Overcoming forensic psychiatric hospitals in Italy, five years later

Enrico Zanalda[1], Massimo di Giannatonio[2]

[1] *Direttore del Dipartimento Interaziendale di Salute Mentale ASL TO3 & AOU "San Luigi Gonzaga", Piemonte, Presidente Ospedaliero Società Italiana di Psichiatria;* [2] *Professore di Psichiatria Università di Chieti, Direttore del Dipartimento di Salute Mentale ASL 2 Abruzzo, Presidente Universitario Società Italiana di Psichiatria*

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Correspondence
Enrico Zanalda
Direttore del Dipartimento Interaziendale di Salute Mentale ASL TO3 & AOU "San Luigi Gonzaga", Piemonte, Presidente Ospedaliero Società Italiana di Psichiatria.
E-mail: ezanalda@aslto3.piemonte.it

Massimo di Giannantonio
Professore di Psichiatria Università di Chieti, Direttore del Dipartimento di Salute Mentale ASL 2 Abruzzo, Presidente Universitario Società Italiana di Psichiatria.
E-mail: massimo.digiannantonio@unich.it

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SUMMARY

The authors make some considerations on the situation in Italy five years after the closure of forensic psychiatric hospitals. The failure to adapt the penal code and the failure to strengthen mental health services have led to some critical issues. The custodial and treatment function of the old forensic psychiatric hospitals has been replaced by health service treatment pathways. In all regions, facilities (residences) for the execution of security measures (REMS) have been established, to which only patients who also need custody should be assigned. However, the opinions of judicial and medical experts often diverge: patients who could be treated externally are assigned to REMS or people who have no clinical indication for treatment are sent to REMS. There is a need to review the legal concepts of insanity and its relevance to offender responsibility as well as possible treatment pathways in and out of places of detention. The concept of social dangerousness is a matter for the judge; it is up to the clinician to describe the therapeutic possibilities in relation to the specific situation of the patient offender.

Key words: residences for the execution of security measures (REMS), forensic psychiatric hospital, social dangerousness, no guilty by reason of insanity

Introduction

Five years have passed since the law decreed the overcoming of forensic psychiatric hospitals. There has been the transfer of the management of care of mentally ill offenders from the Ministry of Justice to the Ministry of Health. The aim was to promote the rehabilitation approach aimed at recovering people with mental disorders who have committed a crime, have no criminal responsibility and are considered socially dangerous. In these extra-prison care pathways the custodial aspect is limited to the period of stay in the forensic residential facilities called REMS (residences for the execution of security measures) [1]. From 2014 to 2017, 20-bed REMS were built and implemented by regional health authorities. In these facilities healthcare professionals encourage inpatients to participate in a recovery-oriented rehabilitation project, in order to return them to community services as soon as possible [2,3]. It is therefore very important that the practice of such services is consistent with the highest standards and is based on the best quality evidence [4,5]. The REMS-based approach led to an improvement of forensic psychiatric care but also to emerging issues that are still partially or totally unaddressed. A correct management of these care pathways requires a better coordination between the health care providers judicial system that decides on the time and limits of the forensic psychiatric measures. The overall assessment of the changes would be positive, but much remains to be completed.

Five years considerations

Five years after the implementation of the overcoming of Forensic Psychiatric Hospitals in Italy, some considerations can be made on the functioning of the system. Law 81/2014 was applied into a penal system that dates back to 1930, when the asylum was the system for the treatment of mental illness. This old code states that "the defendant cannot be held criminally responsible for his crimes if mental illness deprives him of the ability to understand and will" (art. 88 of the Penal Code). The judge may apply security measures if these persons are considered socially dangerous. At the same time, the legislators, had introduced the concept of double track for the execution of a sentence: the defendants criminally responsible on the "track of penalties", while those found not guilty of mental illness (art. 88 CP) are assigned to the track of "security measures". The double track excludes the possibility that a person not guilty by reason of insanity (NGRI) (Art. 88) remains in prison. This approach made sense as long as forensic psychiatric hospitals existed.

With the law 180/1978 psychiatric hospitals were closed and the treatment of the mentally ill was assigned to mental health departments (MHD). The overcoming of the forensic psychiatric hospitals also allows the mentally ill offenders to no longer be treated in asylums but by MHD operators who work inside and outside the penitentiaries. What changes the path of care of the mentally ill offender is if he is qualified as socially dangerous. This is a concept that has remained in the legal sphere and has disappeared from the psychiatric clinic. In forensic psychiatry, social dangerousness is the probability that the mentally ill or partially mentally ill person, due to mental illness, may commit further crimes. This prediction of the future is beyond clinical concepts and for years the Italian psychiatric society has been proposing to the judiciary that the judge's question about dangerousness be reformulated in a request for a clinical prognosis or the possibility of treating the infirmity. In many other countries 'Dangerousness' or 'risk to others' is the key admission criterion for forensic services, as well as an important metric during admission and pre- and post-discharge. This risk can be estimated through various methods, but all have had their validity and/or utility questioned. Clinical judgement is prone to overestimation of risk and a wide range of biases [6]. Hence, at times, these categories can become meaningless in practice [7]. The social dangerousness of the offender should be a criterion that the judge decides, not the medical expert. In relation to mental infirmity, a prognosis should be associated with the prognosis on the trackability. This is because the behavior of people is determined more by the character, experiences, education of the subject than by his pathology [8]. Psychiatric care facilities are well equipped for the treatment of patients and not equipped for their care. Custody should be provided in prisons where health professionals can provide care. The path of the mentally ill should begin in prisons and then evolve in REMS and territorial facilities in relation to patient collaboration. Instead, because of the old penal code, a person who is totally mentally ill cannot stay in prison because he or she is considered not guilty; because of the control of his or her social dangerousness, he or she is improperly included in a health care path. Among the possible health care pathways, REMS is the only custodial path.

