The sentence is not sickness: a case for health-centered justice in Europe

Across Europe, prisons have become ground zero for a growing mental health crisis; one that reflects not only the vulnerabilities of those incarcerated but also the failures of public institutions. Despite longstanding international obligations, mental health care in detention remains insufficient.[1] The consequences range from limited access to essential treatment to suicide, which continues to be an alarmingly frequent cause of death.

This report explores how European penal systems have come to absorb the burden of unmet mental health needs, often functioning as default psychiatric institutions without the capacity or mandate to provide adequate care. It examines the legal frameworks and governance failures that perpetuate this crisis.

Detention houses offer a viable replacement by promoting small-scale, differentiated, and community-integrated forms of detention. This ecosystem-based approach recognizes health as an independent priority rather than a peripheral concern. The wellbeing of people in detention is a matter of public health and should be governed as such.

The mental health crisis of European prisons

The state of mental health within European penal institutions is a critical and often overlooked dimension of public health, although over 1,5 million individuals are imprisoned across the European region on any given day.[2] While the general population grapples with mental health challenges, the prevalence and severity of these issues are dramatically amplified in the prison environment.

According to the World Health Organization's (WHO) Health in Prisons European Database (HIPED), roughly one in three people in detention (32,8%) live with a mental health condition, though this is likely underestimated due to underreporting.[3] By contrast, in the general population of the European Union, only about one in six individuals is affected by a mental health condition.[4]

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[1] The scope of this report encompasses prisons and where appropriate, detention facilities. For the purpose of this report, the latter refers to facilities where individuals serve sentences involving the deprivation of liberty. The following settings do not fall under the scope of this report: juvenile detention centers, police stations, immigration holding centers, psychiatric hospitals, social care homes, etc.

[2] Although it is estimated that 6 million people are incarcerated every year in the WHO European Region. See World Health Organization (February 2023). Status report on prison health in the WHO European Region, XI.

[3] World Health Organization. (s.d.). Health in Prisons European Database (HIPED). Retrieved October 8, 2025 from https://www.who.int/data/region/europe/health-in-prisons-european-database-(hiped). For this purpose, the World Health Organization defines mental health conditions as depression, bipolar affective disorder, schizophrenia and other psychosis, dementia, and developmental disorders, including autism.

[4] European Commission. (June 2023). Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on a comprehensive approach to mental health (COM(2023) 298 final), 1.

Perhaps the most tragic and clearest signal of system failure is suicide. It is consistently the leading cause of death in custody across Europe (14%). In addition, the mortality rate after release is significantly higher than in the general population, especially within the first month, largely due to preventable causes such as suicide and drug overdose.[5]

Women in detention in particular are disproportionately affected by mental health conditions. They represent a fast-growing segment of the prison population and are heavily impacted by adverse social determinants of health, such as domestic violence, sexual abuse, trauma, difficult childhood experiences, homelessness, substance use, and mental illness.[6]

It is no coincidence that mental health conditions are overrepresented in prisons

It is no coincidence that mental health conditions are disproportionately common in prisons. Their prevalence reflects a convergence of social, systemic, and institutional forces that shape both health and incarceration. The risk factors that contribute to poor health coincide with those that increase the likelihood of incarceration, including substance use, unstable housing, and low educational attainment.[7]

In some cases, behaviors arising from untreated mental illness lead directly to criminal charges; in others, structural disadvantages, such as inability to pay fines, result in incarceration for minor offenses. In both cases, societal responses often criminalize mental illness, treating mental health conditions as legal issues rather than providing appropriate care.

The relationship between mental health conditions and incarceration had already been observed as early as 1939 by Lionel Penrose. Penrose's Law describes an inverse relationship between psychiatric hospital capacity and prison populations: as the number of psychiatric beds declines, the number of incarcerated people rises.

When mental health services are underfunded, prisons take their place, absorbing individuals who might otherwise have received treatment. This process, called transinstitutionalization, transforms prisons into de facto mental health facilities, albeit ones designed for confinement rather than care.[8] Yet prisons are profoundly ill-suited to serve this role. The prison environment is utterly counter-therapeutic: overcrowding, constant noise, unsafe conditions, and the absence of privacy or safety continuously erode mental health.[9]

The use of solitary confinement is an extreme and particularly harmful example of a punitive measure that actively exacerbates psychiatric conditions, with disproportionate numbers of mentally ill individuals placed in these restrictive settings. The conditions in these units, characterized by the absence of social

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[5] World Health Organization. (February 2023). Status report on prison health in the WHO European Region, 39.

