Is involuntary psychiatric hospitalization a measure for preventing the risk of patients’ violent behavior to self or others?
A consideration of the Italian regulation

Summary

Objectives
The authors focus on the issue of involuntary psychiatric hospitalization as a possible measure for preventing a patient from harming himself or others. The possibility that a mental disorder could induce people with mental illness to have violent behavior is still debated in Italy, and patients’ dangerousness is not a criterion for involuntary hospitalization. Nonetheless in several other member states of the European Union and in the USA, involuntary commitment is an acknowledged procedure to prevent this risk. Implications of the Italian jurisprudence for evaluating the psychiatrists’ alleged malpractice will be discussed, including the practical implications of psychiatrists’ duty of care.

Methods
The authors will first survey the legal framework of involuntary psychiatric hospitalization also providing examples of regulations. A critical discussion of data of recent research on involuntary psychiatric hospitalization will follow, underlining possible interactions and conflicts between concepts such as mental capacity, duty of care, professional liability, and patients’ dangerousness.

Conclusions
Although the Italian regulation for civil commitment does not include danger to self or others, nor mental capacity evaluation criteria, the clinical practice and the jurisprudence advocate their consideration.

Key words
Capacity to consent • Mental illness • Violent behavior • Duty of care • Involuntary hospitalization

Introduction
Informed consent is a fundamental prerequisite of medical treatment and is widely recognized as such by the legislation of the European Union. In Italy, as in most democratic states, there are a few possible exceptions to the duty of obtaining patients’ informed consent, including some medical emergencies and “natural incapacity”. This latter concept relates to mental incapacity to take decisions concerning specific purposes, e.g. inability to discern a proposed treatment. People affected by mental disorders are moreover protected by the Law 833 of 1978 under articles 33, 34, and 35, which determines the conditions for patients’ involuntary hospitalization/treatment, and community-based compulsory treatment.

In the present work we will focus on involuntary psychiatric hospitalization and treatment in Italy. The legal regulation concerning involuntary psychiatric hospitalization requires three concurrent circumstances: 1) the patient is suffering from “psychic alterations” that require immediate treat-
ment; 2) the patient refuses treatment; and 3) the patient cannot be adequately treated by other non-hospital based means. This procedure allows treatment and compulsory admission of patients; however, two medical certificates are required (proposal and confirmation) – neither of which should be issued by a psychiatrist. The decision is issued by the city’s mayor and a judge acts as a further guarantor. Maximum length of initial placement is 7 days, which can be extended upon a motivated medical decision certifying the persistence of the 3 criteria above.

The Italian regulation for civil commitment no longer considers danger to oneself or others as a prerequisite, superseding the Royal Decree 36 of 14 February 1904, which allowed the admission to psychiatric hospitals of those recognized as being of “sick mind” and dangerous to oneself or others. In accordance with international bioethical guidelines, which identified in the principles of autonomy and self-determination the inviolable rights of patients, Italian Law 833 substantially provided freedom of care to the mentally ill. Nonetheless we must consider that, in most Western countries, psychiatric involuntary hospitalization is still among the main measures to prevent the risk of self or other-directed violent behaviors due to mental illness.

Psychiatric patients’ disease awareness and treatment adherence usually show a significant degree of variability throughout time, and can change in relation to the disease course, as well as in relation to psychopathological features. This implies that clinical features and competency could vary accordingly and that the same patient could be judged competent or incompetent at different moments. Robust data exists, however, indicating the lack of a clear association between psychiatric diagnoses and mental capacity and competency.

Nevertheless, some psychopathological characteristics, e.g. acute mania or catatonia, can affect capacity to consent to the extent that it might be abolished. Lack of consent and need for treatment are prerequisites of the Italian involuntary psychiatric hospitalization regulation (Trattamento Sanitario Obbligatorio, TSO). The approach aimed at evaluating TSO candidate patients raises two kinds of issues due to its dichotomy: on the one hand, the clinical approach; on the other hand, the medical-legal and forensic implications. The clinical approach should rely on a functional analysis of patients’ psychic abilities underlying informed consent through standardized and validated procedures. The medical-legal approach should, on the other hand, assess consent or dissent validity, as well as consider its possible changes. Cognitive dysfunction and psychopathological features have long been considered factors associated with impaired informed consent decision-making. Specifically, they could compromise the ability to understand, appreciate, reason and express treatment choices.

