pharmacotherapy related to the pathological addiction, always in agreement with the patient and the local PAS. However, main aim of the pharmacological program should always be to stop or reasonably decrease the substitution treatment within the first 12 months of detention (4). This is for using the imprisonment as a "cathartic" moment to make prisoners aware on the importance of changing their existence, with the aim to limit health damages and to promote a life without pathological addictions.

According to the inmate's ITRP, PAST *educators and psychiatric rehabilitation therapists* may offer both individual and group rehabilitation treatments (e.g. psychoeducational sessions aimed at increasing therapeutic compliance or motivation to change from an existence dominated by the pathological addiction, at promoting harm reduction and risk prevention behaviors, at supporting basic autonomy and daily functioning; specialized interventions aimed at rehabilitating specific residual socio-cognitive skills [such as those based on the "Skill Training" model]; psychoeducational groups focused on specific rehabilitation issues; mutual self-help groups [also using "peer-support"]) (20-22). In particular, group interventions within the PPI are considered as extremely useful to favor an effective peer support on common areas and problems related to pathological addictions, and to optimize the existing professional resources (23, 24).

Also the PAST *psychologist* may be involved in the achievement of the ITRP's goals, providing both individual treatments (e.g. orientation/support interventions in the initial detention phase [for deepening problem behaviors associated with pathological addictions, for exploring individual experiences related to the relationship with drugs, for increasing a motivation to change from pathological habits]; specific support interventions based on defined inmate's needs, in order to promote resilience and the best adjustment to the prison context or to implement daily functioning and basic autonomy; focal psychotherapy [i.e. more structured psychotherapeutic interventions on specific goals agreed with the prisoner]) and group treatments (e.g. psychoeducational group sessions specifically oriented to reinforcing compliance with therapy, the acquisition of specific socio-cognitive skills or a "drug-free" existential orientation in the fase of release from jail; psychotherapeutic groups aimed at increasing a reflective functioning, at favoring a more mature emotional expressiveness or on specific issues related to pathological habits [e.g. alcoholism, gambling, harm reduction, prevention of infection]) (19).

In case of dual diagnosis (pathological addiction and severe mental illness), a PAST *psychiatrist* may also be involved in the "variable-setting micro-team" and in the definition of an effective ITRP.

Hospitalization

When *hospitalization* is clinically useful, it may be requested in accordance with specific procedures agreed with the psychiatric ward network of the

Parma Department of Mental Health and Pathological Addiction. As an alternative, a transfer request to specific prison sections for diagnostic observation and treatment may also be proposed (Figure 1).

(c) Release from prison

The release phase may be a difficult step, with a high risk of relapse in drug abuse and overdose (25). Thus, it must be carefully monitored, providing information for a correct connection with the local PADS and social services. Moreover, release from jail almost inevitably leads inmates to consider economic, housing, employment and/or interpersonal difficulties that remained "outstanding", and to deal with an external reality often different from what they had hypothesized during detention.

Close to their discharge from prison, the following interventions may be planned (Figure 1):

-) in case of PPI prisoners with pathological addictions already taking in charge in a local PAS, the PAST directly activates *network interventions* for a continuity of care, working in close collaboration with healthcare and social professionals operating in the caring community;

-) in case of severe psychological distress due to release from prison (especially for PPI inmates without a past taking in charge in a local PAS), PAST members (i.e. clinical psychologist, professional educator, psychiatric rehabilitation therapist, social worker) may implement specific individual and/or group psychoeducational sessions to inform prisoner about his local social/healthcare services in the belonging community and how to access them in order to reduce fears and anxiety related to the extramural reality return. Specifically, in patients requiring healthcare continuity, the activation of the a local PAD should be encouraged, as well as a direct connection with the local social agencies, also directly accompanying them during the first clinical visits with their new local treatment referents.