[6] *Ibid.*, 3. See also Caccia, E. (May 2025). Women in detention: Challenges and new approaches.

[7] Council of Europe. (May 2022). Prisons and probation: a Council of Europe White Paper regarding persons with mental health disorders (PC-CP (2021) 8 Rev 6).

[8] Schildbach, S., & Schildbach, C. (October 2018). Criminalization Through Transinstitutionalization: A Critical Review of the Penrose Hypothesis in the Context of Compensation Imprisonment.

[9] MacDonald, M. (June 2018). Overcrowding and its impact on prison conditions and health. Council of Europe. (February 2019). Organisation and management of health care in prison, 37.

interaction and physical stimulation, can lead to psychosis, paranoia, and a dramatically increased risk of suicide.[10]

The overrepresentation of people with mental health conditions in prisons is therefore the product of both upstream social inequalities and downstream institutional practices. It reflects systemic gaps in mental health care, social support, and criminal justice policy, as well as the inherently harmful effects of the prison environment.

The right to health is a fundamental right

The overrepresentation of mental illness in prisons is not accidental; it is the result of systemic neglect, both before and during incarceration. Yet even within these harmful environments, the fundamental right to health remains inalienable. The law does not, and must not, bend to accommodate societal indifference or institutional failure.

Still, a dominant belief today is that incarceration is a form of deserved suffering, where deprivation of liberty is conflated with deprivation of dignity. This retributive mindset fuels the idea that people deprived of their liberty should endure hardship. But the sentence is confinement, not cruel and degrading treatment in the form of medical neglect. The loss of freedom does not strip a person of their fundamental rights.

The right to health applies equally to those in detention and those in the community. This is affirmed by the principle of equivalence, which holds that healthcare provided in detention must meet the same standards as care available outside. Deprivation of liberty cannot justify inferior treatment: people in custody must have access to necessary medical services without discrimination based on their legal status.[11]

Although the European Convention on Human Rights (ECtHR) does not expressly guarantee a "right to health," the European Court of Human Rights has, over recent decades, interpreted Article 3 European Convention on Human Rights (ECHR), which prohibits torture and inhuman or degrading treatment, as a legal safeguard for protecting the health and well-being of people in detention.

Consequently, a positive obligation weighs on States to protect the physical integrity of people deprived of freedom. The absence of adequate medical care in such a situation should be qualified as inhuman treatment. In *Kudła v. Poland* (2000), the Court declared for the first time that liberty deprivation must not jeopardize health. States are obliged to provide the requisite medical assistance and ensure conditions compatible with human dignity.[12]

It marked a shift towards viewing health in line with the WHO's holistic definition: a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. From this

[10] World Medical Association. (October 2019). Statement on solitary confinement.

[11] Council of Europe Committee of Ministers. (April 1998). Recommendation No. R (98) 7 of the Committee of Ministers to member states concerning the ethical and organizational aspects of health care in prison; United Nations. (December 2015). Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), Rule 24; Council of Europe. (June 2006). European Prison Rules (Recommendation REC(2006)2), Rule 40.

[12] Kudła v. Poland, no. 30210/96, 26 October 2000, §94. See also Xiros v. Greece, no. 1033/07, 9 September 2010, which systematized the years of case-law following Kudła.

moment, the Court framed health care in detention as an obligation, not a discretionary privilege: scarce resources or overcrowding cannot justify failing to protect persons in detention's health.[13]

Detention is stressful for anyone, but for those with mental illnesses, it can be devastating. In the jurisprudence of the Court, the negative impact of detention on the health of the persons with psychological conditions is presumed.[14] In *Dybeku v. Albania* (2007), the ECtHR held that treating a person with a mental health condition the same as the rest violated Article 3.[15] In *Rivière v. France* (2006), it required persons with severe disorders to be placed in hospitals with equipped personnel, not ordinary cells where their condition would inevitably deteriorate.[16]

The Court is increasingly scrutinizing not just the conditions of detention, but the very appropriateness of continued liberty deprivation for vulnerable individuals. In *G. v. France* (2012), the Court explicitly stated that the applicant's health was "incompatible with detention", marking a clear shift toward questioning the legitimacy of detention itself when it obstructs medical care.[17]

