Evidence based Psychiatric Care
Journal of the Italian Society of Psychiatry

Original article

Società Italiana di Psichiatria

Considerations on treatment pathways for psychiatric offenders: critical points and Piedmont's regional coordination

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Summary

Objectives. This work addresses the evolution of psychiatric offenders pathways from Law 81/2014 to the current day, analysing critical points and highlighting Piedmont's experience on regional coordination.

Methods. The main consequences of Law 81/2014 are analysed and the situation of REMS in Italy is outlined, explaining function of security measures, treatment by mental health departments and the relationship between the latter and the judicial authority.

Results. The analysis of current situation in Italy reveals some critical points, to which the authors also aim to provide possible solutions, taking as an example the experience of managing waiting list and admissions to REMS in Piedmont. The establishment of Regional Single Points (PUR), through the Unified Conference of the Italian Presidency of the Council of Ministers of 30 November 2022, will encourage a multidisciplinary take-over by DSMs.

Conclusions. REMS are useful detention health rehabilitation facilities when placed within a patient care pathway that starts with the detention centre, passes through REMS and continues with a community based program. PURs can be useful tools that help different actors involved in the treatment pathway of psychiatric offenders.

Key word: psychiatric offenders, treatment pathways, REMS, waiting list, PUR

Introduction

As a result of Law 81/2014, assessment and treatment pathways for people with mental disorders who have committed a criminal offence have changed without amending the Penal Code. An offender undergoing psychiatric evaluation during pre-trial phase may remain in custody in prison or be sent to a treatment facility by public prosecutor. Whether the patient is acquitted, after psychiatric evaluation and according to Article 88 of the Penal Code, he or she cannot stay in prison and, when considered socially dangerous, must be subjected to a security measure. When the patient has a diminished mental capacity/diminished responsibility, security measure is carried out after detention in prison. Security measures are mostly non-custodial, consisting of territorial therapeutic pathways for patients on probation carried out in 80% of the cases by the Department of Mental Health (DSM) of the competent Local Health Agencies (ASL).

How to cite this article:
Crespi G, Ciminiello M, Turco M, et al. Considerations on treatment pathways for psychiatric offenders: critical points and Piedmont's regional coordination. Evidence-based Psychiatric Care 2023;9:3-6; https://doi.org/10.36180/2421-4469-2023-2

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Conflict of interest
The authors declare that they have no conflict of interest nor that they have received compensation from third parties for the creation of this article.

Whilst detention security measures are carried out in therapy-intense facilities called REMS, which are healthcare facilities with a maximum of 20 beds per module depending on Regional Authority [1,2]. There are 33 REMS in Italy, placed in almost every region, other than Umbria, Molise and Valle d'Aosta, which lean on REMS in nearby regions. The highest concentration of REMS is located in Castiglione della Stiviere, Lombardia, with 6 modules of 20 beds in the former OPG area [3].
Two (new) REMS were built in 2022. One of the last REMS built, Santa Maria Calice di Cornoviglio in Liguria, works differently than other REMS on national territory: waiting list is managed at a national level and aims to reduce waiting time for inmates patients to access regional REMS. Last REMS being built is in Girifalco (CZ), which opened after years of delays and postponements.

Definitive security measures

An article published in 2022 on the "Rassegna Italiana di Criminologia" [4] analysed the evolution of security measures in the register of final sentences from 2001 to 2019, when the overcoming of forensic psychiatric hospitals (OPGs) process (Supreme Court decision of 2003) has begun. In almost 20 years non-custodial security measures increased from less than 10% to more than 80% of total security measures. This raise leads to an enormous burden on Italian Mental Health Services (DSM). We are talking about 800 final sentences per year, with a steady increase due to the sharp rise of non-custodial security measures. Since 2014 Italian DSMs have also struggled in replacing retiring specialists and in managing economic constraints occured in health care. This evidence shows that REMS are not a replacement for old Forensic Psychiatric Hospitals (OPGs) and according to Law 81/2014, they should be considered as the end of the line for patients who are deemed to be socially dangerous and a non-custodial territorial pathway is not possible.
Unfortunately, the failure to reform the Italian Penal Code and the difficult dialogue between judiciary and health services have led to a REMS assignment which far exceeds their ability to take in patients, resulting in a waiting list.
According to a recent study led by the Prisoners' Guarantor [5], on the 31 December 2021 there were 31 Italian REMS with a capacity of 656 places. 87% of all were occupied by 573 internees, of whom 512 (91%) were men and 61 (9%) women; 451 (79%) were Italians and 122 (21%) foreigners; 305 (53%) had a definitive measure and 243 (42%) a provisional one; 25 (5%) were (in the process of) changing from a provisional to a definitive measure. The average time spent in REMS, at national level, (nationally) was 708 days, and there were 630 patients with a REMS assignment on waiting list on the 31 December 2021, of whom 42 (7%) were incarcerated.
According to the intention of Law 81/2014 bed in REMS were not intentionally equal to the OPG. Unlike the Public Health System, which involves the basic concept of waiting list, Judiciary does not accept when issuing orders are not carried out immediately. The conflict of competences arose because REMS system, which was designed for permanent internees, was extended by the Minister of Justice to temporary internees as well, whom would be more appropriately located in mental health protection areas (ATSM) in prisons. The correctional system has opposed to this solution and has demanded that REMS could accommodate temporary inmates, which constitute the 42% of the inmates accessing REMS. In a census carried out on REMS residents, Catanesi et al. described the population present in 2018: 89% male, mean age 41.7 years, with a duration of mental disorder of more than 11 years; 82 % of the internees were already known to the DSM before entering the REMS and 71 % had previously been admitted to a specialised psychiatric setting. 60% of patients had a diagnosis of schizophrenia spectrum disorder and 30% a personality disorder; 21% showed a comorbid substance use disorder [3].

