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Psychopathology in forensic setting

Guest Editor: Roberto Catanesi, Stefano Ferracuti

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Contents

This issue of the Journal of Psychopathology brings together an array of national and international experiences aimed at providing an integrated perspective of current forensic psychiatric problems. Credit should be given to Prof. Rossi for his sensitivity and attention for proposing a complex and difficult subject such as that of psychopathology in the forensic field. What happened in Italy in the last 10 years certainly establish an important moment of discontinuity with the past, as reported by various authors. Several authors of this issue have been promoters and organizers of the process of closing the judicial psychiatric hospitals in Italy, and the difficulties that have arisen and the current perplexities are well represented in the various contributions.

The assessment of the risk of possible future violent behaviors emerges as a central theme, especially in relation to the possibility of applying or prolonging measures limiting personal freedom to individuals identified as being at risk for antisocial behaviors. Other aspects of violence related to psychopathology are thematized, such as intra-family violence and possible specificities of violent behavior in relation to diagnostic categories, demonstrating the breadth of the theme. Elements of more strictly medical-legal assessment are also inside the issue, in reference to the general framework of risk assessment from a risk management perspective a novelty theme in forensic evaluations.

We believe that the current situation of forensic psychopathology in Italy, and generally in Europe, shows very clearly that few areas of psychiatry and psychopathology are more linked to social and legal choices. Forensic psychiatry is a discipline of strategic importance in the context of the study of human behavior that combines, in a not always linear and coherent form, purely clinical dimensions with the methods of organizing the control of deviance and, in particular, of the violence linked to mental illness. In this sense, the problem in Italy today is a system of different instances and philosophies, which have stratified over the course of almost a century.

In fact, in the same clinical-social-juridical scenario there are rules that establish the responsibility of the person entrusted with the supervision of the incapacitated in case of damage caused by the latter (art.2047 of the Civil Code), an evolved and refined doctrine on informed consent (Law 319/2017), a legislation on coercive treatment which excludes the possibility of recourse to it due to the risk of violent conduct and in any case strongly limits its duration. This last aspect must be related to a legal doctrine which, on the other hand, has progressively extended the psychiatrist's "position of guarantee", attributing ever greater responsibility to the healthcare professional in relation to possible future violent behaviors of his clients, provided that they are "predictable ". Certainly it becomes paradoxical and in any case unmanageable on a practical level, a situation where a psychiatrist can be accused of an omission if he has not been able to prevent a violent act of his client when there is another legislation that prevents coercive treatment except for the need for treatment and does not allow involuntary treatment as a possibility for limiting action on the client's conduct.

Even the lack of intermediate civil treatment, other than compulsory medical treatment, is a strong limit to a correct practice aimed at protecting patients and potential victims. We take this opportunity here to highlight

that all the choices of the legislator with respect to the closure of the Judicial Psychiatric Hospitals were exclusively aimed at the perpetrators and there was no attention to the possible victims of crimes committed by patients, even knowing that for the most part, their violence is exercised within the family or towards close relatives. This legislative vacuum certainly does not help to reduce the elements of social friction: the victims of crimes committed by psychiatric patients seek compensation to the detriment of the health professionals, increasing a spiral of conflict of which the limit is not seen.

The lack of an overall perspective is reflected in confused proposals for the abolition of the not-guilty for reasons of insanity legislation tout-court, often advocated by those who believe that problems can be solved with a work of social-legal engineering without considering that, on the other hand, these problems belong to an anthropological dimension. much deeper culture and in any case they seem to ignore many years of juridical (and also medico-legal) reflection on the subject.

It is not a case that the debate reported in this issue of the Journal of Psychopathology is completely lacking the voice of the prison dimension. In fact, if it is true that on the one hand the criminal asylums have been closed, thus achieving the "political" objective, on the other hand very little has been done to improve psychiatric treatment in prison institutions, nor does this problem seem to be of concern to the General Managers of the local health authorities, if not for sporadic exceptions. Prisons have become the new containers for a large number of psychiatric patients who often do not have sufficient economic protection to have an adequate lawyer or to pay for a consultant. The set of rules that governed the closure of the criminal asylums envisaged, at the same time, the development of "health articulations" in the penitentiary environment, that were conceived as authentic psychiatric structures, separated from the prison context and with treatment and environmental standards comparable. Today this health resource is available in a scattered way in the different areas in Italy and is absolutely residual inside the department organization.

Many of the problems highlighted in the REMS interventions reported in this issue are related to the presence of a subgroup of people with high rates of psychopathy and mental illness. It is a limited number of people, who nevertheless absorb considerable energy and resources from the staff working in REMS, in addition to exposing them to the risk of suffering violence. The rule originally envisaged the establishment of two types of REMS, one for stabilization and one for treatment, and certainly the problem of the existence of a subgroup of people who appear resistant to treatment and a continuous source of social alarm cannot continue be neglected or treated as a speciousness of forensic psychiatrists, deserving instead an appropriate organizational reflection.

In our opinion, a serious comparison with reality must be implemented: how many people, suffering from mental illness, are currently included in the system of security measures? The number certainly cannot be assessed only with REMS inmates. These form the tip of an iceberg whose immersed volume is completely ignored. Furthermore, the security measure of probation, unlike the custodial one, does not have a defined time limit and some of these subjects can be in charge of the departments of mental health for many years, in situations that appear problematic if evaluated from the point of view of the freedom of the single. It is also common knowledge that sometimes people assigned to REMS are sent to community treatment with a revision of the safety measure only because there is no bed available in REMS, thus finding themselves in conditions of community management that can last for a much longer time of the original measure.

The solution, at least the first step towards a solution, passes in our opinion from the establishment in each Region of an Observatory for a standardized and capillary data collection. In fact, only by having a vision of the actual dimension of the problem, that is, of how many offenders are actually affected by mental illness, where they are allocated, how they are treated, etc., will it be possible to adequately calculate the level of capacity necessary to deal with this problem in dignified terms, central to human rights. Having a dimension of the problem, it will be possible to think of a treatment system differentiated by structures and programs, more able than the current one to balance personal freedom, health protection and the interest of the community. It is time to abandon ideological prejudices and tackle the issue of the protection of psychiatric patients who are offenders scientifically and concretely, without forgetting however the protection of their possible victims.

Roberto Catanesi e Stefano Ferracuti

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Overcoming forensic psychiatric hospitals in Italy, five years later

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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.