In real-world clinical practice, however, psychiatrists often struggle with the decision to involuntarily hospitalize a patient. This might be due to the difficulty in balancing the need for hospitalization – which is associated with psychopathology severity and behavioral alterations – with the patient’s right to decline hospitalization, which might be challenging in the presence of resilience and preserved cognitive functioning, despite severe psychopathology.

Recent data emerging from empirical studies on capacity to consent to treatment in acute psychiatric hospitalization questioned the inevitable correlate of mental incapacity in those patients involuntarily hospitalized for and acute mental disorder. These findings prompted an ongoing discussion on regulations for involuntary commitment, as well as possible tools useful to measure decision-making capacity in coercive clinical settings, such as the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), that will be the focus of the present work.

**Involuntary hospitalization and treatment: examples of regulations**

In 2004, Dressing & Salize reviewed compulsory admission criteria in European Union member states and found some shared approaches, although they underlined inconsistency among different legislative and procedural details. The need for cross-national harmonization of regulations concerning involuntary psychiatric hospitalization has also been invoked, but no shared vision in this field has been defined in the EU countries.

In general two types of regulations for involuntary commitment exist: a) those requiring mental illness and danger, and b) those requiring mental illness and need for-treatment; with some countries (Denmark, Finland, Greece, Ireland, United Kingdom, Portugal) providing both possibilities.

Significant heterogeneity exists as concerns placement duration, guarantee institutions, whether a psychiatrist is required for initial assessment, and if involuntary admission and treatment are legally defined as different modalities.

For example, in France Law no. 90-527 of 27 June 1990, which was modified by Law of 4 March 2002, regulates psychiatric involuntary hospitalization, providing two types of involuntary commitment. The first scenario is a) commitment at the request of a third party (Hospitalisation à la Demande d’un Tiers, HDT). Requests for HDT frequently come from a family member and imply that 1) there must be a mental disorder,
2) there is no patient consent for hospitalization, and 3) there is a need for immediate care and constant surveillance in a hospital setting. HDT prerequisites must be ascertained by two independent doctors. The second scenario is b) commitment by the public authorities (Hospitalisation d'office, HO). HO implies that 1) there must be a mental disorder, 2) the patient needs care, and 3) there must be a threat to the safety of individuals or a serious threat to public order. Commitment by the public authorities can be issued in emergency and non-emergency situations. In the former the mayor, or, in Paris, the commissioner of police, may order temporary emergency measures. In non-emergency conditions HO are issued by the prefect of police in Paris or by the prefect in other départements, upon the presentation a detailed medical certificate. The certifying doctor must ascertain that there is need for immediate care and that the patient's condition seriously compromises the safety of individuals and public order. A judge acts as guarantor of the protection of the subject's rights. The patient can resort to the president of the Tribunal de Grande Instance for the withdrawal of the measure. From 2011, a new law offers the possibility of day-hospital involuntary treatment for patients who are not considered “dangerous”. A judge acts as a guarantor in this case. In England and Wales involuntary hospital admission and detention for assessment or treatment are regulated by the Mental Health Act 1983 and the Mental Capacity Act 2005, which were amended by the Mental Health Act 2007. Section 2 of the Mental Health Act 1983 defines criteria to admit and detain a person in hospital for assessment for up to 28 days, while Section 3 defines criteria used to admit and detain a person in hospital for treatment, for up to 6 months. An application for hospital admission for treatment can be issued when the subject suffers from a mental disorder which requires hospitalization, to protect the patient's health, or to protect other people from possible threats. The procedure requires certification of two independent physicians and an assessment by an approved mental health professional.

