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Sedated behind bars: the inappropriate use of psychiatric medications in Italy's incarcerated populations

Abstract

The pervasive administration of psychiatric medications within Italy's custodial institutions has evolved into a normalized yet ethically questionable practice, which remains clearly under examined in both clinical policy and public discourse. As global scrutiny intensifies around the long-term effects of psychotropic agents-including metabolic, neurological, and cognitive sequelae—their use in Italian prisons increasingly reflects institutional convenience and inertia rather than therapeutic necessity. This phenomenon is particularly pronounced for immigrant detainees, who endure multiple vulnerabilities stemming from linguistic isolation, cultural misdiagnosis, and systemic marginalization.

Extensive scientific literature underscores the risks associated with prolonged and off-label use of medications such as antipsychotics and benzodiazepines, mainly when prescribed without rigorous oversight or individualized care. Within correctional environments, these substances are frequently utilized as tools of behavioral management-prioritizing sedation over engagement, and containment over rehabilitation.

This author argues that the misuse of psychiatric medications in Italy's detention facilities is not just clinical negligence but a deeper structural and ethical violation. Using epidemiological data, investigative reporting, and clinical vignettes, the analysis reveals how pharmacological practices in detention settings mirror broader patterns of neglect and institutional coercion. The effects are significant, including iatrogenic injury, the erosion of clinical ethics, and the violation of civil liberties.

Urgent reform is necessary. Such reform must include more effective independent oversight, culturally responsive and trauma-informed care, expanded access to non-drug treatments, and full integration of custodial psychiatric services into Italy's national healthcare system. Without these key changes, psychiatry risks becoming part of a control system rather than fulfilling its healing role. This article urges clinicians, policymakers, and human rights advocates to address this overlooked crisis and to reimagine mental health care in custodial settings as both a clinical duty and a moral obligation.

Keywords: custodial psychiatry, psychotropic overmedication, immigrant mental health, ethical reform, institutional racism in forensic care

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Introduction

Pharmacological containment: psychiatry's ethical crisis in detention settings

The convergence of psychiatric care and incarceration in Italy presents an apparent ethical and clinical dilemma. In recent years, prisons have increasingly operated as de facto psychiatric institutions, holding individuals with complex mental health needs-not through deliberate policy or therapeutic investment, but as a consequence of systemic neglect and the erosion of viable alternatives. Following the formal closure of Italy's judicial psychiatric hospitals in 2015, the government introduced REMS (Residenze per l'Esecuzione delle Misure di Sicurezza) as decentralized, community-based alternatives intended to house individuals deemed socially dangerous due to psychiatric conditions. This transition was framed as a progressive move toward deinstitutionalization and rights-based care. However, in practice, the REMS system has struggled to fulfill its mandate. Facilities are chronically under-resourced, unevenly distributed across regions, and lack sufficient capacity to meet clinical and legal demand-resulting in extensive waitlists, delayed admissions, and prolonged detention in inappropriate custodial environments such as jails or general psychiatric wards.[1] These structural deficits have effectively displaced psychiatric responsibility onto correctional institutions, undermining both therapeutic continuity and legal safeguards. The result is a fragmented system in which forensic psychiatric care is inconsistently delivered, and individuals with complex needs are left in limbo-caught between judicial directives and clinical inaccessibility.[1,2]

In these settings, prisons have functioned more as psychiatric containment centers, often lacking the necessary clinical infrastructure, therapeutic objectives, or ethical safeguards. Psychotropic drugs—particularly antipsychotics, benzodiazepines, and sedating antidepressants-are frequently administered not as tailored treatments but as means to control behavior. These drugs are used to calm agitation, ensure compliance, and lower institutional risks, often without thorough diagnostic assessment, informed consent, or ongoing care.[2]

Such practices fundamentally violate psychiatric ethics. The core principles of autonomy, beneficence, non-maleficence, and justice—cornerstones of clinical integrity-are often compromised in detention settings. Autonomy is infringed when individuals are medicated without understanding or consent. Beneficence is undermined when treatment prioritizes institutional convenience over patient well-

being. Non-maleficence is breached when medications are prescribed without monitoring for adverse effects or long-term harm. Justice is undermined when vulnerable populations, especially immigrants, are disproportionately subjected to pharmacological containment.[3]