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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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Commentary on "the new Italian Residential Forensic Psychiatric System (REMS). A one-year population study"

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Catanesi and colleagues [1] are to be commended on their publication of a substantial survey of patients in the Italian 'Residences for the Execution of Security Measures' (REMS). The REMS system consists of a regional system of around 30 secure units, focussing on mental health recovery and rehabilitation rather than the high security and more penitentiary-like large hospitals they replaced (the six *Ospedali Psichiatrici Giudiziari,* OPGs). These smaller units, however, with approximately 20 beds each, only provide approximately a third of the capacity of the OPGs (604 beds *versus* 1639), raising the important issue of the characteristics of the patients who are admitted to this new, reorganized forensic mental healthcare system. This is the question Catanesi and colleagues answer. Between June 2017 - June 2018, they detailed the socio-demographic, criminological and mental health characteristics of over 95% of those residing in the REMS.

In many respects this redesign of the Italian forensic mental health system parallels the journey of the UK, which has also sought to supplement and replace the function and capacity of its original four high security ('Special') hospitals. Two key reports [2,3] from the government's Department of Health and Social Security found that these Special hospitals were significant barriers to the rehabilitation and eventual discharge of patients back to community living. Firstly, they were generally located far from their patients' family, friends, and sources of community support. Secondly, there was no formalised 'step-down' pathway for gradual reduction in security and supervision of patients prior to their discharge. The result was the founding of a tier of regional 'Medium Secure Units' (MSUs) within forensic psychiatric hospitals, currently providing around 3500 beds. Patients are detained under the Mental Health Act 1983 (amended 2007), and most have either received a 'hospital order' at the point of sentencing (a direction for detention in hospital rather than prison) or have been identified as mentally ill in prison and transferred to hospital. Like the REMS, the units focus on recovery, relatively shorter stays, and are designed to integrate with low secure and community forensic services.

Catanesi and colleagues found that most REMS patients are male (89%), had a long disease duration (mean 11.5 years), and were already being treated by public mental health services (82%) or had previous civil hospital admissions (71%). 13% had more than four previous admissions. In terms of diagnosis, patients were frequently comorbid (mean 1.4 diagnoses per patient) but predominately suffered from schizophrenia-spectrum

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disorders (60%). 30% had a diagnosis of personality disorder (with borderline personality disorder being the most common subcategory), and 21% substance use disorder. In terms of crime, approximately 80% of patients had a conviction for a crime against the person involving violence, of which homicide or attempted homicide was the most common (and family members were often victims). Almost half (48%) of patients had criminal convictions prior to the index offence.

Treatment with antipsychotic medication was common. Overall, 71% received an oral antipsychotic medication, with 47% prescribed a long acting injectable antipsychotic (mostly haloperidol or paliperidone palmitate); more than half of these patients (57%) also received a different oral antipsychotic medication (with almost half receiving a mood stabiliser). We note no use of clozapine in the treatment of this Italian sample, a typical choice in the UK for treatment resistant psychosis.

These patient characteristics are broadly similar to those in British MSUs. For example, in a sample [4] of 409 forensic patients discharged from MSUs, 87% were male and had a mean age of 30.2 years. Over two thirds (72.5%) had previous admissions, with a mean of previous 3.6 admissions. Diagnoses were predominately schizophrenia or schizoaffective disorder (63%), drug dependence (26%), alcohol dependence (26%), antisocial personality disorder (21%), and other personality disorder (14%). Index crimes were homicide (17%), other violence (52%), sexual offences (7.8%), acquisitive crime (17%), and arson (13%).

Now the baseline characteristics of REMS patients are known, the key issues facing the REMS system will be to evaluate the service by examining admissions and patient outcomes. Who *should* the REMS admit, given the system has only about a third of the beds of system it replaced? What are the goals of admission? How will these be measured along the patient pathway through the whole forensic service, from before admission through to after discharge?

'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 [5]. Structured professional judgement tools such as the HCR-20 are frequently time consuming and require specialist training [6], and poorly validated in real world settings [7]. Actuarial assessments such as the VRAG (Violence Risk Appraisal Guide) may have little predictive validity for the populations on which they are used, with 'high risk' false positives being a particular problem [8]. Categories of 'high', 'medium' and 'low' risk generally used by these instruments are also limited in utility: two patients may share the same 'high' risk category yet have considerably different absolute risks that range very widely [9]. Hence, at times, these categories can become meaningless in practice.

The future of risk prediction for forensic patients will be the use of scalable, evidence-based instruments which are derived from and validated for populations similar to the person for whom prediction is required. These should be based on the most important empirically derived risk factors, rather than those traditionally thought to contribute to dangerousness. Such instruments can be used to 1) help prioritise admissions to a service by assisting clinical decision making; 2) raise the ceiling of quality of risk assessment; and 3) communicate risk accurately and consistently both within REMS and to other agencies, for example when patients are discharged. They should be cost effective and allow reallocation of resources to risk management rather than risk assessment [10].

An example is the OxRisk series of instruments from our research group (https://oxrisk.com) which has different tools for specific patient groups, assessing static and dynamic risk factors for outcomes of interest and giving a probability score of a specified outcome event (e.g. violent crime or suicide) for a given person over a specified time period. For example, OxMIV assesses risk of violent crime for people living in the community with severe mental illness [11], whereas FoVOx calculates the risk of violent reoffending for forensic psychiatric patients at the point of discharge using a probability score over 1 and 2 years and also pre-defined categories of low/medium/high [12] (https://oxrisk.com/fovox/). The scales typically take less than five minutes to complete and are free to use. Four complementary visualisations of the outcomes are provided on the online risk calculators.

Although prediction of risk to others (and management of that risk) may be the *sine qua non* of forensic psychiatry, a large range of instruments, indicators, and other outcomes are available [13]. Domains other than risk will also be important for the service and its patients, such as mental health, quality of life, social function, and psychosocial adjustment. The Italian REMS, as with MSUs in the UK, seem to have been designed with these latter goals in mind as much as minimizing risk and reducing reoffending. Choosing service eligibility criteria and the right outcome measurements will be key in evaluating whether the Italian REMS succeed in their goals.

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Evaluation and management of violence risk for forensic patients: is it a necessary practice in Italy?

