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Italian REMS, limits and critical issues: from a clinical case to the comparison with the European forensic systems

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SUMMARY

Six years after the Law of 30 May 2014 n. 811, which sanctioned in Italy the closure of the Judicial Psychiatric Hospitals (OPGs) and the establishment of the Residences for the Execution of Security Measures (REMS), there is the need to highlight the criticalities and limits of the new system, starting from an illustrative clinical case and analysing the mode of operation of the major European states' forensic psychology systems.

Key words: antisocial personality disorder, forensic psychiatry, social dangerousness, criminal responsibility, residences for the execution of security measures, psychiatric forensic services

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Introduction

The healthcare's organization and management for perpetrators with mental illnesses who follow restrictive measures (precautionary measure, custodial and non-custodial safety preventive measure) have widely changed in Italy in the past years.

The process of overcoming the Judicial Psychiatric Hospitals' (OPGs) structure, and of identifying new courses of treatment and rehabilitation, has seen its turning point with the Law of 30 May 2014 n. 811 [1], through a journey started in 2008 [2]. The law, a milestone in Italian psychiatry, has sanctioned the closure of all OPGs, soon to be replaced by the REMS (Residences for the Execution of Security Measures). These are facilities designated for patients' treatment and rehabilitation, which entail a step toward the establishment of a community psychiatry based on an alliance among clients, family members and operators and which help overcome the detention structure of the OPGs, in the wake of what was started with the Law of 1803, 14 [3].

This work aims to illustrate a cross-section of the current reality of Forensic Psychiatric Services in Italy, starting with the sharing of the direct experience of a case and a brief overview of the organization of forensic psychiatry in our country and in Europe. This, to highlight the differences between the various systems and to think about the strengths and criticalities of the Italian organization, so as to be able to implement the current structure of care for psychiatric patients.

Clinical case: R.M.

Patient R.M. is 23 years old. He grew up in a rather difficult family context: his parents, after having lived a rather conflictual marriage, eventu-

ally separated when R.M. was about 13 years old. The father is described as a tough and authoritarian figure. Arguments between parents were not isolated and paternal violence, both physical and verbal, was also frequent.
These attacks also occurred against R.M. who, since his early age, began to manifest dysfunctional and violent behaviours, both at home and at school. The case was brought to the attention of the Mental Health Centre and of the Social Services, which entrusted R.M. to a therapeutic rehabilitation community at the age of 14. After a year spent at this institute, R.M. returned to his home, where he began to engage in violent behaviours again, combined with the abuse of alcoholic beverages. This last habit has also led the patient to undergo hospitalization for an alcohol-induced coma. Returns to the recovery community followed, interrupted by escapes or by transfers from the aforementioned structures due to his aggressive conducts. Shortly before reaching the age of majority, the Juvenile Court had confirmed R.M.'s custody to a therapeutic community for the treatment of his disorders. A period of partial psychopathological compensation followed, when, during the permits granted for returning home, he seemed to behave in a non-violent manner.
At 18 years of age, however, he violently attacked his mother with a chair, causing displaced fractures in her right leg. During his mother's rehabilitation period, R.M. stayed at home with his younger sister, resuming his abuse conducts (alcohol and drugs). After having reentered a community and subsequently escaping from it, he returned home attempting a territorial rehabilitation process. This was initiated with the help of the locally assigned psychiatrist of the Mental Health Centre. However, even in this case, R.M. was unable to complete the therapeutic project developed at the diurnal centre of the competent Mental Health Centre, nor did he follow the prescribed psychopharmacological therapy.
During that same year he also caused a road accident by tugging on the steering wheel of the car he was traveling on while his mother was driving, provoking a further bone injury to her arm; moreover, a few days later, he attacked his mother while she was working at her business. This episode was followed by a Mandatory Health Assessment with subsequent voluntary hospitalization at the Psychiatric Diagnosis and Care Service. He was discharged from the hospital with a diagnosis of "Antisocial Personality Disorder".
After this other episode of aggression, his mother decided to press charge, following which the Judge for Preliminary Investigation arranged for him to be transferred to a REMS. Nonetheless, a few days after, this provision was revoked and subsequently replaced by a rehabilitation probation measure to be implemented in a Therapeutic Community. Following an episode of aggression that occurred at this facility, however, he was taken by the Carabinieri to the emergency room and then hospitalised at the local SPDC (Psychiatric Diagnosis and Treatment Service). The probation measure was then revoked and the transfer order to a REMS facility reintroduced. In the absence of availability at a REMS, R.M. remained hospitalised at the SPDC for several months.
Due to the incongruity of the hospitalization at the SPDC, the Mental Health Centre tried to develop several rehabilitation therapeutic plans that could be carried out in places different than the hospital, without however being able to find a connection point between the judicial provision and the patient's therapeutic needs.
After several months spent in the ward, R.M. managed to escape and return to his home despite the judicial order, receiving periodic checks at the Mental Health Centre: the latter, thus, had become the temporary control facility that R.M. had to visit to be able to carry out his rehabilitation process. He did, however, undergo several hospitalisations under Mandatory Medical Treatment regimes for violent behaviour, often associated with substance abuse.
The Judge's provision, therefore, has retained its validity, so that, once a bed was vacated, R.M. could be introduced in the REMS. In this facility, however, he behaved aggressively, uncooperatively, non-compliant with the psychopharmacological therapy. After about a year of stay in the REMS, R. was hospitalised seven times under the Mandatory Medical Treatment regime because of highly destructive conducts against operators and patients. This behaviour was triggered by his insistent claims to obtain dosages of drugs that could have allowed him to achieve the effects generated by ordinary narcotics. The REMS operators stated that the criminal conduct was carried out with planning, lucidity and total disregard for the consequences of his actions.
The position of the REMS' doctors was thus rather awkward: they reported that such violent acts were not attributable to any psychiatric pathology; on the contrary, he was to be considered deserving of a penitentiary structure. This request was made with the aim of avoiding any harmful consequences within the REMS which, precisely because of its specific nature in terms of rehabilitation, is not designed to contain and face criminal and delinquent behaviours.