Immigrant detainees face compounded vulnerabilities within this system. Language barriers, cultural misunderstandings, and legal precarity make them especially vulnerable to psychiatric aggressive practices. Investigative reports have documented the routine use of sedatives in migrant detention centers, often administered without proper evaluation, clinical justification, or legal safeguards.[4] Expressions of distress rooted in trauma, displacement, or culturally specific idioms are pathologized and medicated instead of understood and supported. This racialized use of psychiatry reflects a broader pattern of exclusion—where immigrant bodies are managed through medication rather than care.[5]

The scientific literature now provides strong evidence about the long-term effects of psychotropic medications. Chronic use of antipsychotics has been associated with metabolic syndrome, extrapyramidal symptoms, and cognitive impairment.[6] Benzodiazepines, when used without proper oversight, can cause dependency, emotional blunting, and withdrawal syndromes.[7–10] These risks become even greater in custodial settings, where monitoring and treatment options are limited.

Despite the seriousness of these issues, the psychiatric treatment of incarcerated individuals in Italy remains a neglected topic in both public discourse and clinical policy. This article seeks to address the limited discussion on the subject. Using epidemiological data, clinical vignettes, investigative journalism, and policy analysis, it highlights the misuse of psychiatric medications in Italy's prisons and detention centers. It argues that reform is not only necessary but also urgent. Psychiatry must restore its ethical foundation and refocus on healing, dignity, and justice. Anything less risks turning a healing profession into an instrument of punishment.

The landscape of custodial care: numbers that speak

Italy's prison system is not only overcrowded but also structurally unprepared to address the psychiatric needs of its inmates. As of June 2025, the inmate count stood at 62,728, while the official capacity was 51,276, with over 11,452 beds unavailable due to infrastructure decay. This results in an actual overcrowding rate of 134.3%, with 62 institutions exceeding 150% and eight surpassing 190.0%.[11] Chronic congestion worsens stress, interpersonal conflicts, and psychological decline, creating conditions where psychiatric symptoms are both triggered and worsened.[2,11]

Mental illness is widespread: an estimated 12–15% of inmates have a formal psychiatric diagnosis, although the actual prevalence is likely higher due to underreporting and diagnostic gaps. Some facilities see up to 70% of inmates on psychotropic medications—often without personalized treatment plans, therapeutic oversight, or proper follow-up.[11] A national review by the Council of Europe's CPT found that off-label use is common, documentation is inconsistent, and clinical justification is often missing—especially in CPRs and high-security facilities.[2,5] These numbers suggest a system where medication is used not only as a clinical tool but also as a means to control behavior.[4]

The misuse of pharmacologically induced sedation in migrant detention centers (CPRs) has been documented by investigative journalists and human rights monitors, revealing patterns of pharmacological containment without consent or clinical oversight.[4,5] These practices raise serious ethical concerns, especially when viewed through the lens of Beauchamp and Childress's principles of biomedical ethics-autonomy, non-maleficence, beneficence, and justice—which are routinely violated in carceral psychiatric settings.[3]

Suicide rates further highlight the severity of the crisis. In 2024, 91 suicides were recorded in Italian prisons, the highest annual number ever documented.[2] By mid-2025, an additional 33 suicides had occurred, showing a worsening trend.[11] A systematic review by Fazel et al.,[9] found that suicide rates among incarcerated people are two to six times higher than in the general population.[8] The World Health Organization's 2022 prison health report also identifies suicide as the leading cause of death in European prisons, followed by COVID-19 and overdose.

Psychiatric staffing remains critically low, averaging less than seven hours per week for every 100 inmates, with many facilities lacking full-time psychiatric staff altogether.[2,11] The closure of judicial psychiatric hospitals and the limited capacity of REMS facilities have further shifted psychiatric responsibilities to general prisons, where infrastructure and staffing levels are insufficient to meet clinical needs.[1]

Pharmacological interventions in these settings pose risks. Antipsychotics are linked to significant metabolic and cognitive side effects, mainly when prescribed without a precise diagnosis or ongoing monitoring.[6]

Benzodiazepines, often used in CPRs, have a high risk of dependence and withdrawal issues, particularly in individuals with trauma histories.[7]