The *Bamouhammad v. Belgium* judgment (2015) exemplifies this evolution. The applicant, suffering from "prison psychosis," was subjected to extreme security measures that worsened his condition. Despite repeated expert recommendations for alternatives, authorities refused to adapt his sentence. The Court found this refusal amounted to distress exceeding the inherent suffering of detention, breaching Article 3.[18]

Finally, the Grand Chamber in *Murray v. the Netherlands* (2016) reminded that Article 3 may go as far as to impose an obligation on States to transfer incarcerated individuals with mental health conditions to specialized facilities to receive adequate treatment, especially for those serving life sentences. Treatment and a realistic prospect of release must be part of the framework.[19]

Taken together, these rulings raise a larger question: can prisons ever be the right place for people with serious physical or mental illness? While the Court has stopped short of a categorical "no," its judgments increasingly suggest that they are fundamentally ill-suited to medical and psychiatric care.[20]

How European states fail to provide adequate mental healthcare in detention

Despite decades of international guidance, thousands of individuals suffer from mental health conditions that are either untreated, misdiagnosed, or exacerbated by the very systems meant to treat them. Across

[13] Kuznetsov v. Ukraine, no. 39042/97, 29 April 2003, § 128. Dybeku v. Albania, no. 41153/06, 18 December 2007, § 33. Poghossian v. Georgia, no. 9870/07, 24 May 2009, §48. Elefteriadis v. Romania, no. 38427/05, 15 January 2011, §48.

[14] Tulkens, F., & Dubois-Hamdi, C. (April 2015). Prison et santé mentale. La jurisprudence de la Cour européenne des droits de l'homme.

[15] Dybeku v. Albania, No 41153/06, 18 December 2007.

[16] Rivière v. France, no. 33834/03, 11 July 2006, §72.

[17] G. v. France, no. 27244/09, 23 February 2012, §45-48. See also Council of Europe. (July 2020). Appendix to European Prison Rules of 2006 (Recommendation REC(2006)2), §12.1.

[18] Bamouhammad v. Belgium, no. 47687/13, 17 November 2015, §153-155.

[19] Murray v. the Netherlands [GC], no. 10511/10, 26 April 2016, §105-109.

[20] Tulkens, F., & Dubois-Hamdi, C. (April 2015). Prison et santé mentale. La jurisprudence de la Cour européenne des droits de l'homme. For a more complete overview of the case-law, see European Prison Litigation Network. (January 2020). The right to the protection of health guaranteed under Article 3 of the ECHR.

Europe, mental health care in detention remains one of the most neglected aspects of criminal justice policy.

This failure is not incidental; it is structural and deeply embedded in the way health care in detention is governed, resourced, and delivered. As part of the RESIZE project, RESCALED examined the legal and institutional frameworks governing detention in 15 European States, with a focus on how national policies and legal structures influence the functioning of the penal system.[21]

This study revealed many deficiencies in the field of (mental) health governance. These findings echoed the 2023 *World Health Organization's Status Report on Prison Health in the European Region*, which surveyed thirty-nine countries and found widespread non-compliance with international standards of care.[22] Taken together, seven aspects of contemporary European detention policy in the field of mental health care stand out as particularly critical.

1. Governance gaps and poor interinstitutional coordination:

A primary failure in European penitentiary health systems is governance. In most countries, prison health care is managed by the ministry of justice rather than the ministry of health, leading to an institutional conflict between enforcement and care. This undermines the independence and quality of medical services. Expert bodies like the WHO and the Committee for the Prevention of Torture (CPT) advocate transferring prison health care to national health ministries, which better ensure care aligns with public health standards and the principle of equivalence. [23] Yet, few countries have done so.[24]

Where justice ministries oversee prison health, security often overshadows medical needs, forcing health professionals to balance the roles of "prisoner" and "patient." The European Court of Human Rights, in *Cosovan v. Moldova* (2022), found that a lack of independence from custodial authorities resulted in delayed due to a lack of trust, violating Article 3 ECHR.[25] Responsibility is often (unclearly) divided between justice and health ministries. This leads to a lack of accountability and inconsistent standards, especially in mental health screening, suicide prevention, and post-release care.[26]

Ultimately, prison health is a public health matter, as most individuals return to the community and neglected illnesses place additional strain on societal health systems. The persistent lack of integration with national health systems means incarcerated people frequently receive inferior care. Mental health

[21] The countries surveyed were Albania, Austria, Belgium, Bosnia and Herzegovina, Croatia, Denmark, Germany, Greece, Italy, the Netherlands, North Macedonia, Portugal, Romania, Slovenia, and Spain.