In Spain the Ley De Enjuiciamiento Civil (8 January 2000), Book IV, Title I; Chapter II, Article 763 regulates involuntary commitment. Similar to the Italian regulation, the Spanish law does not provide, among criteria for hospitalization, the risk to third parties; it focuses on the need for treatment criterion, instead. A psychiatrist assessment is mandatory for initial hospitalization; moreover, a judge must be informed about the patient's condition every six months. In Germany, the state and federal laws regulating involuntary commitment of individual require the presence of serious mental pathology. The condition must moreover constitute immediate personal or public threat. A psychiatrist's opinion is not required for the initial assessment but is requested for confirmation of the involuntary hospitalization. The procedure is issued by a judge who guarantees the patients' rights. Persistence of involuntary treatment could follow involuntary hospitalization.

In Sweden the law for compulsory psychiatric care and the law for forensic psychiatric care of January 1991 and January 1997, regulate involuntary hospitalization of psychiatric patients. The Swedish regulation poses more emphasis on patients' capacity evaluation, and lack of insight. Three conditions are required: 1) the patient must suffer from a serious mental disorder; 2) there is need for full time psychiatric care; and 3) the patient must refuse the necessary care and, because of her/his mental disorder the patient is unable to express an informed decision. A medical certificate is required to activate the compulsory procedure. Involuntary psychiatric admission lasts for 4 weeks, a judge may authorize compulsory assistance for additional four months, then for six months. Excluding Italy, Spain and Sweden, all European Union countries include, to some extent, an evaluation of possible danger for patients or others. All regulations require that involuntary commitment is temporary, nonetheless there is wide variability as concerns duration; Denmark, France, Portugal and Spain do not provide a maximum initial involuntary placement duration. A jurisdictional authority, usually a judge, must act as a State authority guarantor in most countries. In the USA, each state acts autonomously, however potential dangerousness for the patient or others is a widespread criterion for involuntary commitment. Involuntary hospitalization precedes a more accurate assessment, which can then result in subsequent continuation of hospital or non-hospital-based involuntary treatment. The last phase is guaranteed by a judge’s supervision.

Empirical data on patients’ capacity to consent in involuntary psychiatric hospitalization

In recent years researchers have shown a particular interest in the evaluation of psychiatric patients’ capacity to consent to treatment in acute and, also, in coercive settings. The existence of specific instruments tailored to perform a standardized assessments of treatment decision-making capacity, such as the MacCAT-T, allowed the collection of growing empirical data in this field. A clinical approach such as that provided by the MacCAT-T allows for a useful methodology to study the effect of different legal regulations in determining the
A recent longitudinal multicenter study from our research group focusing on treatment decision-making capacity of involuntarily treated and hospitalized psychiatric patients, showed that in some cases decisional capacity was beyond presumable expectations. Specifically, almost 20% of 131 enrolled patients scored within the high range of the 4 MacCAT-T subscales, thus showing good understanding of their diagnosis and treatment implications, adequate evaluation of their clinical condition, satisfactory reasoning abilities, as well as the capacity to express a clear and non-ambivalent treatment choice. In patients affected by bipolar disorders this percentage reached 32%, while those affected by schizophrenia spectrum disorders had significantly poorer decision-making capacity.

Beyond delineating possible diagnosis-related implications, these data raised concerns as to whether and how involuntary commitment based on mental-illness and need for treatment criteria guarantees adequate ethical standards. In other words, is a non-capacity based regulation for civil commitment sufficient to warrant a forced psychiatric hospitalization? The dissent to hospitalization expressed by the patients recruited in the study was considered non-influential, as the Italian law permits such medical evaluation, nonetheless a significant percentage of patients evaluated with reliable methods showed adequate capacity to dissent to hospitalization/treatment. This seems to allow for further consideration of residual paternalism or for the surreptitious introduction of variables not included in a regulation based just on a need for treatment, specifically dangerousness. The existence of involuntarily treated acute psychiatric inpatients showing good functional abilities/mental capacity, moreover raises doubts about the possibility that there was room for treating those patients with less coercive approaches.