These data reveal more than just logistical flaws-they expose a systemic neglect of psychiatric responsibility. In such situations, the overuse of psychotropic medications becomes not only predictable but also unavoidable, as institutions turn to pharmacological solutions for systemic issues they cannot address. The UN's Nelson Mandela Rules explicitly state that healthcare in prisons must uphold the same ethical and professional standards as in the community, and that solitary confinement and pharmacological restraint should never replace clinical care (Table 1).[10]

Table 1 Key indicators of psychiatric strain in Italian prisons (2024–2025)

Indicator	Value	Reference(s)
Total incarcerated population	>62,000	11
Official prison capacity	~51,000	11
Overcrowding rate	~134%	11
Inmates with psychiatric diagnoses	12–15%	11
Inmates receiving psychotropic medications	Up to 70% in some facilities	2,5,11
Suicides in 2024	91	2
Suicides by mid-2025	33	11
Psychiatric staffing (per 100 inmates/week)	<7 hours	2,11

Sedation as strategy: when medication replaces meaning

In the absence of adequate psychiatric infrastructure, psychotropic medications have become the default institutional response to distress, agitation, and behavioral nonconformity. Inmates frequently report being medicated to "calm down," "sleep through the sentence," or "avoid trouble"-phrases that reflect not therapeutic engagement, but institutional pacification.[11] These accounts, echoed in WHO's regional prison health report, suggest that sedation has become a substitute for

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care in environments where psychiatric staffing is critically low and individualized treatment is rare.[9]

The medications most commonly used—antipsychotics, benzodiazepines, and sedating antidepressants-are powerful drugs with serious side effects. When prescribed without careful diagnosis or medical supervision, they can reduce cognition, dull emotional responsiveness, and hinder recovery efforts.[6–8] These effects are not accidental; they are often the desired result in settings where sedation is prioritized over recovery. The Ashton Manual warns that benzodiazepines, in particular, pose high risks of dependence, withdrawal issues, and long-term cognitive problems when used chronically or without proper tapering protocols.[7]

A review cited in the Council of Europe's CPT findings highlighted the ethical risks of psychopharmacology in correctional settings, noting that off-label prescribing is widespread and often undocumented.[2] Other recent audits and investigative reports confirm that prescribing practices in Italian prisons and CPRs frequently lack transparency, clinical justification, and follow-up care.[4,5] Medications are often started without a thorough psychiatric evaluation, and dosage adjustments are made based on institutional behavior rather than clinical need.[2,4,5]

This substitution of sedation for care undermines the very foundations of psychiatric practice. It transforms medication from a therapeutic intervention into a disciplinary tool-eroding trust, violating autonomy, and foreclosing the possibility of meaningful recovery. Ethical psychiatric care must uphold the principles of autonomy, beneficence, non-maleficence, and justice-principles routinely compromised in carceral settings.[3] The Antigone Association's 2025 report further documents how psychotropic use in Italian prisons often functions as a mechanism of containment rather than healing.[11]

The ethical tension between care and control in forensic psychiatry must be actively managed, not passively accepted. When sedation becomes a tool of institutional power, it risks blurring the line between clinical judgment and custodial convenience. This blurring is increasingly evident in Italy's penal system.[13] International human rights law affirms that incarcerated individuals retain full rights to health care, and that coercive pharmacological practices may amount to cruel, inhuman, or degrading treatment (Table 2).[12–14]

Table 2 Characteristics of psychotropic use in Italian prisons

Characteristic	Description	Reference(s)
Commonly used medications	Antipsychotics, benzodiazepines, sedating antidepressants	1–7,11
Prescribing rationale	Behavioural control, sedation, institutional management	1–5,11
Evaluation practices	Often absent or superficial; rarely individualized	2–5,11
Documentation quality	Frequently lacking; off-label use poorly recorded	2,4,5,11
Intended outcomes	Emotional suppression, compliance, pacification	1–8,11
Ethical concerns	Violations of autonomy, beneficence, non-maleficence, justice, and human rights	1–5,9–14

Clinical fallout: the cost of coercive psychiatry

The consequences of inappropriate psychotropic use in prisons are both immediate and long-term. Physiologically, incarcerated individuals may suffer from metabolic syndrome, extrapyramidal symptoms, and withdrawal syndromes—conditions that are often unrecognized or untreated in custodial settings.[6,7] Psychologically, they may experience emotional blunting, dependency, and a profound loss of agency, especially when medications are administered without diagnostic clarity or therapeutic oversight.[5,11]

One of the most harmful effects is diagnostic overshadowing-a phenomenon where behavioral symptoms are wrongly attributed to psychiatric labels, hiding underlying trauma or substance use histories. Inmates with complex clinical profiles are often categorized simply, and their distress is medicated rather than investigated.[9,15] This results in misdiagnosis, overmedication, and neglect of conditions that require careful, trauma-informed care.

