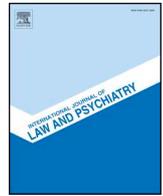




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## Evolution of forensic psychiatry in Italy over the past 40 years (1978–2018)

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## HIGHLIGHTS

- The 4-1-2008 Presidential Decree closed forensic psychiatric hospitals in Italy.
- Alternative structures for the mentally ill convicted were thus instituted.
- New issues emerged as a consequence, for example, social dangerousness.
- The new act completed the deinstitutionalization that started in 1978.

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## ABSTRACT

In Italy, following the closure of psychiatric hospitals in 1978 and the release of psychiatric patients into community care, there was a mismatch between common psychiatric patients and the convicted mentally ill who were sentenced to serve in state forensic psychiatric hospitals. The recent closure of such structures following the Prime Minister's Decree of April 1, 2008, fostered the need to create new structures. These are called "REMS," and they are based in the community and led by psychiatrists and healthcare staff who may rely on the collaboration of public security staff. This act completed a course of progressive deinstitutionalization of all psychiatric patients. However, some problems remain, and persons regarded as "partially mentally disabled" at the time of crime perpetration must serve part of their sentence in prison and the rest in the aforementioned structures or in psychiatric rehabilitation communities, depending on their claimed "social dangerousness." Psychiatric services now face the ambiguity of treating persons who are considered dangerous by court orders, while the civil law criteria for involuntary hospitalization is based only on the need of care. The complete closure of forensic hospitals may be considered a decisive step forward in the humanization of society, but there are still some issues to address to make it work better. The implementation of multidisciplinary teams and effective psychotherapy, psychoeducational, and rehabilitation interventions can help.

## 1. Introduction

In European countries, forensic psychiatry (FP) spans from providing expert support to justice to the clinical care of patients with psychiatric disorders who have committed a crime (Ciccione & Ferracuti, 1995). In Italy, there existed a division between the penitentiary and healthcare systems. This was probably due to historical reasons, namely, the major influence of the thought and work of Cesare Lombroso (Ferracuti, 1998; Fioritti, 2008a; Salize & Dreßing, 2005),

and after the introduction of Law 180, this separation became even wider when the civil law abolished mental health hospitals (Dario, Del Missier, Stocco, & Testa, 2016), leaving forensic mental hospitals in a separate jurisdiction and health system under the Ministry of Justice. Cesare Lombroso (Verona, 1835-Turin, 1909) was an Italian physician and criminologist who postulated the existence of specific somatic characteristics and traits that distinguished the criminal from the noncriminal, despite admitting the molding influence of socio-environmental conditions (Lombroso, 1896). On the one hand, FP as a

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clinical practice focusing on mentally ill offenders has been confined to criminal asylums (later renamed “judicial psychiatric hospitals” [abbreviated in Italian as “OPGs”]) for over a century, but on the other hand, in its justice support aspects, it has remained an expert knowledge system (Ciccone, 1992).

This gap, present even before the enforcement of Law 180 of 1978, later Article 833, that ensued in the closure of all asylums in Italy and the deliverance of psychiatric patients in the community, widened even more thereafter (Fioritti, 2004; Fioritti & Melega, 2000). In fact, from an institutionalization perspective, the Italian National Healthcare System (NHS) was making a decisive move away from the system of OPGs and prison psychiatry (Jones, Wilkinson, & Craig, 1991; Lowell, 1986). The above anachronistic dichotomy has begun to resolve, with an outcome that is still uncertain, following the approval of the Prime Minister’s Decree of April 1, 2008 (DPCM of 1.4.2008) (Italy, 2008). This decree resulted in the penetration of community medicine in penitentiaries, which previously had their own, and in independent healthcare facilities that were entirely transferred to the NHS.

This article briefly reviews the history of the reforms concerning FP in Italy in the last decades.

## 2. The legal paths of the “insane criminal” before and after the DPCM of April 1, 2008

The first consequence of the application of the DPCM of 1.4.2008 and subsequent laws was the gradual closure of OPGs, which was planned and regulated by Annex C of the same decree. This change was also made possible by a series of legal and administrative measures adopted previously. In fact, without the Constitutional Court judgment N. 253/2003 in the Italian legal framework, the possibility of implementing security measures for patients acquitted because of insanity would never have been conceived. This judgment, in turn, followed a series of other legislative decisions on the same issue. These decisions had, for example, abolished the presumption of “social dangerousness” (Art 10.10.1986, N. 663, Art 10) (Maj, 1985). This provision was rendered necessary after the enforcement of Art. 180 (Italy, 1978), which had initially increased the number of people interned in an OPG (Coordinamento Interregionale Sanità Penitenziaria, 2014; Mosher, 1982; Perris & Kemali, 1985). It is noteworthy that the number of persons detained in OPGs remained higher than it was before the enactment of Art. 833 (Fornari & Ferracuti, 2008). We consider it appropriate at this point to briefly recall the provisions of criminal justice legislation relating to the judicial paths for convicted persons with mental disorders (De Girolamo, 1989; De Girolamo & Cozza, 1999).