Critical points

In 2019, the National Bioethics Committee (CNB) presented an opinion on mental health and psychiatric care in prisons, which contained elements of undoubted interest in analysing the issues resulting by the effects of Law 81/2014 [6]. The expert opinion pointed out that closure of OPGs was carried out without a comprehensive treatment plan for psychiatric offenders and without overcoming concepts and terminology that are outdated with current knowledge: "folle-reo" and "reo-folle"*, "licenza finale di esperimento"**, social dangerousness etc.
In order to properly manage the clinical situation of mentally disordered offenders would have been important the adaptation of national standards to healthcare regional realities: for example, the organisation of DSMs differs from region to region, whereas people with mental disorders who have commetted a criminal offense often

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* The term "folle-reo" was used in the Penal Code of 1930 to describe an offender who was mentally ill, unaccountable and considered socially dangerous. The offender, if found insane, was declared insane, incapable of defending himself in court, incompetent to serve a sentence of imprisonment, and sanctioned by an ad hoc institution, the OPG, run by the Ministry of Justice. The security measure imposed continuous social and psychiatric surveillance, even for life. Whereas the term 'folle-reo' was understood to mean the offender who commits an offence as a result of his mental disorder, the term 'reo-folle' was understood to mean the offender who commits an offence completely independently of his mental disorder and is therefore fully culpable.

** It is a (maximum) six-month licence that can be granted in the period immediately prior to the date set for the social dangerousness re-assessment.

require a unified response from the ASLs, with the involvement of addiction services (SerDs) and territorial services dealing with elderly and disabled, in addition to those of psychiatry.

OPGs' closure has not been sustained by an adequate review of current legislation, which still refer to the OPGs and it severely restrict the possibility to build appropriate treatment pathways both for people who commit crimes with excluded or severely diminished mental capacity and for people diagnosed with a mental illness while in custody.

The biggest unsolved problem of mental health in prison is the persistence of the so-called 'double track' (doppio binario), whereby the offender who was mentally incapacitated had to be committed to the OPG and could not stay in prison. With the overcoming of OPG, it has not been clarified where the offenders considered unaccountable and a danger to society should be placed. Incorrectly, judges frequently consider REMS as a replacement for OPG. The abolition of the asylum in 1978 and current abolition of the OPG should have overcomed the 'double track' by giving back dignity and responsibility to the mentally ill offender. As long as they need to be detained because they are a danger to society, they should be kept in an appropriate secure facility. Once OPG is overtaken, REMS should be considered more like rehabilitative facilities than restrictive. The eccessive use of REMS assignment ensure that patients considered to be socially dangerous are placed on waiting lists and are managed in different ways: prison, residential facilities, hospital services for the diagnosis and treatment of psychiatric disorders (SPDCs), home, etc. This can lead to risky situations, precisely because the Penal Code has not been revised.

The concept of "psychiatric" social dangerousness must be revised: it is a very difficult prediction even for an experienced psychiatrist, who could express more competently about patients' prognosis. Only judges should decide on social dangerousness, with an expert opinion on possible outcomes of the patient's treatment. Human behaviour, and even more so the behaviour of patients who have committed a crime, is affected by a large number of individual variables. Therefore, illness alone does not explain the behaviour of psychiatric patients who have committed a crime. It is incorrect to predict the future behaviour of a subject solely taking into account only symptom development or resolution.

One of the possible solutions is to set up health care facilities within prisons; at present, prisons have designated areas for the 'protection of mental health' (ATSM), where socially dangerous psychiatric patients can be hold while waiting the admission to REMS. Indeed, the Italian Psychiatry Society (SIP) promotes to improve quality of life of inmates improving the quality of medical care in prisons and through the creation of units within prisons maneged by the DSM [7]. Mental illness should be considered as physical illness, and it is necessary to allow suspended sentences for inmates who become ill and need treatment in facilities outside prison. This requires investment in DSMs, in order to establish forensic psychiatry units (UPFs)*** in each ASL, also including the Penitentiary Psychiatry in all of those ASLs hosting a correctional facility on their territory. In order to be able to identify community network resources for treatment of serious diseases, these units should be an integral part of the DSMs.