Informed consent is often missing. People say they get medications without explanation, without knowing of side effects, and without the chance to refuse.[5] This goes against the principle of autonomy and makes psychiatric care feel coercive. As Beauchamp and Childress highlight, ethical care should be based on respect for autonomy, beneficence, and justice—principles that are often ignored in correctional settings.[3]

Transfers, administrative delays, and lack of integrated health records also disrupt continuity of care. These systemic gaps lead to abrupt medication discontinuation, increased relapse risk, and greater vulnerability to suicide and self-harm.[8,11] The WHO and UNODC have repeatedly warned that such disruptions violate international standards for prison health and may constitute cruel or inhumane treatment.[9,10,14]

These harms are not theoretical-they are documented, recurring, and preventable. They reflect a system that has abandoned its ethical mandate and replaced clinical judgment with institutional expediency. As Lines argues, the right to health in detention is not aspirational-it is a binding legal obligation under international human rights law.[12]

Vignettes from custodial clinics: illustrating systemic patterns

To understand the human cost of coercive psychiatry, one must move beyond statistics and into the lived experiences of those subjected to it. The following vignettes are composite illustrations, drawn from investigative journalism, clinical literature, and firsthand accounts. Though anonymized, they reflect documented patterns across Italy's prisons and migrant detention centers-where sedation often replaces care, and pharmacological control substitutes for therapeutic engagement.

Ahmed, a 27-year-old Tunisian man, was detained in a CPR after overstaying his visa. Following a peaceful protest over food conditions, he was forcibly medicated with a sedative antipsychotic. No psychiatric evaluation was documented, and no consent was obtained. He described feeling "foggy" and "unable to think clearly" for weeks. His requests for legal counsel and medical review were ignored.[4,5] The CPT's 2024 report confirms that such practices-forced sedation without clinical oversight—are widespread in migrant detention facilities.[2]

Giulia, a 42-year-old woman with a history of trauma and prior psychiatric care, was incarcerated for a minor theft. Within days, she was prescribed three psychotropic medications she had never taken before. Her requests for psychotherapy were denied due to staffing shortages. After being placed in isolation for "noncompliance," she attempted suicide. Her care plan consisted solely of medication adjustments, with no psychological support or trauma-informed

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intervention.[3,11] The WHO's 2022 prison health report identifies suicide as the leading cause of death in European prisons, often linked to untreated trauma and lack of therapeutic alternatives.[9]

Marco, a 19-year-old with ADHD and a history of substance use, was administered high-dose benzodiazepines to "manage agitation." He quickly developed tolerance and dependence. Upon transfer to another facility, his medications were abruptly discontinued, resulting in withdrawal seizures and emergency hospitalization. No continuity of care was provided, and no psychiatric follow-up was arranged.[7,8] The Nelson Mandela Rules explicitly prohibit such disruptions, affirming that incarcerated individuals must receive care equivalent to community standards.[10]

These vignettes are not anomalies; they reflect a system in which medication is used as a means of containment rather than a means of healing. They demonstrate the ethical failure of psychiatric practice in carceral settings—where informed consent is often bypassed, diagnostic thoroughness is lacking, and continuity of care is broken by institutional turnover. As Sirdifield et al.,[15] emphasize, most prison mental health assessments fail to address the complexity of inmate needs, especially among neurodivergent and trauma-exposed groups. And as Lines reminds us, the right to health in detention is not optional-it is a legal obligation under international law.[12]

Immigrant detainees: psychiatry and the politics of exclusion

Among the most neglected and vulnerable populations in Italy's prison and detention systems are immigrants-individuals whose legal status, cultural background, and social marginalization render them disproportionately subject to psychiatric intervention. Their experiences reveal a disturbing pattern: psychiatry is not deployed to heal, but to manage, suppress, and contain. This is not merely a clinical oversight-it is a manifestation of institutional racism embedded in custodial logic.[2,4,5,14–16]