With the presentation of this clinical case we wanted to share some of the difficulties and limitations that are faced daily in REMS. On the one hand, a clear problem of management and placement of the antisocial and psychopathic patient emerges, sometimes considered as an acute patient to be managed in SPDCs, others as

an offender to be relegated to detention facilities. On the other hand, the responsibilities of the psychiatrist within REMS emerge, whose duties go beyond the ordinary formulation of a diagnosis, treatment and prognosis and who finds himself in an ambiguous position between the request for care and custody. There is also the need to deepen the concept of social dangerousness, especially in relation to health treatments and places of hospitalization, as well as the problem of the safety of REMS personnel and of the patients themselves within the structures. Starting from this observation, we want to make a brief European overview on the management of forensic psychiatry and then go on to deepen the aspects mentioned.

The Forensic Psychiatric Services in Europe

Italy has been the first, and currently the only, country in the world to abandon a hospital model of forensic psychiatric assistance in favour of residential security units within the community [4].

Originating from the de-institutionalization movement, the Law 81/2014 resulted in the closure of the Judicial Psychiatric Hospitals (OPG) and their remodelling into Residences for the Execution of Security Measures (REMS), a service no longer provided by the Ministry of Justice, but by the National Health System (SSN) to accentuate the transition from a detention to a rehabilitation place [5].

At an international level, this model has no precedents or analogies; in fact, in almost all countries, the centrality of the Judicial Psychiatric Hospital remains, albeit flanked by an integrated system composed by other structures such as intra-prison units or, for patients who are no longer inmates, by General Psychiatry Hospitalisation Units or by forensic outpatient care [6,7].

The United Kingdom (UK)

The British Psychiatric Forensic Services, monitored by the Ministry of Health, have set a model for many Commonwealth nations [7]. They are mainly constituted by hospitals divided according to their safety level: high, medium and low [8]. Today in the UK there are nearly 4500 beds in high- and medium-security level Forensic Services [9].