A continous cooperation with the Judiciary of Cognition and Surveillance is necessary for a more attentive and precise use of security measures, consistently with the therapeutic purpose of REMS, limiting the access to REMS to individuals towards whom a definitive custodial security measure has been applied. For defendants in the cognitive phase and inmates with temporary psychiatric treatment needs, psychiatric observation units within prisons can be used. The existence of special prison psychiatric units run by DSMs within forensic psychiatric units structured using specialised resources might improve mental health in prisons, REMS and community-based treatments [8].

In REMS and community-based pathways an accurate selection of patients eligible for a specific treatment must be carried out, for example using a few REMS for people with mental disabilities and for people with substance dependence comorbid with a personality disorders. It is also essential to improve communication between psychiatric experts and mental health services, which must be mandatory in order to improve custodial and non-custodial treatment pathways, balancing as far as possible therapeutic needs with containment of behavioural changes that may lead to criminal misconduct [1,2].

The recent Constitutional Court decision 22/2022[9] is very critical towards the current situation related to Law 81/2014 and proposes to increase the number of REMS and to have them run by the Judiciary, which is inappropriate because these are health facilities. In health care, an increase in supply matches with an increase in demand: an increase in the number of REMS does not necessarily correspond to a reduction in waiting lists[10]. An improved management in terms of assignments and resignations for REMS is mandatory. Patients with a provisional security measure should be adressed to psychiatric observation units or ATSM in prisons, together with an improvement of health care in correctional facilities.

Piedmont's experience of regional coordination

The model of REMS allocation in the Piedmont region is virtuous: it does not delete waiting list but it highlights legal and clinical aspects in the priority of REMS admissions. In Piedmont, UPFs have been set up in all the ASLs, whose

*** Multidisciplinary teams of psychiatrics, psychologists, social workers and nurses who manage and plan the care of mentally ill offenders.

representatives meet every three weeks, coordinated by regional officials, with the directors of the two Piedmont REMS and the ATSM psychiatric liaison officer at the Lo Russo and Cutugno Prison in Turin. The establishment of Regional Single Points (PUR), through the Unified Conference of the Italian Presidency of the Council of Ministers of 30 November 2022 [11], through managing and assessing the situation of REMS assignments and patients already interned, will encourage a multidisciplinary take-over by DSMs. This conference formalized, regarding Piedmont, the existing management of waiting lists and patients in REMS, ensuring a homogeneity of interventions and health and treatment services throughout the country. Piedmont's waiting list and REMS management model has resulted in a shorter average REMS stay of eight months and a waiting list stay of REMS assignees of less than two months on average: this shows that this continuous dialogue between ASL representatives and REMS directors is useful for REMS management and allows to focus on territorial treatment pathways. The majority of probation and discharge projects from REMS take place largely within psychiatric residential facilities (SRPs): only 6% of patients return home directly from REMS****.

Thanks to the REMS assignment assessment in Piedmont, from 2016 to 2022, 25% of the patients on the waiting list were never interned, precisely because of the work of regional governance. The latter identified effective alternative territorial pathways that convinced the competent judge to review the REMS assignment and transform it into a non-custodial territorial pathway, according to Law 81/2014. Another way to reduce the number of REMS admissions is to provide in the REMS Discharge Plan for an aggravation of the security measure, other than re-entry into the REMS, for possible non-compliance with the probationary or final licence conditions.

Essentially, in order to reduce the waiting lists of those assigned to REMS, instead of increasing the number of places in REMS, we can a) ensure that psychiatric experts cooperate on treatment pathways with DSMs operators; b) through regional governance, examine the accuracy of REMS assignments; c) actively involve DSMs operators in taking charge of inmates in REMS in order to reduce length of stay.

Conclusions

In conclusion, authors believe that collaboration between DSM, REMS and ATSM professional through the implementation of PURs is a useful tool to reduce length of stay and verify the adequacy of the assignment to the REMS and therefore make better use of them. Priority of entry into REMS must be based not only on a chronological order, but also on legal and clinical criterias. REMS are useful detention health rehabilitation facilities when placed within a patient care pathway that starts with the detention centre, passes through REMS and continues with a community based program. PURs can be useful tools that help different actors involved in the treatment pathway of psychiatric offenders. After a reasonable period of time it will be necessary to assess how they are implemented and managed in different regions, especially where they are not already in place, and whether they allow us to reduce waiting time for REMS allocation, which is the main criticism of the current system that replaced OPG.

**** Data processing by Unità di Monitoraggio e Programmazione Clinica (UMPC) of the Mental Health Department ASL TO3 & A.O.U. San Luigi Gonzaga.

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