Process analysis: preliminary findings

Further aim of this research was to perform a preliminary process analysis on the first 6 months of the PAST clinical activity in the PPI. Our preliminary findings support the feasibility of an integrated intervention model for PPI prisoners with pathological addictions, in line with what recently reported in other international studies. In this respect, Haviv and Hasisi (26) observed that prisoners who completed drug rehabilitation programs in the Israeli Prison Service (based on cognitive-behavioral therapy, therapeutic community, long duration, intensity and positive social climate) were incarcerated and arrested less than a comparison group of drug-addicted inmates who had not taken part in any drug rehabilitation program. These Israeli programs also succeeded in retaining participants through completion. Moreover, Arseneault and colleagues (27) also suggested a certain treatment effect related to impulsivity and psychological distress in PA prisoners provided by a jail-based addiction intervention program in a Quebeck prison.

In *conclusion*, the Parma integrated treatment approach has been specifically structured in line with what provided by local PASs in the caring community, while considering peculiarities of the prison context and psychological distress due to freedom restriction, in a more general framework of treatment equity and respect of healthcare rights between inmates and free citizens (i.e. without discrimination of any kind). Central points must remain the continuity of care (extramural-intramural-extramural) and the ITRP co-planning (in close collaboration with the patients, their family members and the local social/healthcare services of their belonging community) (28).

Acknowledgments: This research did not receive any specific grant from funding agencies in the public, commercial or not-for-profit sectors. The authors also wish to thank all the patients who entered the service for newly admitted inmates from January 2020 to June 2020.

Conflicts of interest: Each author declares that he or she has no commercial associations (e.g. consultancies, stock ownership, equity interest, patent/licensing arrangement etc.) that might pose a conflict of interest in connection with the submitted article.

References

1. Carrà G, Giacobone C, Pozzi F, Alecci P, Barale F. Prevalence of mental disorder and related treatments in a local jail: a 20-month consecutive case study. Epidemiol Psichiatr Soc 2004; 13: 47-54.