[22] World Health Organization. (February 2023). Status report on prison health in the WHO European Region.

[23] World Health Organization, & United Nations Office on Drugs and Crime. (November 2013). Good governance for prison health in the 21st century. A policy brief on the organization of prison health.

[24] These countries include Finland, Italy, Slovenia, the United Kingdom. See World Health Organization. (s.d.). Health in Prisons European Database (HIPED). Retrieved October 8, 2025 from https://www.who.int/data/region/europe/health-in-prisons-european-database-(hiped). Portugal may soon implement this change as well. See Justiça Portugal (April 2024). Apresentado o Plano de saúde para as prisões: Grupo de trabalho propõe a integração no SNS através da transição faseada de competências da Justiça para a Saúde. Retrieved October 8, 2025, from https://justica.gov.pt/Noticias/Apresentado-o-Plano-de-saude-para-as-prisoes).

[25] Cosovan v. Moldova, no. 13472/18, 22 March 2022, §86.

[26] World Health Organization. (s.d.). Health in Prisons European Database (HIPED). Retrieved October 8, 2025 from https://www.who.int/data/region/europe/health-in-prisons-european-database-(hiped).

professionals in prisons are isolated from broader clinical networks, resulting in a fragmented and reactive system. A whole-of-government approach is needed to treat health in detention as a public health responsibility.[27]

2. Chronic understaffing and resource shortages:

Chronic understaffing and resource shortages further undermine penitentiary health governance. Detention facilities are expected to manage some of society's most complex health needs with a fraction of the workforce available in community settings. Despite the high health needs of people in detention, health services are severely under-resourced, with the WHO reporting just over 30 health-care staff, 5 psychologists, and 1,3 psychiatrists per 1.000 persons in detention.[28]

The lack of mental health specialists means general practitioners or undertrained custodial staff often conduct initial screenings, resulting in widespread underdiagnosis and inappropriate treatment. Overburdened staff face unsustainable caseloads, leading to compromised care, professional burnout, and fear of liability.[29] Without significant investment in staffing and resources, the principle of equivalence will remain an empty promise.

3. Lack of infrastructure and inappropriate placement:

Another failure is the persistent placement of people with severe mental health conditions in ordinary prisons rather than in specialized treatment facilities, contrary to the longstanding jurisprudence of the ECtHR. This is most often the result of the lack of appropriate infrastructure: therapeutic facilities such as forensic psychiatric centers are in short supply, and those that do exist are often overwhelmed.

As a result, many individuals with complex psychiatric needs remain in unsuitable environments, where their conditions deteriorate. Addressing these shortcomings requires not only expanding forensic psychiatric capacity but also embedding trauma-informed, therapeutic environments within detention systems. Without such investment, detention facilities will continue to function as ill-equipped holding facilities for people whose primary need is care, not custody.

4. Inadequate screening and care:

Screening and care practices in European prisons are deeply inadequate. Although the European Prison Rules require prompt medical exams after admission, initial psychiatric screenings are inconsistent and often substandard, with 14% of countries failing to screen for severe mental conditions.[30] Untrained staff frequently conduct these assessments, resulting in many individuals with mental health conditions remaining undiagnosed and untreated.

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[27] Council of Europe. (February 2019). Organisation and management of health care in prison, 35.

[28] World Health Organization. (February 2023). Status report on prison health in the WHO European Region, 20.

[29] See for example this testimony by a Belgian psychiatrist (in Dutch), published by the Flemish public broadcaster. VRT. (May 2025). Gevangenisarts: "De medische zorg in gevangenissen is ondermaats". Retrieved October 8, 2025 from https://www.vrt.be/vrtnws/nl/2025/05/07/gevangenisarts-de-medische-zorg-in-gevangenissen-is-ondermaats/.

[30] Council of Europe. (June 2006). European Prison Rules (Recommendation REC(2006)2), Rule 16. World Health Organization. (February 2023). Status report on prison health in the WHO European Region, 25.

Mental health conditions often receive punitive rather than therapeutic responses, such as solitary confinement. Harm reduction and suicide prevention measures are rarely implemented, despite high rates of substance use and suicide. Vulnerable groups -such as women, young adults, and the elderly- face unique challenges, but few systems offer tailored, trauma-informed care.[31] This failure to provide consistent, high-quality screening and appropriate support perpetuates neglect and preventable suffering, especially among the most vulnerable.