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SUMMARY

The Law of 30 May 2014, n. 81 represents the point of arrival of an important reform of the Italian psychiatric forensic system. With it, in fact, Italy passed from a forensic psychiatric model based on OPGs to one based on REMS. The structural and functional characteristics of the REMS are aimed at assuring general security, individual care, rehabilitation programs in community environment and small scale dimensions. Our forensic model of treatment is very unusual indeed, so the use of such tools and specific practices for assessing the risk of disturbing conduct would provide more objective data with which to support statements that today may appear self-referential.

Key words: OPG, REMS, forensic psychiatry treatment, risk assessment, forensic psychiatry evaluation

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Introduction

The question for the title is of special interest in Italy after replacement of its large high secure forensic psychiatric hospitals, the OPGs (*Ospedale Psichiatrico Giudiziario*) with small local secure treatment facilities, the REMS (*Residenze per l'Esecuzione delle Misure di Sicurezza*) [1]. This model of care for the mentally ill who commit crime is different from the other European countries [2].

The REMS is designed as a residential treatment community, integrated within the larger community model of general psychiatry under the coordination of Mental Health Care (*Dipartimento di Salute Mentale*, DSM) [3]. The REMS units are small residences limited to a maximum of 20 beds. These are for persons who have been charged with criminal offences and for whom criminal responsibility has been either totally excluded or reduced due to a serious mental illness at the time of the crime. Such patients must also be judged socially dangerous, (art. 203 Italian penal code). Within the REMS the residents live in a setting where they are assisted by health professionals 24 hours a day.

Inside the REMS, patients take care of their personal hygiene, participate in therapeutic and psychotherapeutic plans and rehabilitation activities. The forensic patients regularly are treated with pharmacotherapy under the supervision of staff. Adherence to therapies takes place in REMS only with the consent of the inpatients [4] as with any other psychiatric patient in Italy.

Inpatients with comorbid substance abuse problems are provided with specific treatment programs [5].

Outside the REMS, activities include the acquisition of social skills, participation in physical exercise and sports, cultural, educational, and job

training activities. The patients are allowed to spend free time outside of the facility with their family when it is permitted. They also participate in psychoeducational programs with their family in the REMS and in the community [6].

Since the closure in Italy of the psychiatric hospitals (*Ospedale Psichiatrico*, OP) in Italy more than 40 years ago, the new forensic treatment model is now in harmony with the care model of general psychiatry [7].

The Law 9/2012 ordered the closing of the older, larger forensic hospitals (OPGs) and the change to a model of care based on regional residential facilities in the community (REMS) and this new convergence of intents and objectives has been welcomed by forensic psychiatrists and general psychiatrists [8] although some problems are emerging [9].

During the 40 years since the closure of psychiatric hospitals in Italy, psychiatrists have acquired specialized skills that characterize their clinical practices. Psychiatrists pay more attention to prognostic protective factors such as increasing intimate and non-intimate relationships, intra-familial relationships, supporting economic independence, working and living independently, the regularity and frequency of contacts with the mental health services, the constancy and adherence of care, the motivation for treatment. Each of these is likely to enhance the patient's residual autonomy.

The Structured Assessment of Protective Factors for violence risk (SAPROF) is a structured professional judgement tool to assess protective factors that mitigate the risk of violence [10,11]. In Italy structured professional judgment (SPJ) using such tools is less common, with the most common practice amongst experienced clinicians still being unstructured professional judgement. Drawing on the experience gained in the years following the closure of the OPs, Italian psychiatrists hoped that after the closure of OPGs, attention to such protective factors would contribute to a reduction in the risk of future criminal behavior in mentally ill offenders and would promote their social reintegration into their home environments. It is now useful to think about evaluating the effectiveness of this model over time for mentally ill socially dangerous offenders. Little use has been made of formal evaluation of the changed models of care in the last forty years.

By law, internment in REMS is a custodial security measure which is "extreme and exceptional". Law 81 of 2014 limits the maximum duration of internment in REMS to the maximum time of imprisonment had the offender been found guilty of the crime and sentenced. Catanesi and colleagues [6] reported that the average length of stay of patients in all Italian REMS is less than one year. This relatively short length of stay may be in part because the 30 REMS in the twenty regions of Italy have 604 beds [6] less than half the total beds in the six OPGs before their closures. This is a period of time much shorter than those considered in other jurisdictions as indicative of stabilisation and readiness for return to the community [12-15].

Can we be sure that treatment in REMS for these periods of time will protect patients or prevent patients from carrying out new violent acts?

Catanesi and colleagues [6] in the only study conducted so far in Italy on the situation of REMS, showed that the great majority of the offences by inpatients in REMS were acts of violence against the person (80%). About fifty percent of the inpatients had previous criminal convictions, mostly also offences against persons. Using the Italian version of the Modified Overt Aggression Scale (MOAS) [16] Catanesi and colleagues [6] demonstrated that more than one third of inpatients committed some type of violence while interred, in the month before the research assessment. Moreover, because this new forensic treatment model had not been tried before, its actual benefits and liabilities remained untested.

So why is it important to assess the risk of violent acts within REMSs and other Italian forensic facilities?

The answer is twofold, in our opinion. The seriously mentally ill under certain conditions, can engage in violent conduct with a higher risk than the general population [17-27].

Consequently, it is necessary to assess the level of specific therapeutic safety to match the needs of each patient following a verdict of not guilty for reason of insanity (NGRI) [28] where possible by using effective structured professional judgment tools [29].

The same can also be said for patients deemed socially dangerous and subjected to psychiatric security measures in REMS.

In these first years of REMS activity, contrary to expectations, the available beds proved to be insufficient and this has generated long waiting lists that are difficult to dispose of and the equally complex problem of having to keep patients waiting for their entry in REMS [9,30]. A more precise and reliable assessment of the necessary level of therapeutic security would allow the adoption of psychiatric security measures other than REMS internment in many cases [31]. This happens in other countries, e. g. in England and Wales for high security [32], medium or low security hospitals [33,34] in Belgium [35,36], and in Ireland [37-39]. Having structured judgment tools capable of assessing the risk of violence, the seriousness of violence and security needs would allow us to expand the treatment solutions offered by our system and to calibrate them more precisely to the needs of the individual subjects to be treated.