In interpreting this evidence we must however consider that also other variables, besides those identified by the law, could have influenced a psychiatrist's decision in favor of involuntary commitment. It is conceivable that other than a defensive medicine approach, some contingent and context-related features, including pressures from family members, health-care operators or from civil society, could have played a role. Another possible factor which could account for those results is possible danger to self or others due to the patient's behavior. Even though the Italian regulation does not consider patients' dangerousness among criteria for civil commitment, it seems conceivable that upon concrete predictability of threats or violence, psychiatrists might decide for commitment anyway. This hypothesis seems to be confirmed by the findings of the follow-up of our multicenter study which showed that discharged patients undergoing a new involuntary admission within 6 months had had significantly more episodes of violence (20% vs 3.8%) and criminal justice issues (20% vs 1.9%).

This interpretation, which deserves further in-depth analyses, however underlines a possible contrast between the existing Italian jurisprudence that obligates the psychiatrist to impede possible damage to patient or other, and the regulation for civil commitment which does not refer to dangerousness.

**Involuntary psychiatric hospitalization as an obligation to protect the patient**

The “duty of care” that weighs on the Italian psychiatrists, as well as mental health operators, implies the duty of protecting the patient (Italian Criminal Supreme Court, Number 9739 of 1 December 2004 “the operators of healthcare facilities, doctors and paramedics, are all under a duty of care towards patients, which derives and is an expression of the solidarity obligation ratified by articles 2 and 32 of the Italian constitution, whose health they serve to protect against any hazards that threaten the integrity; and this obligation of protection lasts for the whole time of the work shift”).

An extensive interpretation of such duty of care has raised wide debate, as well as concerns and criticisms among health care operators, especially due to some Supreme Court verdicts involving Italian psychiatrists. Further concern originated from reparation requests deriving from a wide juridical interpretation of the operator's duty of care. It is not the aim of the present work to discuss the appropriateness of such interpretation (for an in-depth discussion see Felthous et al.5). It must be underlined, however, that the *Italian Society of Psychiatry* 6 has recently issued a document stating that a broad interpretation of the duty of care could apply especially to those acutely-ill, incapable patients requiring involuntary commitment. The issues in the field, at this point, can be summarized in the following questions:

1. Must the psychiatrist consider the problem of patients’ likely violent behavior due to psychopathological reasons?

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1. Italian Criminal Supreme Court n. 10795, 2008 the psychiatrist has “a legal obligation to prevent the event of damage of the patient, or those inflicted to others”; Italian Criminal Supreme Court n. 4107, 2009: “the observance of the precautionary rules exempts from liability for foreseeable but not preventable risks, only if the person (i.e. the psychiatrist) has strictly adhered not only to the common precautionary rules, but also to those rules with which compliance was required by those circumstances that increase the risk and thus require the adoption of additional and stricter precautionary measures”.
2. Can we consider the patient at imminent risk of a violent conduct to self or others because of his/her psychopathological condition, “a danger to self and/or others”?

3. Must the psychiatrist act only in a therapeutic perspective when confronted with situations represented in the previous paragraph?

4. In the absence of consent to treatment, could involuntary psychiatric hospitalization represent an appropriate therapeutic measure in certain situations? We think that the answer can be positive to all the questions posed. The decision not to include patients’ dangerousness in the regulation for civil commitment, as is the case in Italy and a few other European countries, does not exempt the psychiatrist from implementing all possible therapeutic measures to prevent danger to self or others due to a violent act.

In terms of liability, the more clear and transparent the decision-making process justifying the intervention, the lower the chances of charges of negligence arising. Forced hospitalization in psychiatric practice must be considered itself as a necessary therapeutic option also in order to cover the risk of possible violent acting out to self or others, which can be traced to psychopathological reasons.

Besides juridical implications, the relationship between psychiatric disorders and violence is a cultural issue and has long been debated among psychiatrists with practical implications in real-world clinical settings. We believe that the debate is far from being concluded. Italian psychiatrists undoubtedly perceive the issue of patients’ violent behavior, as more than 50% have experienced verbal or physical aggression; even so this phenomenon is likely to be underestimated. The difficult balance between the patient’s right to refuse a treatment and the medical duty to treat incapable patients needing urgent interventions could, however, find a correct response by an evidence-based approach. For example, a standardized assessment of patients’ capacity to consent/dissent to treatment, to be repeated during the hospitalization period, would be a recommendable procedure to apply routinely. A clear documentation of violent behaviors, or threats to self or others’ safety due to psychopathological reasons should likewise be part of routine procedures, especially in those incapable patients who are involuntarily hospitalized or treated. Such detailed procedures could also hypothetically discourage defensive medicine approaches.