5. Uneven access to external services and community partnerships:

Access to external services and community partnerships is uneven and often dependent on local initiative rather than national policy. While some prisons collaborate with NGOs and community-based mental health providers, these partnerships are typically project-based and lack long-term sustainability.

Smaller facilities, particularly in rural areas, often lack any formal partnerships with external providers. In these areas, people are often released without support, increasing the risk of relapse, homelessness, and reoffending. The absence of structured, nationwide frameworks for community engagement means that many individuals fall through the cracks, both during detention and after release.

6. Lack of continuity of care:

The lack of continuity of care is another critical failure. Mental health support often ends abruptly, with no structured handover to community services. While 92% of countries in the WHO European region reported some form of linkage between prison and community health systems, these links are often limited to infectious disease treatment and do not extend to mental health or substance use care.[32]

Individuals with psychiatric conditions are frequently released into the community without medication, referrals, or housing. This absence of continuity places an unreasonable burden on emergency services, shelters, and families. Moreover, it contradicts -once more- the principle of equivalence of care, as continuity of care is a basic patient right.

7. Data deficiencies:

Finally, the absence of robust data undermines accountability. The Health in Prisons European Database (HIPED) represents a milestone, but many countries still fail to collect or report data on key indicators such as prevalence of mental disorders, substance use, or suicide. Standardized data collection and systematic reporting are essential to monitor health outcomes, evaluate policies, and ensure transparency.

The current lack of transparency allows the other systemic failures, from poor screening to inadequate care, to persist without public or legal scrutiny. The system is fundamentally incapable of self-correction because it lacks the foundational information required to identify problems, measure their extent, and assess the impact of any attempted solutions. Without data, evidence-based policy is impossible, and the cycle of neglect continues.

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[31] See also Caccia, E. (May 2025). Women in detention: Challenges and new approaches.

[32] World Health Organization. (February 2023). Status report on prison health in the WHO European Region, 19.

These failures are symptomatic of a system unfit for care

The failure of prisons to safeguard mental health at large is not a coincidence but a structural inevitability of the current penal paradigm. Centralized prisons are built to prioritize security, control, and efficiency at scale. Within this framework, health needs are consistently subordinated to custodial imperatives. This is not a matter of isolated neglect, but the predictable consequence of institutions designed as instruments of containment.

Even as penal systems have shifted rhetorically from punitive to more restorative frameworks, mental health care has remained marginal. It is rarely integrated into the core of operations; instead, it is treated as secondary, offered sporadically, or reduced to crisis management through segregation or medication. Centralization compounds the problem: oversized facilities depersonalize care and isolate services from community health networks.

These institutional incentives, where custody always outweighs care, produce predictable harm. They leave people in detention without adequate treatment, safety, or dignity, and they release individuals back into society in worse condition than before. Far from enhancing public safety, this cycle of neglect and deterioration makes communities more unsafe. If prisons are designed in ways that guarantee the failure of mental health care, simply increasing funding would merely serve as a band-aid.

The RESCALED movement: a health-centered approach

If the failures of centralized prisons are so widespread, the question remains: what is the alternative? Detention houses offer clear benefits, consisting of three core principles: small-scale, differentiation and community-integration. Detention houses demonstrate that incarceration can be organized in ways that safeguard dignity, health, and public safety at the same time. They represent a shift away from punitive, siloed institutions toward a justice system that is restorative and health-promoting.

These ideas are not merely aspirational. Across Europe, hundreds of facilities already embody the principles of small-scale, differentiated, and community-integrated detention. These facilities all emphasize individualized care, strong community links, and multidisciplinary support.[33] These initiatives prove that humane, health-centered detention is not only possible but already working in practice.

Concretely, these three RESCALED principles shape detention as follows:

1. Small-scale:

Detention houses accommodate small groups of residents, typically between 8 and 30 people. This scale transforms detention from a depersonalized, bureaucratic system into a human-centered environment where staff and residents can build meaningful relationships. The small size enables tailored care plans,

[33] For example, Belgium's detention and transition houses, Italy's Residenze per l'Esecuzione delle Misure di Sicurezza (REMS), Spain's PAIEM program, Switzerland's Vollzugszentrum Klosterfiechten, Portugal's Torres Novas, and the Netherlands' Huis van Herstel. For more inspirational practices, see RESCALED. (s.d.). Inspirational practices. Retrieved October 8, 2025, from https://inspirational-practices.rescaled.org/.

flexible daily routines, and trauma-informed practices that simply cannot function in the anonymity of a large prison.