All beds located in high-security facilities are provided by the National Health Service (NHS), subject to the British Ministry of Health, and are reserved, under the Mental Health Act (deliberated in 1983), for inmates who are of "serious and imminent danger to the society" [10].

These structures, derived from the "criminal lunatic asylums", were built during the late Victorian age with the pure purpose of detaining criminals with mental disorders, to evolve, later on, into today's high-security hospitals with curative and rehabilitation purposes.

The beds in "medium-security" facilities are provided by both the NHS and by the private sector and are intended for detainees who "represent a serious danger to society", while those in low-security (also provided by the NHS and by the private sector) are intended for individuals who represent "a significant danger to themselves or others".

Detainees with mental illnesses are usually transferred to low-security institutions after having spent a period in medium-security facilities; the maximum recommended length of stay is about 8 weeks, before favouring the progressive reintegration of the detainees into society [9].

Special services have recently been created alongside these structures, both a medium-security one for female detainees who need special treatments (such as women who commit crimes in the course of psychiatric pathologies during their peri-partum period, or who need a mother-child therapeutic community while serving their condemnation time) called WEMSS (Women's Enhanced Medium Secure Services) [9] and a "Dangerous and Severe Personality Disorder Programme" (DSPD programme), designated for convicts with severe personality disorders and with highly damaging potential to society [11].

The latter was designed for those individuals who may constitute an actual danger to society, despite the fact that in the forensic field personality disorders are not considered serious pathologies. Ultimately, the English forensic services seem to function well; despite the risk of relapse in discharged patients is high (about a third of the men is readmitted to the facilities and almost 1 out of 5 for violent crimes) the rate of violent crimes is considerably lower after discharge [12].

France

France's situation is perhaps the most problematic because of the strong dichotomy between the Ministry of Health and the Ministry of Justice in their shared management of the Forensic Mental Health Services; in the country, very much alive is the debate between supporters of the development of a specific assistance system for detainees and those who believe in the opportunity that psychiatric teams should stay out of the prison system [13]. Enough to say that, in France, before the establishment of the "Unités d'Hospitalisation Spécialement Aménagées" (UHSA), there were no specialized structures for detainees suffering from psychiatric diseases.

The prisoners, regardless of the type of psychiatric or internal pathologies, were sent to the Unité Hospitalière Sécurisée Interrégionale (UHSI), facilities that provided "general" medical care to inmates who could not be treated directly by the outpatient facilities present in each prison [14].

The UHSA's creation became necessary due to the very high rate of suicides inside the French prisons which, by

the year 2000, had reached a rate of 25 every 10,000 people and whose main risk factor was to be found in the psychiatric comorbidity [15]. In fact, it was following the birth of the first UHSAs, which came into operation only in 2010 [13], that the rate significantly dropped [16]. These are full-time hospitalisation structures similar to the former Italian OPGs, where patients can be admitted both with voluntary hospitalization and upon request of the state institution after a psychiatric-forensic evaluation confirming the presence of a mental defect affecting the execution of the crime (article L. 3214-3 of the French Public Health Code).
The health workers collaborate inside the UHSA with the prison's administration staff that ensures the transfer of the prisoners together with the entry and exit control [14]. In France, at the beginning of 2016, 9 UHTAs with 440 beds were active, but the French government has planned up to 17 units (705 beds) that will be made available in the upcoming years. Pending the finalization of the UHTA's creation program, it is still possible to admit detainees in the general health facilities [14].