It seems all the more necessary to assess this need for a level of therapeutic security in the population of socially

dangerous NGRI offenders in our country in the light of what law 81/2014 has determined or has not changed [9]. This law has left unchanged the phases of ascertaining criminal responsibility and social psychiatric dangerousness. These assessments are left exclusively to the decision of the competent judge advised by his/her trusted expert forensic psychiatrist. The contribution of the diagnostic systems such as DSM in that preliminary phase is scarce or limited, except for those regions or single judicial offices such as Emilia Romagna region where memoranda of understanding have established collaborations in this sense.

Consider, for example, the recognition of the resources available to a specific territory in order to prepare a defined rehabilitation project with the possibility of success. Consider also that this kind of assessment is made up of many specific items for evaluation in risk assessment and needs assessment tools, including the assessment of readiness to move to lower levels of therapeutic security or to the community [40,41]. This is one of the reasons that led us, after collaborating in the validation of the HCR-20 V3 [42] for the Italian population [43], to promote the validation in Italy also of the DUNDRUM toolkit [44].

Secondly, we believe that the safety of the health professionals working in REMS and other forensic facilities is a topic that has been neglected up to now [45-47]. It seems necessary to deepen our understanding of this [4] given the extent and frequency of aggressive episodes to the detriment of health professionals [48]. That will be the subject of a further study in another article in this same issue.

With this contribution instead we will try to address the first of the answers to the previous question, and in particular what to expect in making an adequate and correct assessment of risk and seriousness of risk of violence for these patients including the need for therapeutic security.

Violence, harm and social dangerousness

We are interested in violence risk because it is relevant to social dangerousness. Social dangerousness is a legal concept. From a psychiatric point of view dangerousness is a clinical concept and arises from two things, risk of harm and the seriousness of harm [49-51].

Risk of harm

Risk or probability of violence is a statistical measure. How likely is it that the violence in question will arise in a defined period such as a day, a month or a year and how likely (probable) is it that the violence in question will arise per person, per 100 people or per 100,000 people, in men or in women, in a particular age group, in patients or in the general public. For example, the incidence rate of homicide can be expressed as 1 per 100,000 per annum. This is the risk that any person in a population might die due to homicide in a year.

Seriousness of harm

The seriousness of the violent incident is less easy to measure mathematically. Most people would agree that a fatal injury or an injury that is potentially fatal is serious. Most people would agree that a playful pat with the hand on the back of a friend is not serious. The seriousness of the area between these two extremes is a social judgment.

Evaluation of violence risk

There are a number of reasons why Psychiatrists must assess risk in forensic patients. We are concerned here with the most common clinical reasons why we must do this. Advising courts on risk of violence (probability of harm) is the least common reason and often the most problematic.

Assessing how to reduce the risk of violence and mitigate the seriousness of violence for our patients is common. For example, all Psychiatrists must constantly be aware of the risk of suicide. Risks and causes of suicide overlap with the risks and causes of serious violence to others [11,52].

The evaluation of risk of violence and of harm generally is the product of scientific research. Like all scientific research this has developed over time. The assessment of risk has developed conceptually and more importantly it has developed scientifically.

So called unstructured professional judgement is based on training and experience. However, it is variable from one expert to another, it produces an assessment which cannot be measured or tested and is neither transparent nor reliable.

Actuarial evaluation approaches are statistically valid in so far as they identify risk factors that increase the likelihood of a violent event within a defined time. However, they can exclude important factors, they can inadvertently discriminate against certain groups and although statistically predictive, they are often weak predictors. Most commonly, actuarial risk checklists identify risk factors which are historic or fixed and not amenable to change.

Modern risk assessment instruments rely on structured professional judgement based on risks for which there is reasonably good evidence. The best known of these is the HCR-20 [42,53]. There are also newly emerging risk assessment instruments for protective factors such as the SAPROF [54,11] and for specific risks such as sex offending, risk of violence in children, domestic violence and suicide. Of note, not all the risk factors included in risk assessment instruments are predictive of risk of violence in all populations or all settings [55,56].

Risk and cause

An added problem with risk factors is that they may not be causal and therefore may not be relevant for treatment to reduce probability or mitigate seriousness of future violence. For example, having a poor employment record or not being married are statistical risk factors for future violence in the mentally ill. But they are not causal factors. They are indirect consequences of having severe mental illness. These may have no causal role (confounders) or they may be intermediate steps between a causal factor and an outcome (mediators or moderators). Actuarial risk factors may have low sensitivity if they have high false negative rates. More commonly actuarial risk factors and risk instruments may have low specificity with large numbers of false positives, particularly when the true risk (incidence rate) is very low [57,58].

Risk factors may be distal (at several removes from the violent event), they may be indirect (one risk factor leads to another factor which leads to the violent event) [59] or they may be accidental statistical associations with both causal or risk factor and outcome (confounders) which are not relevant at all [60]. Causation in psychiatry and human behaviour is seldom in the mathematical form 'if A then B'. Much more commonly, a causal model allows for high levels of uncertainty 'in some cases of A, some examples of B may follow'.

Causal factors are therefore more important for treatment and risk management [22,61-64]. Causal factors are a subset of risk factors. Causal factors always are antecedent to the violent event, that is they must occur prior to the violent event and they are usually proximate (close in time) to the violent event. Early experiences and later behaviour may be understood as indirect contributory factors that are not causal in themselves [59,65]. There may be a distinction here between a necessary causal effect and a sufficient causal event. Causal factors are good explanations for the violent event. Good explanations can be tested and can be falsified. Good explanations are hard to vary. And good explanations may have unexpected 'reach' so that they cast light on other phenomena [66]. An explanation that is meaningful and comforting may be completely incorrect from a causal point of view [67] though a good scientific explanation may also be a discovery that arises from a creative conjecture provided it then meets the other conditions of being antecedent, proximate, falsifiable, hard to vary and having some reach [66].

When considered from this point of view, many of the confusions in the research literature on the relationship between mental illnesses and mental disorders and harmful events such as violence can be clarified. There is no statistical association between mental illness (broadly defined) and crime (broadly defined). However, there is a relationship between untreated severe mental illness (for example psychosis) and violence particularly when delusions are active, are associated with anger [64,68] and are associated with strong moral judgements [69,70]. All of these are relevant to treatment. Substance misuse is the strongest statistical association with future violence probably because it is close to being a causal factor. Personality disorder and negative attitudes are also strongly associated with future violence. Risks and causes for self-harm and suicide overlap with the risks and causes of violence including serious violence [11,52].