In Italy, when an offender is judged to be insane, he/she may be sanctioned by two different articles of the Italian Penal Code: 1) Art. 88 (total infirmity of mind, implying total mitigation of criminal responsibility) or 2) Art. 89 (partial infirmity of mind, i.e., partial mitigation of criminal responsibility, with judging ability “greatly diminished”) (Fornari, 2015). If the judge, based on the expert’s opinion, ensures a current condition of social dangerousness, defined as a “probability” of crime recidivism, the person is declared “socially dangerous.” More specifically, a person is socially dangerous – even if not responsible or not punishable for criminal acts – when he/she has committed a crime or a quasi-offense (Articles 49 and 115 of the Italian Penal Code [IPC]) and it is probable that he/she can commit new acts that the law classifies as crimes (IPC Article 203, Italy, 2017a, 2017b). The “totally infirm” are acquitted by the application of Article n. 222 of the IPC, while the “partially infirm” are convicted and IPC Art. 219 applies. Before the DPCM of 1.4.2008, this different legal classification, not repealed by the current system of standards, would have led to different fates. People subject to Art. 222 (totally infirm) would not be able to stand trial, hence – if convicted – they were interned in an OPG, while those referred to in Art. 219 were restricted to a dedicated nursing home, termed “house of care and custody” (HCC). In fact, OPGs and HCCs were never distinct structures (Fornari & Molinaro, 1987). Persons

subjected to IPC Art. 219, after being sentenced, could serve part of their sentence in prison (that part corresponding to their partial non-infirmity) and then be transferred to the HCC, according to the degree of their “social dangerousness” (Ferracuti & Roma, 2008).

Defining someone as socially dangerous implies the application of a security measure that is not a penalty, but rather a precautionary measure dealing with the probability of future recurrence. The determination of social dangerousness of an individual is proportionate to a fact that has already taken place, i.e., the criminal act, and as such is related to a temporary context. However, reassessment is warranted, as the subject’s dangerousness may vary with time and the predictive value of a social dangerousness definition varies with time. Furthermore, the duration of the security measure is unspecified, since it is proportionate to an arbitrary attribution of a hazard and may only cease with the cessation of the hazard itself. In this regard, however, IPC Articles 207 and 208 establish a minimum duration for each security measure in response to a presumption of dangerousness which can be renewed at the end of the minimum period set by the magistrate. This contradictory aspect has been partly addressed by Art. 81, dated May 30, 2014, which deals with the gradual closure of OPGs. The article places a precise time limit for provisional or final security measures, considering the total duration of the sentence. Regarding detention security measures, a determination of social dangerousness cannot exceed in duration that of the sentence for the offense; thus, the article de facto avoided the risk for a life sentence of social dangerousness, which previously constituted a frequent occurrence.

Parallel to the closure of the OPGs, the Italian government established residences for the enforcement of security measures (REMS) on behalf of the individual Italian regions. REMS are buildings closed to the public that are similar to rehabilitative therapeutic communities but are more restrictive and have security precautions.

Typically, REMS operators are two psychiatrists, one psychologist, three psychiatric rehabilitators, six social health workers, twelve nurses, and one social worker. There should also be an administrative manager. Two types of REMS were planned: 1) assessment/stabilization and 2) maintenance. However, this distinction is not yet fully represented at the regional level (some regions have two types; others have only one type) since the reform is very recent and is being defined on the territory.

REMS are closed facilities that residents cannot leave without a magistrate’s permission. On average, REMS can admit 20 people, who can be men or women only, although in some regions, such as Campania and Sardinia, REMS admit both genders. Everywhere, REMS are single communities, except in Lombardy, where the former OPG “Castiglione delle Stiviere,” which had 200 seats, has been converted into various 20-place communities, totaling 120 residents. Overall, there are 30 variously sized REMS (ranging from 2 to 40 residents) in Italy, of which 24 are state-owned, 5 are private, and one is mixed (private and state property), and all of them are part of the National Health System’s mental health departments (MHDs) spread throughout the country.