By 2025, foreign nationals make up approximately 32% of Italy's prison population, despite accounting for only around 9% of the overall population.[16] This disproportion is intentional. It reflects wider patterns of criminalization, racial profiling, and systemic exclusion that push immigrants into punitive institutions rather than supportive ones. In these facilities, psychotropic medications are often used as tools of control-administered to suppress agitation, enforce compliance, and neutralize protests.[5,14]

Investigative journalism and human rights reports have documented the routine use of sedatives in migrant detention centers, often administered without proper psychiatric evaluation, informed consent, or legal oversight. These medications are usually prescribed in response to behavioral expressions of distress rather than clinical diagnoses, reflecting a pharmacological approach to containment rather than care.[5,11,14]

The lack of culturally competent psychiatric services worsens the problem. Evaluations are often done without interpreters, and clinicians frequently lack training in cross-cultural psychiatry.[12,17,18] As a result, symptoms rooted in trauma, displacement, or culturally specific idioms are often labeled as abnormal and medicated. For example, expressions of spiritual distress, somatic complaints, or culturally specific grief may be mistaken for signs of psychosis or mood disorders.[11–14,16–21] This results in misdiagnosis, overmedication, and the overlooking of cultural context in clinical decisions.

Institutional racism is further reflected in the lack of legal safeguards for immigrant detainees. Many are unaware of their rights, lack access to legal counsel, and face language barriers that prevent them from challenging medical decisions.[11,13] The result is a system where psychiatric intervention is not negotiated but imposed-where immigrant bodies are rendered passive recipients of pharmacological control.[11–14,16–26]

The consequences are profound. Medications administered without consent or cultural understanding can lead to emotional blunting, dependency, and long-term cognitive impairment.[2,7,8,11,27–34] In some cases, detainees are discharged from detention centers with no follow-up care, no medical records, and no understanding of the medications they have been taking.[2,5,11,13,17,35] This discontinuity not only jeopardizes their health but also reinforces a cycle of neglect and invisibility.

Despite these realities, the psychiatric treatment of immigrant detainees remains largely absent from public discourse and policy reform. Few studies have examined the intersection of migration, incarceration, and psychiatry in Italy, and even fewer have proposed concrete solutions.[1,2,4,11,12,14,16,17] This silence is itself a form of institutional violence-a refusal to acknowledge the suffering of those deemed politically and socially expendable.

To address this crisis, reform must begin with recognition. Psychiatry must confront its complicity in systems of racialized control and reorient itself toward culturally congruent, rights-based care. This includes:

a) Mandating the presence of certified interpreters during psychiatric evaluations.[12]

b) Training clinicians in cross-cultural diagnosis and trauma-informed care.[12,13,17]

c) Establishing legal safeguards to protect immigrant detainees from coercive treatment.[11]

d) Creating oversight mechanisms to monitor prescribing practices in detention centers.[1,2,11,12,14]

e) Integrating prison and detention psychiatry into broader public health systems to ensure continuity of care.[13]

Without these changes, psychiatry risks continuing the very forms of exclusion it claims to oppose. The immigrant detainee is not just a patient in need of medication-they are a person whose dignity, culture, and rights must be upheld. Anything less is not care-it is confinement.

Structural violence and the illusion of reform

Italy's prison psychiatry operates within a framework of structural neglect, where institutional bureaucratic inertia and disciplinary logic come together to cause harm often disguised as care. The 2015 closure of judicial psychiatric hospitals was seen as a progressive move toward deinstitutionalization. In their place, REMS (Residenze per l'Esecuzione delle Misure di Sicurezza) were created to provide therapeutic options for individuals considered socially dangerous due to psychiatric conditions.[1] However, REMS facilities remain chronically underfunded, unevenly spread across regions, and unable to meet demand. As of late 2024, over 600 people with court-mandated REMS placements were on waiting lists, with average stays exceeding 700 days—far beyond therapeutic norms.[19]

This failure has left custodial institutions to absorb the psychiatric burden without the infrastructure, staffing, or ethos of care required. Many facilities operate at over 120% capacity, with some exceeding 150%.[1,2,4,11,14,16]

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Psychiatric staffing averages less than seven hours per week per 100 inmates,[11] rendering meaningful evaluations, continuity of care, and therapeutic engagement nearly impossible. Isolation cells—often used to manage psychiatric crises-are punitive, unsanitary, and psychologically damaging.[1,2,4,5,11]

The absence of structured therapeutic programs means that medication becomes the default intervention. Inmates are rarely offered psychotherapy, trauma-informed care, or rehabilitative activities.[1,2,4,9,11,14,16,17,20] Instead, psychotropic drugs are used to suppress symptoms, manage behavior, and maintain institutional order.[2,4,6,11,26,27] This pharmacological containment is not reform-it is a clinical and ethical retreat. It reflects a system that has abandoned its therapeutic mandate and replaced psychiatric judgment with custodial expediency.