2. La Cerra C, Sorrentino M, Franconi I, Notarnicola I, Petrucci C, Lancia L. Primary care program in prison: a review of the literature. J Correctional Health Care 2017; 23: 147-156.
3. Peloso PF, D'Alema M, Fioritti A. Mental health care in prisons and the issue of forensic hospitals in Italy. J Nerv Ment Dis 2017; 202: 473-478.
4. Regione Emilia Romagna (RER). Programma regionale per la salute negli istituti penitenziari: indicazioni alle aziende USL per la redazione dei programmi aziendali. Bologna: Centro Stampa della Regione Emilia-Romagna; 2019.
5. Leuci E, Quattrone E, Pellegrini P, Pelizza L. The Parma-Early Psychosis program: general description and process analysis after 5 years of clinical activity. Early Interv Psychiatry 2019; DOI: 10.1111/eip.12897.
6. Haynie DL, Whichard C, Kreager DA, Schaefer DR, Wakefield S. Social networks and health in a prison unit. J Health Soc Behav 2018; 59: 318-334.
7. Landi G, Leuci E, Quattrone E, Azzali S, Pellegrini C, Pellegrini P, Pelizza L. The "Parma-Early Psychosis" programme: characterization of help-seekers with first episode psychosis. Early Interv Psychiatry 2020; DOI: 10.1111/eip.12968.
8. SPSS Inc. Statistical Package for Social Science – version 15.0 for Windows. Chicago, IL: SPSS Inc. Press; 2010. SPSS Inc. Statistical Package for Social Science – version 15.0 for Windows. Chicago, IL: SPSS Inc. Press; 2010.
9. American Psychiatric Association (APA). Joint principles on opioid crisis call for comprehensive, public health approach to addiction treatment. Washington DC,: APA Press; 2020.
10. National Institute for Health and Care Excellence (NICE). Alcohol withdrawal management for acute admissions to hospital. London: London North West University Press; 2019.
11. Sinha S. Adjustment and mental health problem in prisoners. Ind Psychiatry J 2019; 19: 101-104.
12. Grisso T. Jail Screening Assessment Tool (JSAT): guidelines for mental health screening in jails. Psychiatr Services 2006; 7: 1049-1050.
13. Pelizza L, Pellegrini C, Quattrone E, Azzali S, Landi G, Pellegrini P, Leuci E. Suicidal ideation in patients experiencing a first-episode psychosis: findings from the 2-year follow-up of the "Parma-Early Psychosis program". Suicide Life Threat Behav 2020; DOI: 10.1111/sltb.12625.
14. Eck M, Scouflaire T, Debien C, Amad A, Sannier O, Chan Chee K, Thomas P, Vaiva G, Fovet T. Suicide in prison: epidemiology and prevention. Presse Med 2019; 48: 46-54.
15. Pelizza L, Azzali S, Paterlini F, Garlassi S, Scazza I, Chiri LR, Poletti M, Pupo S, Raballo A. The "Reggio Emilia At-Risk Mental States" program: a diffused, liquid model of early intervention in psychosis implemented in an Italian Department of Mental Health. Early Interv Psychiatry 2019; 13: 1513-1524.
16. Ministero della Salute. Regolamento concernente la determinazione delle procedure diagnostiche e medico-legali per accertare l'uso abituale di sostanze stuoefacenti o psicotrope, delle metodiche per quantificare l'assunzione abituale nelle 24 ore e dei limiti quantitativi massimi di principio attivo per le dosi medie giornaliere. Roma: Gazzetta Ufficiale della Repubblica Italiana; 1990.
17. Weiss RD, Rao V. The prescription opioid addiction treatment study: what have we learned. Drug Alcohol Dependence 2017; 173 (suppl. 1): s48-s54.
18. Presidenza della Repubblica. Decreto del Presidente della Repubblica n.309/1990: testo unico stupefacenti. Roma: Gazzetta Ufficiale della Repubblica Italiana; 1990.
19. Yoon IA, Slade K, Fazel S. Outcomes of psychological therapies for prisoners with mental health problems: a systematic review and meta-analysis. J Consult Clin Psychol 2017; 85: 783-802.
20. Riedel-Heller SG, Guhne U, Weinmann S, Arnold K, Ay ES, Becker T. Psychosocial interventions in severe mental illness: evidence and recommendations - psychoeducation, social skill training and exercise. Nervenartz 2012; 83: 847-854.
21. Ferrazzi P, Krupa T. Mental health rehabilitation in therapeutic jurisprudence: theoretical improvements. Int J Law Psychiatry 2016; 46: 42-49.
22. Franke I, Vogel T, Eher R, Dudeck M. Prison mental healthcare: recent developments and future challenges. Curr Opin Psychiatry 2019; 32: 342-347.
23. Forchuk C, Solomon M, Viran T. Peer Support. Healthcare Quart 2016; 18: 32-36.
24. Brulin-Solignac D, Bouchard JP, Zanetti A, Bouguin S. Support groups, preventing violence and dangerousness. Soins Psychiatr 2018; 9: 34-37.
25. Strang J, Bird SM, Dietze P, Gerra G, McLellan AT. Take-home emergency naloxone to prevent deaths from heroin overdose. BMJ 2014; 349: 6580.
26. Haviv N, Hasisi B. Prison addiction program and the role of integrative treatment and program completion on recidivism. Int J Offender Ther Comp Criminol 2019; 63: 2741-2770.
27. Arseneault C, Alain M, Plourde C, Ferland F, Blanchette-Martin N, Rousseau M. Impact evaluation of an addiction intervention program in a Quebec prison. Subst Abuse 2015; 9: 47-57.
28. Pelizza L, Zambelli U, Rossi E, Verdoliva G, Maestri D, De Amicis I, Paraggio C, Zaimovic A, Veneri B, Urbani B, Gran Dall'Olio D, Adriani A, Cutrino S, Bertoli S, Paulillo G, Pellegrini P. Mental health interventions in an Italian prison: the Parma integrated approach. Int J Prison Health 2020; DOI: 10.1108/IJPH-07-2020-0046.

Correspondence:
Received: 10 September 2020
Accepted: 23 September 2020
Lorenzo Pelizza c/o Centro "Santi"
Via Vasari n.13 - 43100 Parma (PR) – Italy
Telephone number: +39-0521/396502
Fax number: +39-0521/293482
E-mail: lorpelizza@ausl.pr.it