The residents of these new structures are people completely or partially lacking criminal responsibility for their crimes due to mental illness who nevertheless are considered socially dangerous; hence, the Court determined the need for detention security measures. REMS constitute an attempt to overcome the contradictions and anachronisms inherent to OPGs; however, this reform, despite addressing some of the problems of older institutions and legislation, opens the door to new perils and threats (Carabellese & Felthous, 2016).

Each REMS has its own regulations, and the patient must accept them at admission. REMS residents can challenge the decision during Court hearings. They can produce an expert witness opinion, ask to talk with the judge, and have free access to their lawyer.

Since this reform entails that the REMS are part of the Italian NHS, the patient cannot be treated compulsorily but only voluntarily. These patients do not serve a sentence but are interned in a measure of security, that is, a preventive measure that has the purpose of protecting

society from dangers possibly deriving from the patients' behavior. They are not detained in prison but are confined to a residence. As they are not under compulsory treatment, they can refuse treatment. If they manifest an acute episode of a mental disorder, REMS physicians can refer them to a general hospital's acute psychiatric care unit<sup>1</sup> where a compulsory treatment can be completed (if the following criteria are present: 1) The person shows an acute episode of a mental disorder that requires emergency therapeutic interventions, 2) he/she refuses the proposed medical interventions, and 3) timely extra-hospital measures cannot be taken). In fact, there are no judicial measures in the IPC that can force someone to accept treatment. The judge may issue an order that a person needs treatment, but there are no rules that can oblige the patient to coercively receive treatment in any condition other than a compulsory treatment regimen.

Hence, when one patient refuses treatment, he/she is transferred to a hospital's acute psychiatric care unit and involuntarily treated there, with all bureaucratic consequences and difficulties in providing adequate care. Being under the Ministry of Health, workers at REMS are healthcare professionals; no employees of the Ministry of Justice are involved.

Currently, if a person with a mental disorder for whom Art. 222 applies is found guilty and sentenced and subsequently determined to be socially dangerous, he can access a REMS or obtain probation (alternative, noncustodial security measure, or house arrest). If Art. 219 applies (partial criminal responsibility), the person may first be imprisoned in a penitentiary for the part of the sentence corresponding to the proportion of responsibility and then may gain access to REMS or obtain probation. If the person fails to comply with the judge's prescriptions or commits new criminal acts, his/her probation may be converted to a restriction in a REMS; vice-versa, if security measures are loosened, restriction in a REMS may be converted to probation.

The Italian Criminal Code also provides for the possibility of application of a provisional order of forced restraint in REMS (IPC Art 206, Italy, 2017a, 2017b).

In OPGs, some categories of prisoners were also interned (IPC Articles 111 and 112) and detained who had a mental illness arise after they were sentenced (IPC Art 148, Italy, 2017a, 2017b). Detainees with severe mental disorders (DPR 230/2000, Art 111 – New regulation of penitentiary order enforcement), and/or needing psychiatric assessment (Art 112), and/or manifesting self-destructive or highly disturbing behaviors in penitentiary environments, are a heterogeneous group of people who can manifest severe borderline, antisocial, or paranoid personality disorders (Andreoli, 2002; Fornari & Ferracuti, 2008). For some of these cases, there is a suspicion of malingering, i.e., the fabrication of symptoms of a mental or a physical disorder to obtain a material advantage (Fioritti et al., 1998, 2001, 2006). Under the current legislation, these people should no longer be included in the alternative security measures. In this respect, it is highly significant that the Supreme Court of Cassation, the highest and last court of appeal in Italy, whose sentences are definitive, issued a ruling in its penal United Sections (N. 9136.2005 – “Raso” Judgment) extending the absence of criminal responsibility even to cases of very severe personality disorders (Supreme Court of Cassation (Italy), 2005).

Finally, it should be noted that the Penal Code provides for lack of criminal responsibility of persons with chronic alcohol use disorder (IPC Art 95); such autonomous formulation has survived the scrutiny of the Constitutional Court (4 September 1998, N. 114), which stressed the full autonomy of this article in relation to IPC Articles 88 and 89 (Italy, 2017a, 2017b).

<sup>1</sup> Another peculiarity of the Italian psychiatric reform. There are no psychiatric hospitals, but rather acute psychiatric care services (abbreviated in Italian as SPDCs) in NHS hospitals for the treatment of acute psychiatric manifestations, where the patients are hospitalized until stabilization and then discharged and followed up by local community services.