Germany

As in Italy, in Germany it is the criminal common courts' responsibility to implement the juridical norms, provided by the Penal Code, that apply to offenders with mental disorders: for such a purpose, the prosecutor appoints experts to examine the clinical condition of the offender in which a mental disorder is suspected [17].
Alongside the OPGs, with an average of 250/350 beds, in the General Psychiatric Hospitals there are small Forensic Psychiatric Units. The subdivision of the German OPGs into specific departments with different intensity of care and level of safety depending on the patient's diagnosis is quite peculiar; there are therefore areas dedicated to psychopathic patients, to patients with impulse control issues, personality disorders, acute and chronic psychosis, sex offenders, patients with brain damage or mental retardation and drug addicts [18] who are detained in specific Detoxification Centres always inside the Forensic Psychiatric Hospitals [17].
While detention for drug addicts is limited to a maximum duration of 2 years, custody for other detainees deemed not criminally imputable is established for an indefinite period of time and annual assessments are conceived to verify the need for further detention periods. All other prisoners who, despite being affected with a mental disorder have been declared imputable, may be incarcerated in the "general" prison services.
As a possible requirement for parole, the German courts have the right to impose a treatment, the so-called "therapeutic order", forcing the prisoner to adhere to psychiatric, psychotherapeutic or socio-therapeutic therapies and to show up in regular schedules or timings at a doctor or psychotherapist's office [17].
Thanks to the 2007 reform, Forensic Outpatient Centres (Forensische Ambulanz) were also established for the care and treatment of detainees discharged from the OPGs, with a function similar to that of probation. Furthermore, also since 2007, the Courts have the faculty to require drug addicts not to drink alcoholic beverages or to consume other psychoactive substances if potentially capable of increasing the risk of committing a crime. Abstinence can be monitored with specific tools (breathalyser, etc.) by probation officers, but physically invasive procedures such as blood tests are not allowed [17].

Italy

On the Italian territory currently 30 REMS are active. These are residential structures with therapeutic-rehabilitation and socio-rehabilitation functions, finalized for a transitory and exceptional stay. In fact, in the light of the Law 81/2014, it should be noted how the security measure for detention purposes is to be considered residual and applicable to the person only "when elements are acquired from which it appears that any different measure is not suitable for ensuring adequate cares and handle the person's social dangerousness" [1].
The internment in the REMS has therefore taken on not only, as anticipated, the character of exceptionality, but also of transience: the Department of Mental Health responsible for each hospitalisation must predispose – within 45 days of the patient's entry into the REMS – an Individualized Therapeutic-Rehabilitation Project (PTRI), later on sent to the competent judiciary authority, in order to make residual and transitory the hospitalization in the structure [7].
The PTRI includes the consideration of the offense and of its clinical and social determinants together with an intervention plan that the team should provide, as well as the expected duration of the security measure, not exceeding the maximum legal penalty (Article 1 komma quater of the law 81/2014). All REMS have a maximum limit of 20 places. In some cases, there is a polymodal system of several REMS within the same structure, as in the case of Castiglione delle Stiviere. Here the seats in the polymodal system are 154 (compared with a capacity of 160).

Limits and criticalities of the REMS

The professional responsibility to which a psychiatrist may be subjected should be the object of consideration and discussion, since it has peculiar characteristics compared to those of other medical professions. In fact, the psychiatrist's duty is to provide a diagnosis with the subsequent outcome of the clinical condition, predict the patient's future behaviour and what the intervention will arouse in the person, in particular with regards to the risk

of suicide or attacks to that patient's third parties. Therefore, there is a responsibility, defined as vicarious, on the acts committed by others due to the professional's errors. Unfortunately, the law increasingly tends to combine all possible previsions in the condition of liability, and the Supreme Court has stated that the distinction between self-harm and other harmful behaviours is irrelevant. The Italian jurisprudence orientation has consolidated an interpretation of the psychiatrist's security position for which the patient, on the one hand must be protected against possible self-harm and, on the other, against the danger to third parties, who must also be protected [19].

The eternal combination of care and custody can be found in the ambiguity of the figure of the psychiatrist within the REMS. Converting, in fact, to an entirely healthcare management of the residency in the REMS, there has been a complete delegation of the OPG Director's functions to the Director of the REMS. However, this is unrealisable because conceptually incompatible [20].

In fact, the choice to eliminate any form of control in favour of an exclusive sanitary intervention has necessarily determined a change in the professional psychiatrists' position, assigning them new safety management tasks, with the faculty of intervening in emergency situations even above the manager, as well as new responsibilities. The psychiatrists, in order to guarantee the custody requests and neutralization of dangers, could find themselves sacrificing the right to health of patients and the very same purposes of the reform, setting their own modes of operation on containment and control, to the detriment of the social welfare needs and of the therapeutic alliance with patients [21].