Further complexity derives from the wide inclusion criteria for civil commitment provided by Italian Law 833; indeed, it does not require a psychiatric diagnosis, nor the use of standardized classification systems (ICD or DSM). The use of a narrower criterion and the support coming from the use of international classification systems, as well as the documentation of mental capacity status of patients undergoing involuntary commitment is advisable. It is worth mentioning that the Italian National Federation of the Medical Orders has just recently (April 2016) advocated the acknowledgment of informed consent as a medical act to be included as an indicator of “humanity, quality and efficacy for good clinical practice” in every health care service.

**Compulsory treatment choices, outpatient commitment and compulsory evaluation**

In accordance with current bioethical and legal doctrine, involuntary psychiatric hospitalization should be considered a last resort treatment option, and should be limited to those cases in which all the requirements expressly indicated by Law 833 of 1978 are satisfied and documented. In such conditions, involuntary commitment constitutes an approach undertaken in the interest of the patient; however, it should be realized as a measure to protect patients’ rights and dignity. The presence of psychopathology associated with threats or violent behavior and imminent risk of damage to patient or others, especially in the presence of incapacity to consent to treatment, can reasonably motivate involuntary hospitalization. We deem that such approach applies also to a regulation not specifically mentioning patient’s dangerousness, because involuntary commitment is a measure suitable to reduce the risk of damage associated with violent behavior due to psychopathology. We do not include in this framework violent behavior clearly consequent to crime or psychopathy even though they might not be distinguished in emergency settings.

To avoid possible litigation and defensive medicine approaches the psychiatrist decision-making process should be clearly stated in the medical certification, thus permitting an unambiguous ex ante reconstruction in case of legal controversy. It is conceivable that the lack of dangerousness as a criterion included in Law 833 of 1978 discourages physicians to document its presence in certifications supporting involuntary commitment. Such approach could be controversial in the light of the duty of care exposing physicians and psychiatrists to possible professional liability due to omitted or implemented compulsory procedures.

On the other hand, a possible non-hospital based compulsory psychiatric treatment or outpatient commitment (TSO extraospedaliero), which is still an understudied approach in Italy, might prove useful in those situations in which a short coercive approach, e.g. antipsychotic injective treatment, might rapidly improve psychopathological and behavioral characteristics of patients with-
out being too intrusive – possibly avoiding hospitalization in some situations. Outpatient commitment in Italy requires the city mayor’s approval following medical certification. The non-hospital based compulsory psychiatric treatment might also prompt the introduction of long-term rehabilitation programs in which the improvement of patients’ capacity to give informed consent to treatment could be a therapeutic outcome. In this view the longitudinal evaluation of treatment decision-making capacity should be introduced as a routine clinical approach, together with therapeutic adhesion and insight-improving strategies, to reduce perceived and actual coercion.

The implementation of non-hospital-based compulsory psychiatric treatment is an intrinsically less coercive approach than involuntary commitment, as it lacks the obvious limitation of personal freedom to move outside the hospital. The Italian Law 833 of 1978 provides that treatment should be preceded by a preliminary approach aimed at obtaining patients’ consent to treatment, and could be activated in the absence of patients’ consent, once appreciated psychopathological features constitute a possible threat. As in other coercive approaches, the psychiatrist who intervenes will ponder the decisional balance between intervention or non-intervention, documenting it in a clear and transparent way.

Conclusions
Although the Italian regulation for civil commitment does not include danger to self or others, nor mental capacity evaluation criteria, the clinical practice and the jurisprudence advocate their consideration. Compulsory treatment/hospitalization could prevent danger or damage to self or others due to psychopathological features. Outpatient commitment, a less intrusive approach than compulsory hospital admission, should be considered with more attention by Italian psychiatrists.

Conflict of interest
The authors declare no conflict of interest, nor financial relationships with any organisations that might have an interest in the submitted work.

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