### 3. Therapeutic approaches for the “criminally insane”

The reformed legislation has created a prison-REMS-community MHDs circuitry where mentally ill people convicted of crime may circulate. The types of clinical disorders found are mainly schizophrenia, delusional disorders, and severe forms of bipolar disorder, often comorbid with substance use disorders, especially very severe forms of all involved disorders (Fazel & Danesh, 2002; Langeveld et al., 2014). However, since 2005, as a consequence of the Raso judgment, there has been an increase in patients with severe personality disorders. Additionally, the proportion of patients who have received a so-called “dual diagnosis” (a major psychiatric disorder with comorbid substance use disorder with onsets in any order or simultaneously) has steadily increased over the last twenty years. Even if these people have committed similar crimes, it is not advisable to treat them the same way. About 5% of these patients are sex offenders, and these differ on many grounds (Ennis, Buro, & Jung, 2016; Sigre-Leirós, Carvalho, & Nobre, 2015, 2016) and should receive highly specialized treatment (Howard, de Almeida Neto, & Galouzis, 2018; Kim, Benekos, & Merlo, 2016; Schwartz, 2003) and specific social control that Italian community MHDs are currently unable to provide.

A predictor of criminal conduct recidivism is the degree of psychopathy, which is sometimes comorbid with schizophrenia or bipolar disorder (Craparo, Schimmenti, & Caretti, 2013; Vaughn, Howard, & Delisi, 2008). This is conceptualized as a set of psychological traits that inherently favor criminal conduct. The treatment of people with psychopathic traits requires training in specific psychotherapies that could back other types of treatment; these should be made available to the staff of structures like the REMS and adequately assessed for efficacy/effectiveness.

### 4. The role of community mental health departments (MHDs)

The DPCM rendered the entire MHD system an area of encounter between psychiatry and justice. Seen from the judge's perspective, each mentally ill offender can be treated at MHD facilities, if necessary, independent of whether they are currently unrestricted, under house arrest, on probation, or under restriction in REMS (Fioritti & Amaddeo, 2014).

This situation shifts the problem to the set of skills that are required to manage these “difficult” patients.

As a consequence of the new situation that was determined with the closure of OPGs and the enforcement of the REMS, administrative regions will have to organize the monitoring of patients entrusted to the MHD who are currently on probation or are referred by institutions such as the OPGs or the REMS (Fioritti, 2008b; Fioritti & Amaddeo, 2014). Data collection of these patients and intervention is required to enable us to estimate the costs and provide statistically significant parameters regarding the risk of recurrence, that is a measurable concept that may be subjected to verification and criticism, unlike the arbitrary concept of “social dangerousness” (Kennedy, 2002). Since many of these patients have comorbid substance use disorders and some are acquitted under the former IPC Art. 95, an integration with drug addiction and disability departments for the care of patients with drug addiction or mental retardation, respectively, has become extremely necessary (Piselli, Elisei, Murgia, Quartesan, & Abram, 2009).

It is obvious that without the implementation of penitentiary psychiatry it will be difficult to face the difficulties arising within this new context. It seems naïve to endorse a penitentiary system where the complex problems that arise in a prison are managed in absolute autonomy by the (few) psychiatrists working in the penitentiary institution (Kinsley, 1998). Since the REMS cannot treat those patients compulsorily, it follows that these detainees can be referred to an acute psychiatric care unit, which would likely overload the already overwhelmed Italian community psychiatric services.

## 5. Professional responsibility, obligation for care, and safety for the user and worker

One of the most controversial and dreaded aspects for professionals facing the management of integrated structures in legal paths is their risk and professional responsibility, as all health workers are carriers of a so-called “position of guarantee,” that is, psychiatrists and psychiatric nurses may be held responsible for the effects of their interventions on patients and others.

The possible professional liability a psychiatrist may be subjected to has peculiar characteristics compared to that of other medical professions. The psychiatrist is required not only to provide a diagnosis and subsequent outcome of the clinical condition, but also to forecast the future behavior of the patient and what his/her intervention will elicit in the patient, especially regarding issues of suicide or third-party attacks of that patient. This is called vicarious liability and extends to acts committed by others due to hypothetical errors, negligence, or imprudence of the professional. Unfortunately, the law increasingly tends to pool all possible forecasts within the condition of responsibility, and the Supreme Court has stated that the distinction between self-harm and other harmful behaviors is irrelevant. This is because when the disorder manifests through violent attitudes directed to others, the attack harms not only the victim but also the patient, who will be processed and possibly interned. In brief, the Italian jurisprudential orientation has consolidated an interpretation of the position of guarantee of the psychiatrist for which the patient, on the one hand, has to be protected against possible self-aggression and, on the other hand, against the danger for third parties, who in turn must also be protected.