2. Differentiation:

Differentiation ensures that people are placed in facilities tailored to their specific circumstances. This is particularly critical for incarcerated individuals with mental health conditions, who have a right to a differentiated regime under European human rights law. Detention houses can specialize in addressing these needs, with staff trained in relevant approaches.

3. Community-integration:

Detention houses are integrated into local communities, enabling residents to maintain connections with daily life and access local health clinics, community programs, and family support. Such an approach promotes continuity and quality of health care, while reducing isolation and loneliness. [34] This aligns with the WHO's recent call to make social connections a public health priority.[35] In the context of detention houses, promoting community-integration is not just a compassionate ideal but a necessity for addressing individual and societal health risks.

Ecosystems of care and autonomy

The concept of the "ecosystem" helps explain why detention houses succeed where centralized prisons fail. Like natural ecosystems, detention houses depend on balance and interconnection. Rather than isolating care inside custodial walls, they link directly to community health services, ensuring residents remain part of the wider system of treatment and support.

In centralized prisons, these connections are broken. Health services are absorbed into custodial control, separated from broader clinical networks, and subordinated to security priorities. By contrast, detention houses rely on local infrastructures, integrating residents into existing clinics and services, which strengthens both quality and continuity of care. This connection shifts responsibility for mental health from carceral institutions back to health systems.

Seen this way, Penrose's insight is simply an ecological one: if societies neglect investment in mental health, the burden will reappear elsewhere. By embedding detention within broader ecosystems rather than isolating it, detention houses rebalance the system. It recognizes that health and justice cannot be separated, and that sustainable public safety depends on maintaining the health of the whole ecosystem, not overburdening one of its parts.

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[34] Social isolation and loneliness, defined by the World Health Organization as the objective lack of social interactions and the subjective negative feeling from unmet social needs, respectively, are now understood to have profound health impacts, including increased risk of mental health conditions.

[35] World Health Organization. (May 2025). Resolution on fostering social connection for global health: the essential role of social connection in combating loneliness, social isolation and inequities in health (WHA78.9). World Health Organization. (June 2025). From loneliness to social connection: charting a path to healthier societies: report of the WHO Commission on Social Connection.

Conclusion: toward a health-centered justice system

The mental health crisis in European prisons is not a peripheral issue; it is a failure rooted in decades of neglect, misaligned governance, and institutional design that prioritizes control over care. The disproportionate incarceration of individuals with mental health disorders reflects both broader societal inequalities and the shortcomings of current policy frameworks.

Insights presented in this report underscore that the prison environment itself is counter-therapeutic, often worsening the very conditions it purports to address. Centralized, punitive institutions are fundamentally incompatible with the right to health as upheld by the ECtHR. While incremental reforms may offer temporary relief, they fall short of addressing the structural depth of the crisis.

A true shift is needed, one that reimagines detention not as a siloed institution but as part of a broader ecosystem of care. Detention houses offer a viable replacement by breaking from traditional prison models. They prioritize individualized support and adapt to the specific needs of residents, particularly those with mental health conditions.

This ecosystem approach reveals that the boundaries between health care and justice are artificial and counterproductive. When detention is disconnected from clinical and social networks, the system underperforms, and the burden shifts to other sectors ill-equipped to respond. Embedding detention within community infrastructures redistributes responsibility for health, placing it where it can be most effective.

However, the overarching question remains whether incarceration should continue to serve as a response to those in psychological distress. The removal of individuals from their communities should be reserved as a last resort, applied only when neither their safety nor that of the community can be ensured through alternative measures. After all, a justice system that cannot distinguish between those in need of care and those who pose harm risks losing sight of its true legitimacy.

About the RESIZE project

This report was written as part of the RESIZE project: *Reshaping Correctional Competencies through RESCALED Innovation* (2025–2029), funded by Erasmus+ and involving 24 organizations in 15 countries. RESIZE aims to help correctional staff across Europe adapt to changing needs by clearly defining what skills are required, recognizing prior experience, and offering flexible ways to certify those skills.

Through five work packages, RESIZE promotes systemic change by developing regional skills pacts, vocational excellence hubs, and long-term tools like a European Correctional Competencies Observatory. As a deliverable for Work Package 2, coordinated by RESCALED, this report draws on data gathered from national surveys, facility visits, and workshops conducted for the RESIZE project.