The current situation also shows the need to revise the social danger concept, dating back to the 1930 Rocco code, which lacks guidelines that all specialists can follow in a uniform and unanimous manner. The concept of social danger has partly changed with the abolition of the fourth komma (Article 133 of the penal code) which states that 'the individual, family and social life conditions of the offender' must no longer be taken into consideration in the assessment of social danger. On one side this change is useful because it leads to no further penalization of the most vulnerable subjects, but on the other hand it contradicts some basic grounds of the contemporary psychiatric thought, that considers mental illness resting on the well-known 'bio-psycho-social' paradigm" [22].

However, it is important that the DSM (Mental Health Department) considers the context throughout the patient's course of treatment, so as to be able to organise custom-made projects that can adequately provide for it in each dimension of his life.

The same talk must be made for the duration of the social danger, which corresponds to the legal penalty provided for the committed crime. This change aimed at preventing "white life-sentences", that is, endless extensions of detention security measures, generally against people committing minor crimes. In this way, however, the applicability of the measures could lead not so much to the social danger, but to the importance of the crime, with the responsibility-penalty and social danger-security measure dualism losing its value, with a confusion of both diagnostic and prognostic perspectives [23].

Secondly, we face the problem of the lack of a link with the territory, that is the difficulty of taking in charge the subjects at the end of the measure, once discharged, even if still dangerous, since the necessary social-healthcare prevention and treatment tools have not been arranged together with the absence of step-by-step interventions [24]. A better definition of the methods to ascertain mental illnesses, the criteria to define incompatibility with detention, the principles and methods of the DSM to carry on activities in prison, or to identify locations where alternative measures can be realized should also be elaborated.

Evaluation criteria and tools to be utilized should be consistently defined, as well as paths to implement to take into consideration both the ineliminable subjectivity of the psychiatric work and to face the phenomena of manipulation, simulation and the possible deceptive use of psychiatry, for example by criminality [25]. Another important aspect to address is the management of homeless patients, patients who cannot be relocated in their families and non-EU patients without a residence permit.

Another debated matter is the relationship between social danger and medical treatments, together with the fact that detention does not provide for mandatory treatment. On one hand, no therapy can nullify the danger of unlawful conducts, but on the other it must be considered that the refusal of treatment can increase the risk of criminal behaviour by a patient author of crimes. The Mandatory Medical Treatment (TSO) does not involve among its motivations the state of social danger nor the concept of mental capacity.

Due to a persistent shortcoming in the legislative system, there are no rules allowing to treat a patient subjected to safety measures against his will, either with pharmacological or psychotherapeutic treatments. Patients entrusted by the judge to the DSM are often unable to sign an informed consent, thus making any therapy problematic [22]. In addition to the ban, it is possible to obtain the nominee of a support administrator authorized to express said informed consent, but the

procedure is slow and it is also difficult to find individuals willing to take this role. The possibility of conflicts between the support Administrator and the patient's family members should not be overlooked. In conclusion, a clear legislation is needed to allow the management of individuals with chronic mental disabilities and to improve their capacity to express an informed consent to treatment.

The vacancies at the REMS are lower than the requested ones, although the stay must be temporary and without alternatives. The inmates actually admitted to the REMS are 629, with 603 people on the waiting list. This figure should not be seen simply as the need to increase the available places in the REMS, but rather as the need to strengthen the territorial psychiatric services to guarantee adequate pathways for undertaking patients, persuading even the most unwilling judges that the REMS can and must be the last resort, when there truly are no virtuous courses of treatment in the territory that would be capable of protecting the safety often better than the REMS do [26].

In the absence of adequate possibilities for the DSM to take care of patients waiting to enter the REMS, there is a risk that the Psychiatric Diagnostic and Treatment Services (SPDC) may turn into a 'parking' place resulting inadequate for the specific care needs of the patients, for the needs of effective containment and prevention of their symptoms / crimes and because not organized for appropriate rehabilitation purposes for long-term hospitalisations [22].