However, the risks and causes for instrumental and deliberative violence are often different from the risks and causes for impulsive and expressive violent acts. Risks and causes may be quite different for physical violence against the person, sexual violence or other types of harm such as fire setting or robbery. In each of these cases, background factors, current context and current mental state, as well as future therapeutic rapport, adherence to treatment and risk management plans and social situation in the near future are all important though not necessarily equally important [60].

Formulating risk as a means of planning management

It follows that when formulating regarding a risk and the treatment needed to reduce future of probability risk, causes are usually more important than risks. However social supports and contexts, although indirect are also very important. There should be a greater emphasis on causal formulation over risk formulation for treatment planning. But the future prevention and management of violence may also require attention to matters that are not directly causal.

A formulation should start by distinguishing between the different types of violent act identified in the history of the patient. For example, the same patient may have a history of street robbery with violence since adolescence (instrumental and deliberative, to pay for drugs, anti-social attitudes); domestic violence towards serial partners (expressive, impulsive, intoxicated, negative attitudes towards women and children); violence towards others in prison and in hospital (expressive, instrumental, ego centric dominance oriented); and a single act of serious violence acting on delusions (instrumental and deliberative, intoxicated or delusional or both, often with a moral content). The treatment and management of these various behaviours must therefore be complex.

In the community, risk assessment instruments such as the HCR-20 (V3), the SAPROF and the SRAMM are supported by good evidence as a basis for risk assessment and the first part of a risk formulation for treatment and management.

In prison the same measures apply including the HCR-20 and SVR-20 (for sexual risk) the Level of Service

Inventory-Revised (LSI-R) which measures the need for intensity of structures and supports. The Threshold Assessment Grid can be used for screening purposes [71].

Management of violence risk

A forensic patient who requires treatment may represent a risk of violence to those providing social care and those providing psychiatric or psychological treatment. Care and treatment may require conditions of therapeutic safety and security so that care and treatment can be provided safely. Assessing the right level of therapeutic security for each patient is an essential clinical skill for Forensic Psychiatrists [37,72].

Forensic patients may require high or medium or low levels of therapeutic security. It is essential to make sure that the right patient is in the right place at the right time. Therapeutic security describes systems for environmental security, for example a place from which it is not possible to abscond; procedural security for example ways to prevent access to weapons, lighters, drugs; and relational security, ratio of staff to patients or residents and the quality of the therapeutic relationship between the staff (carers and therapists) and patients or residents [28].

It follows that Forensic Psychiatrists must evaluate risk of violence and seriousness of violence in different contexts. For example, in the community before admission, in a prison [73], in a residential unit or hospital or therapeutically safe and secure setting [74,75]; and when returned to the community [76-78].

In a therapeutically safe and secure setting such as a REMS or a Forensic Hospital the DUNDRUM-1 is a measure of the level of therapeutic security needed and this is independent of measures of risk such as the HCR-20 [37], whether high secure [32], medium [33,79] or low secure or all three [39,80]. This depends more on the seriousness of violence than the probability of violence. The DUNDRUM-2 is a measure of the urgency of need for admission, the priority on a waiting list [38].

In such a setting, brief, quickly rated daily assessments of short-term risk such as the DASA [81] or Bröset [82] are helpful in recognising imminent risk and preventing violence [83-86]. The items that make up the DASA and Bröset are antecedent, proximate and explanatory factors which are more like causal factors than risk factors. Similarly, the DRILL Behaviours predict restrictive and intrusive interventions such as restraint, seclusion and increased medication [87] and ensure high clinical standards in the use of interventions to reduce and manage violence in therapeutically safe and secure settings. In such settings, the HCR-20 and similar risk assessment instruments have dynamic measures which should identify reducing risk of violence. However, measures of treatment programme completion and forensic recovery may be more relevant to reduced risk, reduced seriousness of risk and future management of risk [88,89]. It can be shown that measures of global function (GAF) and symptom severity (PANSS) are also highly relevant and can be shown to mediate between treatment and change [11].

On returning a forensic patient from a therapeutically safe and secure setting to the community, risk factors that are relevant to future violence include personality disorder, a combination of mental illness and personality disorder, or relapse of mental illness where that is a sole factor. Relapse of substance misuse is also highly relevant. Most important of all is recovery in a forensic context, the long term engagement with the treating clinicians and adherence to risk management plans that include treatment to prevent relapses of symptoms, relapses of substance misuse or relapse concerning social context [41,76].

Treatment and management

Treatment should be oriented towards the identified causes of violent behaviours – physical health, mental health, substance misuse, violence related behaviours, self-care and activities of daily living, education occupation and creativity, family therapy. These can be summarised as four recoveries – forensic recovery of autonomy and responsibility, symptomatic recovery from suffering, functional recovery of independence, and personal recovery – therapeutic alliance, hope, satisfaction and quality of life. These treatment needs should be evident directly from a formulation of causes of violence.

Prevention and management of future violence also arises from identified risk factors as well as causes. For example, close monitoring of abstinence from substance misuse, social supports and frequent monitoring of mental state, and most of all from a quality of life that fosters engagement, adherence to treatment and abstinence, and enhanced dignity expressed as self-actualisation (to express oneself) and self-transcendence (to contribute to one's society).

Some conclusive considerations

As in all human activities, there is no ideal formula or theory that cannot improve over time. Similarly, the mental health model for Italy or any modern state may for now be among the most effective and respectful for the patient, even the perpetrator of crimes. The forensic treatment model has recently been adapted for the Italian mental health model, which has among its characterizing points its spread in the territory, respect of the patient's rights and the objectives of treatment and recovery massively oriented towards social rehabilitation. Making habitual use in Italian psychiatrist's clinical prac-

tice of the assessment and management tools used in other countries can refer to the same factors (clinical, personological, family, social, cultural, etc.) taken into consideration in those same instruments, with equal effectiveness.

Psychiatrists may feel that by using these instruments and approaches habitually and regularly in Italy's REMSs, in our forensic and non-forensic facilities, they may be abdicating personal experience, individual capacity, intuition and perhaps even their creativity.

However, the use of such instruments to support professional judgment, with all their limitations, would have the advantage of allowing us to speak a common language. And we all know how much we need to do it. We are paying a very high price for the heterogeneity of our public health during this period of the pandemic. We must find a more homogeneous and transparent language and practice in all Italian country.