It is a common and widely shared value in the medical profession that our duty is to cure and not to incarcerate or apply custodial measures. However, the inherent ambiguity that derives from having to accommodate people who are in a regimen of detention results in the need to consider the following two contradictory points:

- 1) If the penitentiary order needs to be applied in the REMS, should the custody obligation be supported by healthcare professionals?
- 2) Italian Law 180 amended the criminal code in articles that involve failure in the custody of the mentally ill, but not Art. 2047 of the civil code that “allows to charge psychiatric services with duties of surveillance so to ensure a fair balance between freedom of movement and the expression of personality of the subjects subjected to control and the necessary protection of third parties.”

These ambiguities are even present in the statutory and administrative rules governing mandatory treatment for psychiatric reasons. Another significant problem concerns the mandatory nature of the treatments. Detention automatically implies the deprivation of individual freedom. However, there is much debate over the fact that it also entails the obligation to receive psychiatric treatment (Fisher et al., 2017). If we reflect on compulsory admission and treatment, it seems unreasonable to establish the urgency of the treatment if the need for prevention of any harmful consequence for that person or others is not considered. Especially in reference to Art. 180, compulsory hospitalization and treatment have the purpose of avoiding all possible negative consequences of an untreated and otherwise unmanageable medical condition, which implies a forecast of possible impending danger or health impairment (Fioritti, 2008c).

People subjected to enforcement of safety measures are found in a legally complex situation from a statutory perspective. To simplify the current difficulty, it can be said that there is a lack of statutory standards enabling the enforcement of drug treatment and/or psychotherapy against the patient's will. The only feasible measure for emergency treatment against the patient's will remains compulsory (involuntary) hospitalization and treatment. This creates a risk of conflict between services and may result in the possible overload of acute psychiatric care units with patients under safety measures (Lora,

2009). This difficulty is further increased by the fact that many of the serious patients entrusted to MHD by the judiciary system are people who, for various reasons, will not or are unable to provide informed consent for treatment. We should stress that the doctor-patient relationship is one of the main pivots of a good outcome and is based on mutual trust, which in this case is severely curtailed. The only possible measure, beyond interdiction, is the possibility of requesting from the court a Support Administrator (SA) with the authority to provide informed consent for the treatment being administered. However, the law is slow to designate an SA, and their availability is often limited. Furthermore, conflicts may arise between the patient's interests and those of his/her family members and the SA, and the whole matter may lack clarity. To overcome legislative ambiguity, the law must provide suitable instruments for managing people with chronic disability and enhance their capacity for expressing informed consent to treatment.

## 6. Conclusions

Law 180 constituted a decisive progress in Italian psychiatric reform, but despite adhering to basic ethical and humane background principles, it failed to adequately manage challenges in the community and in high protection structures. However, the closure of OPGs resulted in the creation of a population that could not be treated the same way as other psychiatric patients in general hospitals in the structures that already existed. The new legislation represented a step ahead in the management of the mentally ill convicted offender. It was followed by the creation of newly conceived structures, the REMS, whose ability to provide responses should be addressed according to a scientific perspective. A problem that needs to be addressed is “social dangerousness,” which is not included among the criteria for compulsory hospitalization under the current legislation, as Law 180 requires the need of care for involuntary hospitalization, and not predicted social dangerousness.

Law 180 excluded social danger from the criteria of compulsory treatment. Before this law there was harmony between civil and penal law. A person with a mental disorder could be hospitalized in an asylum if a psychiatrist judged that the person could be dangerous or damage himself or others. This principle was quite consistent with the penal code. After Law 180, a hiatus was created. Under the civic code, compulsory treatments can be made only if there is a medical need for treatment, while under the penal code a measure of security can be implemented if there is a prediction of recurrence of a fact that constitutes a crime. On these bases, the current status of FP in Italy, with REMS and subjects on probation, sees MHDs involved in treating people who, in strictly civil terms, should probably never have to deal with psychiatry.

Since FP is a field of safekeeping and intervention in patients with a criminal record, there is a need to overcome the classical concept of penalty (i.e., a punishment imposed for breaking a law). Another issue to address is malingering and factitious disorders (i.e., an intentional production, pretense, or exaggeration of the symptoms of a disease, illness, or psychological condition with the aim of playing the patient role) that the new law could be unable to face. The 2008 DPCM Act shifted the treatment paradigm from an approach that could consider offenders with a mental disorder not guilty or partially guilty, from whom society should be protected, to another in which these persons have the right to be cared for and socially integrated through a community service network for prevention, care, and rehabilitation. Current scientific evidence suggests that multidisciplinary teams and effective psychotherapy, psychoeducational, and rehabilitation interventions can be further implemented to possibly obtain greater benefits.

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