The 30 Italian REMS have a total number of beds equal to one third of what the magistrates had available when there were judicial psychiatric hospitals. Most people believe that the REMS are the substitute for the OPGs while for the law 81/2014 they should be used only when it is not possible to design external treatment paths. The new facilities are therapeutic environments, managed by the Regional Health System, built according the same characteristics and standards than community rehabilitation facilities. They must not exceed 20 beds each at maximum, and staff is exclusively clinical. The penal measure of "security" must be provided only by a perimetric confinement based mainly, or exclusively, on technological devices. Security personnel (private guards) only operate in some limited functions such as checking the fence and technological devices and intervene inside the REMS only in case of emergency and under the guidance of health manager. The reduction of the number of beds during the transition from Forensic Psychiatric Hospitals (OPG) to the REMS led to the existence a waiting list; the intention to carry out community projects on patients who already had a REMS entry order led to friction between the legal system and the health system [9].

The main problems derive from this difficult dialogue between healthcare system and justice system that is reflected in several areas: the concept of infirmity, social dangerousness and its containment, the criteria for assignment and permanence in REMS, external territorial routes and the crisis of mental health departments and territorial health services.

Supporters of the reform argue that the abolition of insanity (Article 88 and 89 of the Penal Code) would ensure that all offenders, regardless of their psychiatric status, are detained and treated in the prison system [10,11]. This reform would generate benefits at different levels. On the one hand, it would prevent individuals with marked antisocial behaviour and substance misuse from being diverted from prison to mental health services and reduce the excessive heterogeneity of the patient population, to the benefit of the quality of service. On the other hand, it would ensure equality of

offenders and reduce stigmatization of offenders with psychiatric disorders [12]. Service improvement also requires the implementation of a networking system with REMS having decisional power over the referral and admission processes and over the development of treatment pathways for patients. These measures would ensure that forensic psychiatric services can provide the kind of specialty service they were conceived for, such as for female patients, ageing patients and the complex cases of high comorbidity. Crucial work is also required to ensure the availability of services, especially in those regions which have resorted to waiting lists [13].

One of the main concerns for professionals in general psychiatry is the lack of reform of the Penal Code regarding those articles relating to subjects judged not guilty by reason of insanity. Magistrates still order the referral of subjects to REMS as they did previously in the OPG system, simply accepting experts' conclusions. These experts do usually not interface with mental health services. In the referral phase, REMS maintain a passive role, as they do not have the chance to interface with Magistrates, court experts, and community teams to assess and triage cases based on their severity and urgency. As a result, antisocial people who have no indication for that therapeutic intervention are also sent to REMS. Those individuals may be admitted to the psychiatric track by the law despite their reluctance to engage and the reluctance of services to accept them on to their case-loads. Furthermore, unmediated referrals can result in tensions between services and the magistrates' courts from the beginning. Law 81/2014 prescribes a referral of a person to REMS as *extrema ratio* to be taken after having considered all alternative solutions. After 5 years of the new law, many exceptions have been observed to this rule due to the infrequent checking of available alternative services by the court experts and due to the discrepancy in timing between the court decision and the availability of care. Frequently this tension concludes with an urgent referral to REMS, through the courts' application of a temporary security measure formula (*Misura di Sicurezza provvisoria*), recently the most used route of detention in security residencies.

Moreover, the persisting use of "insanity" as well as "substantially diminished criminal responsibility" (Article 88 and 89 of the Italian Penal Code) as legal requirement for forensic detention introduces a considerable number of individuals with a primary diagnosis of personality disorder and frequent comorbidity with substance abuse and antisocial traits into national forensic care. As the whole system relies on the sustainability of general psychiatric services, there is a growing concern from the Psychiatric National Society (SIP, *Società Italiana di Psichiatria*) regarding the increasing number of persons in community residencies or outpatient services with marked antisocial profiles. It has also been noticed that the utilization of financial resources in the establishment of new REMS facilities reduced the possibility to further develop the community forensic care pathway.

In this evolving scenario, it is still debated which major clinical and criminological features should trigger a referral and pathway care in REMS, in particular regarding those with antisocial and/or psychopathic traits with a high risk of recidivism, severe forms of mental distress associated with severe index offences, elevated impulsivity and comorbidity with substance misuse, and high risk of recidivism with scarce responsivity to treatment.