Moreover, the use of standardised measures would allow comparisons with the models of other countries. It cannot be enough to assert, risking self-referentiality, that one's model is the best, the one that works best, the one that rehabilitates the patient, the one that stigmatizes him/her less, just because we have opted for a non-custodial model.

Comparison with other models is indispensable and this can only take place by adopting in our practices the regular use of assessment and management tools, including those for the risk of violent acts also used in other countries. And to re-use them over time, regularly. Maybe in a few years the REMS project will be able to demonstrate that patients are less violent than in other countries or that the therapeutic relationship and working alliance with the patient, which absorbs so much of the professional energies of psychiatrists, sometimes even at the cost of one's personal safety, is the most important and effective key to prevent the risk of violent acts and helping the patient to consolidate their well-being and their health.

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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 re-entered 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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The role of REMS of Caltagirone in the path of the offender psychiatric patient: a retrospective analysis

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SUMMARY

Objectives

Our study focused on the follow-up of patients admitted in Caltagirone's REMS once the security measure ends, in order to detect critical issues and strengths in the transition from OPGs to REMS in Sicily.

Methods

An analysis of the given data regarding the Caltagirone REMS/Catania DSM (Mental Health Department) system has been carried out. The time-frame covers two intervals: one that goes from the opening on April 2015 to October 31, 2020, regarding male patients who were discharged, and another that goes from the opening on March 2018 to October 31, 2020, concerning the same situation for female patients.

Results

Collected data on the pathway toward recovery and independence of Caltagirone's REMS population confirm the need to scientifically monitor the local psychiatric services and the REMS' system in order to improve the Italian forensic psychiatric health service management. However, the therapeutic model adopted by Caltagirone's REMS, seems quite effective. We found encouraging results about duration of residency in REMS: less than one year for the female sample and less than two years for the male one. Many of ex-guests still live in CTA: this aspect reflects the problem of the "isolated asylum" of forensic psychiatric patients and their difficult full reintegration into the Italian society due to lack of ambulatory services once REMS security measure ends. Finally, we found that a few former male patients are waiting for a new admission into REMS for other crimes: further studies are required to define which diagnostic, social and environmental factors could influence therapeutic and rehabilitative REMS' programs outcome.

Conclusions

The multidisciplinary model adopted by Caltagirone's REMS is successful, although additional improvements are needed in order to enhance psychiatric ambulatory services and to monitor information about forensic psychiatric patients once the security measure ends.

Key words: REMS, deinstitutionalization, forensic psychiatric, discharge, OPGs

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The Authors declare no conflict of interest

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Introduction

The legislative context

After the "Basaglia Revolution" in 1978, the process that led to the reform of the Italian Forensic Psychiatric system was very slow. In April 2008, a ministerial decree [1] established a major innovation: the responsibilities and care management of people who have committed criminal offense is transferred from the Ministry of Justice to the Ministry of Health [1]. In 2011, the investigation of Judicial Psychiatric Hospitals (*Ospedali Psi-*

chiatrici Giudiziari, OPG), conducted by the Italian government, showed that living conditions for people detained in the OPG were deplorable: there were not actual therapeutic programs for their hospitalization and there was a very serious hygiene problem, so a change was absolutely required [2]. For these reasons, the Italian government established that each Regional Health Service must manage the healthcare function of OPG very carefully [3]. From that moment on, in each region, the local psychiatric service, called *Dipartimento di Salute Mentale* (DSM), took care of people detained in OPG, in order to guarantee the man acceptable quality of life and the management of their clinical assistance [4]. Lastly, the Italian Public Law 81/2014 [5] allowed the closure of OPG, in order to start the process for the deinstitutionalisation of psychiatric patients who have committed criminal offense. In this historical context, the REMS (*Residenze per l'Esecuzione delle Misure di Sicurezza*), "Residences for the Implementation of Security Measures" were born: the creation of these new structures represented a significant step towards a better management of the forensic psychiatric system. The closure of all six *Ospedali Psichiatrici Giudiziari* – located in Barcellona Pozzo di Gotto, Castiglione delle Stiviere, Montelupo Fiorentino, Aversa, Napoli, and Reggio Emilia – was very difficult; currently, they are replaced with about 30 REMS, which are scattered all over the Italian territory, with a total of 604 beds for forensic psychiatric patients [6]. The 81/2014 law defined a maximum number of 20 patients for each REMS, in order to give particular emphasis to community treatment and to avoid recreating the logic of OPG: REMS should be chosen as a measure of *extrema ratio,* when no other alternative is possible. Notwithstanding, the reduction of the number of beds in the transition from OPG to REMS led to the problem of waiting lists [7]. Another critical difference from older OPG is the absence of police officers in REMS. Nonetheless, in 2019, a preliminary investigation of 24 Italian REMS showed the total presence of 75 vigilantes (8,9%) and 71 psychiatrists (8,4%); therefore there are plenty of vigilantes in REMS, with some differences among structures, although the presence of these figures to help controlling the patients was not clearly elucidated in the Degree of October 1,2012 [8,9]. This aspect underlines, even today, the strong primacy of the custodial purpose of the REMS. However, the duration of hospitalization in REMS is limited in order to remove the risk of *ergastoli bianchi* (when offenders are still kept in detention because they are considered dangerous, even if they already served their sentence)*:* this aspect can lead to the loss of the dualism "responsibility-penalty" and "social dangerousness-security measure", disregarding the diagnostic and prognostic perspective [4]. In 2015, the Conferenza Unificata (*Accordo Stato-Regioni,* an agreement between the state and the regions) [10] established more explicit rules about the assessment of REMS and the placing of patients, based on the "principle of territoriality", on the "principle of safety" and on communication between UEPE (*Uffici locali per l'Esecuzione Penale Esterna*, local offices for the execution of non-custodial sentences) and Magistracy. The principle of territoriality is often not respected for women for lack of suitable structures intended for them: in fact, women are often placed in REMS far from their home region. Despite the fact that in different regions the SMOP (*Sistema informativo per il Monitoraggio del superamento degli OPG*, informative system for monitoring the superseding of OPG) is active in order to monitor information about each patient admitted in REMS [5], there are substantial differences between Italian regions in the therapeutic program's monitoring of these patients, with a consequential loss of information, especially when the principle of territoriality is not respected. Moreover, the management of socially dangerous patients is difficult for a lack of cooperation with the local services, which often find it very difficult to accommodate these people at the end of the REMS security measure [4]. For these reasons, further studies and investigation are required in order to define critical issues in the transition from OPG to REMS. The success of the REMS will be possible only thanks to a strong collaboration with the local services, in order to create a pathway towards recovery and increasing independence [11].