Alternatively, it may happen that patients wait at their homes where they might be together with their own victims, as in our clinical case. Actually, for a period of time our subject waited at his residence with his mother who, in addition to being victim, had also filed a complaint against her son.

This introduces to another critical issue which should be taken into consideration, namely the safety of the victims, who are often completely scotomized by these rules: they are not entitled to compensation if the person is acquitted, they are not protected if the violent patient returns to the community nor is there an obligation to notify them.

Another issue that we want to address is the consequence of the sentence 99 filed by the Constitutional Court on April 19, 2019, where it appears that also those who have developed a mental illness while incarcerated will go to the REMS. In fact, one factor that must be considered is the risk that the REMS might quickly become overcrowded and unmanageable and that some of these individuals may also prove to be "false patients" who do not need psychopharmacological treatments, often displaying an antisocial personality disorder, transgressing the rules, disrespecting the authority and with possible problematic use of substances, becoming thus an element of distress for the other patients, preventing their correct rehabilitation [27].

On the other hand, the importance of improving psychiatric care in prisons where inhuman conditions persist and in which operational models for adequate care are still not guaranteed is evident [3]. On this line of thought there is an attempt to qualify the courses of treatment within the prisons and, at the same time, to ensure the rights and continuity of the care and to create, when conditions occur, adequate alternative measures to prison.

The difficulties relating to the management of antisocial personality disorders are also encountered in the described clinical case. In this regard, the importance of always considering a psychopathological evolving condition and of recognizing the great relevance of anamnestic elements such as abuse, violence and neglect, pathological attachment styles and dysregulated functioning in the perpetrators of crime must be highlighted, as well as the importance of giving room to preventive and early interventions. This stands in relation to the development of juvenile offenders as well [28]. On this concern, a work of agreement by the various institutions is necessary to prearrange specific programmes that can be more effective than detention itself or than the circumstance when it is recommended to adopt alternative measures to psychiatric fields from which such patients not only receive any benefit, but also endanger other guests' course of treatment [25].

Lastly, another criticality of the current system results in the lack of safeguard of the healthcare personnel and the patients within the REMS. Figures show a total number of attacks equal to 363 (23% of transits), a significant level that concerns, although heterogeneously, almost 80% of the REMS. These rates of aggression are high (23% when considering aggressions against the staff and other patients), when compared to the literature which reports rates between 3 and 15% [29]. The personnel results understaffed, without the possibility to guarantee adequate shifts and adequate resources that can assure a good working performance. Furthermore, the staff is often not sufficiently protected when exposed to some patients' hetero-aggressive behaviours; our clinical case is an example of this.

Conclusions

The difficult classification of the psychiatric patient author of crime, has been, in recent years, a much-discussed topic and has a long history from both a legal/legislative and from a social acceptance point of view. History and the current circumstances have brought to light the complexity of the management of this type of

patients and the importance of thinking about a flexible strategy, which can therefore be modelled on the needs of the individual's care and, at the same time, be homogeneously regulated throughout the national territory.
The presented clinical case offers one of many examples of the mismanagement of the psychiatric patient author of crimes, highlighting the criticalities and limitations of a still young system that, although built with a deinstitutionalization perspective, does not lack contradictions and breaches.
The European models, in particular those of England and Germany, show how systems, well-coordinated and integrated with the territory, offer valid solutions in the management of the psychiatric patient who has committed a crime and also show how, despite the central role of the OPG remains, it can coexist with a system whose primary objective remains patient care and rehabilitation.
It is necessary to work on objective, agreed upon and evidence-based methods for verifying recovery paths and their outcome. Italy risks not knowing how to manage the current reform and transforming strengths and progress into disadvantages. For such a reason, a broader and multidisciplinary vision is essential, as well as to implement the resources of the DSM to ensure that it can manage the care, the monitoring, the working and social reintegration of psychiatric patients who have committed crimes, also strengthening the collaboration between various district services that they belong to with the objective of an increasingly advanced psychiatry aimed at the patient's well-being.

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