The radical reform of the Law 81 implies that public services must directly provide the treatment of forensic patients: inside the REMS, which are managed by the NHS, and within the regional community facilities. The recovery approach is also reflected on individualised care pathways (Progetti Terapeutico Riabilitativi Individualizzati, PTRI), developed upon admission to the service. This includes consideration of the index offence and its clinical/social determinants, a plan of the interventions that the REMS team is aiming to deliver and the expected length of stay of the patient [11]. The care pathway is shared with mental health community services, as per the directives of Law 81/2014 (DL, 2014), to encourage proactive engagement/collaboration in the prospect of future release.

One particular problem with the current changes is the state of public services in Italy at present which have faced significant difficulties in the past years due to a progressive reduction of resources, money, and personnel. This impacts upon the ability of the system to adequately take care of patients. Moreover, the costs of facilities for mentally ill people have increased significantly due to the inclusion of patients under forensic treatments.

Mental infirmity is sometimes attributed to patients on whom mental health departments have no competence to treat; the competence is with addiction or disability services. The REMS are closed therapeutic communities where therapeutic rehabilitative pathways are proposed that work better for people with mental pathology while they are not indicated to treat the delinquent or perverse aspect of offenders. The ideal would be to be able to keep in places of custody for a period of observation patients and send in REMS only those for which there is clinical indication. Both the treatment paths within the REMS and the resignation are subject to the approval of the Magistrate. In order for this to work in the interest of the patient, it is necessary to maintain a dialogue between the caregiver and the person who decides whether or not to allow the participation of the patient in treatments outside REMS or to delay the resignation in the face of recognized clinical improvements. The dif-

ficulty of the dialogue derives from the legal phase in which the patient is (provisional or definitive) and from the possibility of communication between the director of REMS and the competent magistrate. The simultaneous assignment of prison health care and offender patients to mental health departments has significantly increased the work and accountability of mental health departments. This has occurred at a time when there has been a significant staff reduction. The lack of planning of training of specialists together with the contraction of available resources has led to a critical situation in which operators have difficulty in dealing with offender patients with due diligence and efficiency. On the other hand, this assignment to the services of offenders has led to an increase in requests also from the police forces, who continuously report situations of behavioral alterations to mental health centers and more willingly accompany people arrested with "crazy" behavioral anomalies in the ER than in prison. Mental health services are often late in compiling patients' treatment plans and in taking care of people in prison or REMS. Without this work in the territory it will become increasingly difficult to correctly implement what is contained in Law 81/2014 and ensure good care for mentally ill patients who are offenders.

In order to facilitate taking charge, it is advisable that a Forensic Psychiatry Unit (UPF) be set up at the Local Health Authority level, including various professionals from the various territorial services. The UPF has the task to study the patient who is reported by the prison, the REMS or the Magistrate and propose treatment paths for those patients in which it is clinically indicated. Given the recent development of REMS, the system is affected by some limitations that need addressing [12]. One of these pertains to the process of referral and admission. At present time, magistrates refer patients to REMS based on the appraisal of forensic experts [13]. However, these experts usually have very little contact with forensic psychiatric services to ascertain whether they can address the patient's treatment needs [14]. In the referral and admission process, the REMS act as passive recipients of the Courts' decisions most of the time and have little voice in agreeing a patient's care pathway [12]. Recovery-oriented treatment in forensic psychiatry is challenging. It entails engaging patients in their life, on the basis of their own goals and strengths, and supporting them to find meaning and purpose through constructing or reclaiming a valued identity and social roles. Patients should be empowered to become self-determined and, hence, be actively involved in decision-making and treatment-planning. Due to the characteristics of the patients, the risk of recurrence and the restrictive nature of the facility, the implementation of recovery-oriented treatment in forensic psychiatry is complicated. Forensic psychiatric patients have mental health difficulties and functional impairment, but also present a history of criminal behavior, violent or sexual offending, a high prevalence of comorbid personality disorder, behavior disturbance, self-harm, and substance use [2]. The treatment is therefore linked to the clinical and psychopathological needs of the patient, but must also take into account the balance between his therapeutic needs and safety requirements [15]. This limits how much primacy can be given to the perspective of the patient relative to that of professionals and how far recovery-oriented treatment can be fully deployed in forensic psychiatric services. The Italian forensic reform stresses the importance of developing pathways of care at low levels of therapeutic security and focused on recovery-based determinants.

In conclusion, it would be necessary to adapt the Criminal Code to the concepts introduced by the law on overcoming psychiatric hospitals. It should be possible to begin treatment in prison and extend it until the possibilities of treatment exceed the need for custody. The dialogue between the health care world and the judiciary must be increased not forgetting that health care deals with the mental health of the patient in the interest of the patient, while justice deals with social security in the interest of the community. The variables that come into play in each concrete situation are as numerous as the requests of the agencies concerned. Let's not forget that the judge must consider in compliance with the law the accusatory and defensive needs, the compensation of victims and the administration of punishment. Probably in order to overcome the stigma of mental illness it would be better to make the mentally ill offenders responsible for their crimes considering infirmity as mitigating and not as exempting.

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