Sicily Region: the process of superseding OPG

Council's decrees nos. 318/13 of 18/2/13 and 576/13 of 25/3/13 [12] identify in Sicily those structures intended to accommodate people who have undergone security measures for hospitalization in OPG: two REMS for Catania ASP (Azienda Sanitaria Provinciale – Provincial Health Services Authority); one REMS for Caltanissetta ASP; one REMS for Messina ASP. However, there are only two active REMS in the territory: Naso, in the area of Messina, with 20 beds, and Caltagirone, with 40 beds divided into two sections: men and women. The fundamental healthcare plan that targets mental health in Sicily envisions that the Integrated and Community DSM (mental health department) take responsibility for the final passage of the OPG. They wish to establish PTIs (Individual Therapy Plan) with alternative penitentiary programs aimed at those who commit misdemeanours, but who also suffer from psychiatric pathologies (Sicily Health Council, 2012 [13]. In particular, the discharge of the patients from the new REMS is decided by the Magistracy, in agreement with the local DSM. Discharges are established on the patient's rehabilitation and therapeutic path, choosing the best destination based on several factors: a good psychopathological balance, a

sufficient restoration of illness awareness, improvement of therapy's compliance, and the prospect of going back to the family or of being assigned to community structures.

The REMS of Caltagirone

The REMS of Caltagirone is one of the two REMS on the Sicilian territory that for years has been hosting offenders suffering from psychiatric pathology, people who, in the past, would have been assigned to OPG. Based in the small hamlet of San Pietro, 15 km away from the centre of Caltagirone, this REMS was founded in April 2015, with the opening of the male module, located in a pre-existent building adapted to the purpose. The female one, built from scratch, was activated three years later, in March 2018. The structure has a staff consisting of psychiatric doctors, psychiatric rehabilitation technicians, nurses and a nursing coordinator, social workers and healthcare assistants. At the entrance of each module there is an unarmed security guard, trained for the surveillance of the REMS's perimeter space. In the model proposed by REMS of Caltagirone, the path is oriented not only towards the pharmacological treatment and management of psychopathological conditions, but also towards the promotion of the patient's autonomy and the restoration, as well as the enhancement, of the subject's residual resources. The planned activities include cognitive-behavioural training, groups aimed at emotional regulation and recreation activities workshops; these moments are part of a personalized and strategic therapeutic plan, aimed at building a path that also crosses the user's territory.

Aim of the study

This study aims to describe the process of superseding OPG in Sicily, with particular reference to the model of REMS of Caltagirone, in the experience of the provinciall health service authority of Catania, highlighting, specifically, the legislative context and the results obtained at the moment of patients discharge, in terms of primary and last destinations, and therefore, the current clinical, legal, social and employment situation of the former guests. We want, therefore, to discuss the strengths and/or any critical issues of this kind of model, in order to suggest possible and further improvement of the Forensic Psychiatry health service management in Sicily.

Materials and methods

An analysis of the given data regarding the Caltagirone REMS/Catania DSM (mental health department) system has been carried out. The time-frame covers two intervals: one that goes from the opening on April 2015 to October 31, 2020, regarding male patients who were discharged, and another that goes from the opening on March 2018 to October 31, 2020, concerning the same situation for female patients. In particular, we focused on: patients' placement before REMS admission; admission diagnosis; re-admissions to REMS; imprisonments and/or other security measures/detentions; assimilation into CTAs (Assisted Therapeutic Community) or Living Facilities (*Comunità Alloggio*); hospitalization (voluntary ones and/or TSO – Involuntary Treatment); job and/or other information about the social status of the former-guests.

Results

Male module

Data analysis of 46 male patients discharged from the Caltagirone REMS from the opening in April 2015 to October 31, 2020: the average age of the patients who were part of the sample taken into analysis is of 42.86 years; the average stay in the REMS is about 18.26 months, less than two years (Tab. I).

Ten discharges have taken place in 2015, six in 2016, eleven in 2017, nine in 2018, eight in 2019, and two from the 1st of January to the 31st of October 2020.

The collected data of the subjects' placement before REMS admission show the following distribution: 23.91% came from a status of freedom, 21.74% from CTA, 19.57% from OPG, 15.22% from prison, 8.70% from housing facilities, 6.52% from other REMS, 2.17% from SPDC (Fig. 1).

TABLE I. *Socio-demographic characteristics of the sample of 62 patients discharged from the Caltagirone REMS from the opening to October 31, 2020.*

	Males	Females
Sex	46 (74.19%)	16 (25.81%)
Mean age, years	42.86 years	43.31 years
Age, range	28-71 years	21-71 years
Length of stay in REMS	Less than 2 years (18.26 months)	Less than 1 year (11.25 months)

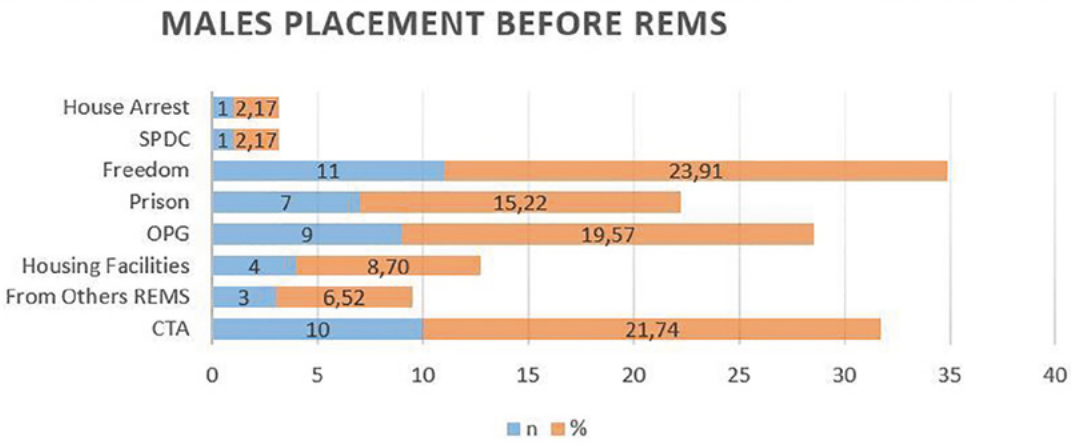

FIGURE 1. *Placement before REMS admissions of n = 46 male patients discharged from Caltagirone REMS.*