Prescribing practices in Italian prisons often lack transparency, clinical justification, and follow-up care.[1,2,4,11,12,14,17]

The ethical tension between care and control, central to forensic psychiatry, is routinely resolved in favor of institutional convenience.[1,2,4,11,13] As several authors have argued, this dynamic is especially pronounced in facilities housing marginalized populations, where psychiatric intervention becomes a tool of exclusion rather than support.[11–14]

The illusion of reform is sustained by bureaucratic language that masks coercion with clinical terminology. REMS facilities, though framed as therapeutic, often function as bottlenecks in a fragmented system where judicial mandates collide with regional health limitations.[19] Without structural reform-one that includes investment in staffing, community-based alternatives, and oversight of psychiatric practices-the cycle of containment will persist.

Psychiatry must confront its complicity in this system and reclaim its ethical foundation. Anything less risks perpetuating harm under the banner of healing.

Toward a rights-based psychiatry: reform and clinical responsibility

To restore dignity and clinical integrity to Italy's prison psychiatry, reform must be structural, evidence-based, and ethically grounded. It must address not only the misuse of medications but the conditions that make such misuse inevitable. The following framework outlines key components of reform, each rooted in clinical necessity and human rights.

Oversight and accountability

Psychiatric prescribing in custodial settings must be subject to independent scrutiny. Without oversight, off-label use, polypharmacy, and coercive practices flourish unchecked.

a) Establish independent psychiatric review boards with legal authority to audit prescribing patterns, investigate abuses, and publish transparent reports.[10,11] These bodies should include clinicians, ethicists, and formerly incarcerated individuals to ensure accountability from multiple perspectives.

b) Mandate comprehensive documentation for all psychotropic prescriptions, including diagnosis, rationale, informed consent status, and follow-up plans.[2,12] This ensures traceability and protects against arbitrary or punitive prescribing.

c) Implement pharmacovigilance systems across facilities to monitor adverse effects, drug interactions, and prescribing trends.[6–10] These systems are standard in hospitals and must be extended to custodial environments.

d) Culturally competent and trauma-informed care

Immigrant detainees and marginalized populations require care that respects their cultural identities and trauma histories. The current system pathologizes difference and medicates distress.

a) Recruit multilingual psychiatric staff and certified interpreters to ensure accurate diagnosis and informed consent.[5,12,17] Without access to language, clinical encounters can become coercive.

b) Require training in cross-cultural psychiatry and trauma-informed care for all prison clinicians.[12,17,18] This includes understanding migration-related trauma, cultural idioms of distress, and the impact of systemic racism.

c) Develop culturally congruent diagnostic frameworks that avoid mislabeling culturally normative behaviors as pathology.[13,18] This protects against overmedication and misdiagnosis.

Expansion of non-pharmacological interventions

Medication should never be the only option. A therapeutic environment requires a diverse range of modalities that foster autonomy, resilience, and recovery.

a. Guarantee weekly access to psychotherapy for inmates with psychiatric diagnoses.[3,20] This must include individual and group formats, tailored to trauma, addiction, and mood disorders.

b. Fund peer support programs and expressive therapies such as art, music, and writing.[10,20] These interventions reduce isolation and promote emotional regulation.

c. Promote structured rehabilitative activities that build skills, community, and self-efficacy.[14,20] This includes vocational training, mindfulness, and restorative justice circles.

Continuity of care and system integration

Psychiatric care must not end at the prison gate. Discontinuity leads to relapse, hospitalization, and preventable death.

a) Create interoperable electronic health records linking prison, REMS, and community services.[10,19] This ensures that clinicians have access to accurate histories and treatment plans.

b) Require discharge planning and community referrals for all inmates receiving psychiatric treatment.[10,15] This includes coordination with local mental health centers and social services.

c) Deploy mobile mental health units to provide transitional support post-release, especially for high-risk individuals.[10,15] These teams can prevent crises and support reintegration.

Legal safeguards and human rights protections

Incarcerated individuals must retain the right to participate in decisions about their care. Psychiatry must not become a tool of punishment.

a) Codify the right to refuse psychotropic medication, except under judicially authorized emergency protocols.[14] This affirms autonomy and protects against coercion.

b) Ensure access to legal counsel trained in health rights and psychiatric ethics.[12,14] Legal advocates can challenge inappropriate treatment and uphold informed consent.

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c) To ensure transparency and accountability in custodial psychiatric care, active partnerships among NGOs (non-governmental organizations), consumer advocacy groups, and international oversight bodies should be established to conduct periodic human rights audits of prison mental health practices.[11,14] These audits should evaluate not only clinical standards and access to care but also the use of psychotropic medications, conditions of confinement, and respect for patient autonomy. Although this occurs to some extent, the efforts are not truly sufficient, as stated throughout the article.

Safe tapering and withdrawal protocols: a scientific and ethical imperative

One of the most overlooked aspects of prison psychiatry is the absence of structured withdrawal pathways. Inmates are frequently medicated with high-dose psychotropics-antipsychotics, benzodiazepines, antidepressants—during incarceration, only to be released or transferred without any plan for discontinuation. This practice is not merely clinically reckless-it is ethically indefensible.[20]

Abrupt cessation of psychiatric medications can precipitate severe withdrawal syndromes: seizures, psychosis, suicidality, autonomic instability, akathisia, and cognitive disruption.[20–24] These risks are magnified in prison environments, where monitoring is minimal, documentation is inconsistent, and therapeutic support is scarce.[3,11,24,25]

Extensive psychiatric literature underscores the need for gradual tapering, individualized withdrawal plans, and close clinical supervision. Withdrawal symptoms are routinely misdiagnosed as relapse, leading to unnecessary reinstatement and polypharmacy.[24–26] Abrupt cessation of psychiatric drugs can cause profound neurological and emotional destabilization, often mistaken for underlying pathology.[25–27] Influential researchers have called for global reform, citing the iatrogenic harm caused by poorly managed psychotropic withdrawal and the systemic denial of its severity.[17,27,28,35]

Additionally, researchers have developed evidence-based hyperbolic tapering models, demonstrating that receptor occupancy declines non-linearly and that slow, individualized withdrawal is crucial to prevent destabilization.[28]

Additional work has documented thousands of cases of protracted withdrawal, challenging the notion that antidepressants are benign or easily discontinued.[29] Other influential authors have further exposed the psychiatric establishment's failure to acknowledge withdrawal syndromes.[30–33]

International guidelines-including those from NICE and the World Health Organization-now recommend slow, patient-centered tapering strategies for psychiatric medications, particularly those with high dependency potential.[24,34] These protocols are essential not only for safety but for preserving dignity and autonomy in vulnerable populations.

In Italy's prisons, such protocols are virtually nonexistent.[1,2,4,5,11,19] Inmates are transferred or released without any plan for medication discontinuation, and community services are rarely informed of their psychiatric history.[17,19]

This discontinuity increases the risk of relapse, hospitalization, suicide, and iatrogenic injury, especially among immigrants and detainees with trauma histories.[5,17,36] In addition, withdrawal management must be embedded in a recovery-oriented, culturally congruent framework—especially in carceral settings where coercion and containment often masquerade as care.[36] Without such safeguards, psychiatry risks becoming a tool of institutional control rather than a practice of healing.

Reform must include:

a) Mandatory tapering protocols for all inmates prescribed psychotropic medications, tailored to drug class, duration, and individual risk factors. These protocols must be evidence-based, trauma-informed, and aligned with international best practices.[21–25]

b) Clinical training for prison staff on withdrawal management, risk mitigation, and patient communication. Staff must understand the physiological and psychological dimensions of withdrawal, including the risks of abrupt cessation and the signs of emerging complications.[25–28]

c) Integration of withdrawal planning into discharge procedures, with referrals to community mental health services, peer support networks, and follow-up appointments. This ensures continuity and reduces harm during the vulnerable post-release period.[25–33]

d) Use of validated assessment tools for psychiatric symptom monitoring and tailored withdrawal scales for psychotropics. These tools help guide tapering decisions and ensure clinical responsiveness.[21–28]

e) Legal safeguards to prevent forced withdrawal or punitive discontinuation, especially in disciplinary contexts. Withdrawal must be a therapeutic process-not a mechanism of control.[32,33]

f) Inclusion of patient voice in withdrawal planning, with informed consent and shared decision-making. Respecting autonomy is not optional-it is a clinical and ethical mandate.[25–34,36]

Conclusion: reclaiming psychiatry as a practice of justice and humanity

The psychiatric treatment of incarcerated individuals in Italy stands at a moral and clinical crossroads. What has emerged from this analysis is not merely a pattern of inappropriate prescribing, but a systemic failure to uphold the ethical foundations of psychiatric care. In prisons and migrant detention centers, psychotropic medications are routinely used to suppress distress, enforce compliance, and manage institutional risk-often without informed consent, diagnostic rigor, or continuity of care.[2,5,11,12,14,18,19]

This is not care. It is containment. And it reflects a more profound societal truth: how we treat those in confinement reveals the values we hold beyond the prison walls. As Dostoevsky wrote, "The degree of civilization in a society can be judged by entering its prisons".[37] In Italy today, that judgment is sobering.

The overmedication of inmates especially immigrants exposes the convergence of institutional racism, clinical neglect, and bureaucratic expediency.[5,17,18] It is a practice that not only violates psychiatric ethics but also undermines the possibility of rehabilitation, recovery, and reintegration.[3,13,14,20] The absence of culturally competent care, trauma-informed services, and safe withdrawal protocols compounds this harm, leaving vulnerable individuals medicated into silence and discharged into uncertainty.[7,8,15,18]

Yet this crisis is not irreversible. Reform is possible and necessary. A rights-based approach to prison psychiatry must be grounded in structural accountability, clinical integrity, and humanitarian values. It must include:

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a) Independent oversight of prescribing practices and psychiatric evaluations.[10–12]

b) Culturally congruent care for immigrant populations, with interpreters and cross-cultural training.[5,12,17,18]

c) Expansion of non-pharmacological interventions, including psychotherapy, peer support, and expressive therapies.[3,10,20]

d) Integration of prison psychiatry into the national health system to ensure continuity of care.[9,10,15,19]

e) Legal safeguards to protect autonomy and prevent coercive treatment.[12,14]

f) Scientifically grounded tapering and withdrawal protocols to prevent iatrogenic harm.[21–34]

These reforms are not optional they are urgent. They represent the minimum ethical threshold for any system that claims to provide psychiatric care. They are a moral imperative for a society that seeks to uphold dignity, justice, and compassion in its institutions.[38,39]

Individuals in custody are not beyond the reach of care. They are not problems to be managed, but people to be understood. Their suffering is not a justification for sedation—it is a call for healing. Unfortunately, studies across European prison systems have documented the overuse of psychotropic medications as a substitute for meaningful therapeutic engagement, often without informed consent or continuity of care.[1,2,4,40,41]

Psychiatry must reclaim its role not as a tool of control, but as a practice of liberation—one that resists the normalization of chemical restraint and affirms the right to recover with autonomy and support.[42–49]

Coercive medication practices in forensic psychiatry often blur the line between treatment and punishment, undermining both clinical integrity and human rights. The situation calls for a paradigm shift toward recovery-oriented care in prisons, emphasizing the need to replace containment with connection.[42–49]

To fulfill its therapeutic mandate rather than reinforce systems of control, psychiatry must undergo structural transformation. Reform must include robust and independent oversight mechanisms, the adoption of culturally responsive and trauma-informed care models, and the systematic expansion of non-pharmacological interventions within custodial settings. Crucially, psychiatric services in prisons must be fully integrated into Italy's national healthcare system-ensuring continuity, accountability, and clinical parity. Without these foundational shifts, the field risks perpetuating harm under the guise of treatment, rather than advancing recovery, dignity, and justice for those confined.

This article is an appeal to clinicians, policymakers, researchers, and advocates: let us make every effort to transform Italy's prison psychiatry into a system that reflects the best of our science and the deepest of our humanity. Let us ensure that those who suffer behind bars are not forgotten, but cared for-with rigor, respect, and resolve.

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