Two (4.34% of the sample) out of the 46 patients discharged from the male module came from places situated outside the Sicilian region (Lecce and Rome).
The most frequently encountered diagnoses have been, in order: Schizophrenic Spectrum Disorder (39.13%), Bipolar Disorder (15.22%), Unspecified Personality Disorder (15.22%), Paranoid Personality Disorder (10.87%), Borderline Personality Disorder (6.52%), Schizoaffective Disorder (6.52%), Neurodevelopmental Disorder (2.17%), Antisocial Personality Disorder (2.17%) Conduct Disorder (2.17%) (Tab. II).
Drug abuse is the main disorder in comorbidity between the patients discharged from the REMS. The amount of unspecified personality disorder diagnosis is particularly evident and often due to the presence of mixed personality traits or to the co-presence of a double diagnosis of drug abuse. In our sample the coexistence of drug abuse was 23.91% in males and 12.5% in females.
Once discharged from the REMS (from the opening on April 2015 to the 31st of October 2020) 29 patients (63.04%) have been sent to different CTAs located on the Sicilian territory. Of these 29, as things stand, 18 are still in CTA, 2 are waiting to be readmitted into REMS (1 of these is in a CTA, the other is on probation), one has gone back to prison, four have been sent to a housing facility, two are on probation without other security measures, two are free.
Six of the 46 male guests (13.04%) have been sent, at the moment of discharge from REMS, to prisons. Currently, one has been re-admitted to the Caltagirone REMS and five are still in prison (three of whom are waiting to be readmitted into a REMS).
Three (6.52%) guests have been discharged and moved into Housing Facilities located in Sicily. At present, two are still in these facilities, while one subject is free. Two (4.35%) patients have been discharged on

TABLE II. *DSM-5 diagnosis of the n = 46 male patients discharged from the Caltagirone REMS from the opening, in April 2015, to October 31, 2020.*

Diagnosis male patients	N.	%
Schizophrenia Spectrum and other psychotic disorders	18	39.13%
Bipolar Disorder	7	15.22%
Unspecified Personality Disorder	7	15.22%
Schizoaffective Disorder	3	6.52%
Neurodevelopmental Disorders	1	2.17%
Borderline Personality Disorder	3	6.52%
Paranoid Personality Disorder	5	10.87%
Antisocial Personality Disorder	1	2.17%
Conduct Disorder	1	2.17%

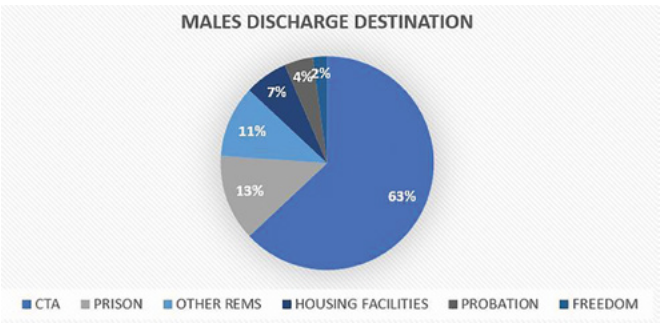

FIGURE 2. *Discharge destination of n = 46 male patients.*

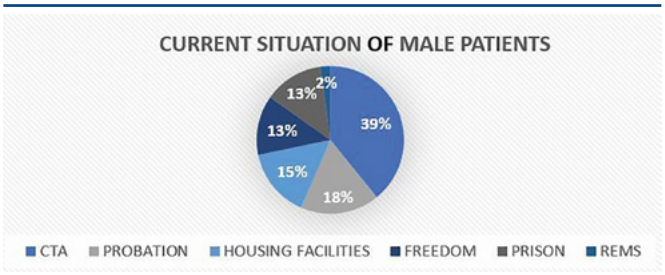

FIGURE 3. *Current situation of n = 46 male patients discharged from the Caltagirone REMS. e organizational model of the "Mental Health Department 4.0".*

probation and now one of them still is in such a condition, while the other is free.

Over the years, five patients (10.87%) have been discharged from Caltagirone to be transferred into other REMS: at present, one of them is in a housing facility, one is free, and three are on probation. Only one patient has been discharged to be free and he still is today (Fig. 2).

In general, we can establish that of the 46 male guests discharged from the Caltagirone REMS from the opening in April 2015 to October 31,2020, eighteen (39.13%) are still nowadays situated in CTA, eight are on probation (17.39%), seven are in housing facilities (15.22%), six are in prison (13.04%), six are free (13.04%), one has been readmitted to the Caltagirone REMS (Fig. 3).

Five subjects (10.87%) are waiting to be readmitted into REMS: of these, one is a guest in a CTA, one is on probation, and three are in prison.

For eight former residents of the Caltagirone REMS, who are at date on probation or totally free, it has been possible to find out their current employment situation: two subjects are waiters, one is a blacksmith, another one is a street artist, another is a cook, a subject is a factory worker, another is a farmer, and lastly, one has now retired.

Of the 46 subjects whose data has been examined, ten of them (21.74%) have undergone at least one TSO after having been discharged from the Caltagirone REMS, across a range that goes from 1 to 7 for each person (with a mean of 2.2 TSO per patient).

Female module

Data analysis of16 female patients discharged from the Caltagirone REMS from the opening, in March 2018, to the 31st of October 2020: one has been discharged in 2018, twelve in 2019, three from January 1 to October 31, 2020. The average age of the female guests who are part of the sample taken into analysis is of 43.31 years. The average stay has been of 11.25 months, less than one year each (Tab. I).

The collected data of the subjects' placement before REMS admission shows the following distribution: 43.75% were free, 25% came from SPDC, 18.75% from prison, 12.25% from CTA (Fig. 4). Five patients (10.87%) came from places located outside of Sicily (Rome).

The most frequent diagnoses have been, in order: Schizophrenic Spectrum Disorder (43.75%), Schizoaffective Disorder (19%), Unspecified Personality Disorder (18.75%), Borderline Personality Disorder (6.25%), Bipolar Disorder (6.25%), Conduct Disorder (6.25%) (Tab. III). The drug abuse has been present in comor-

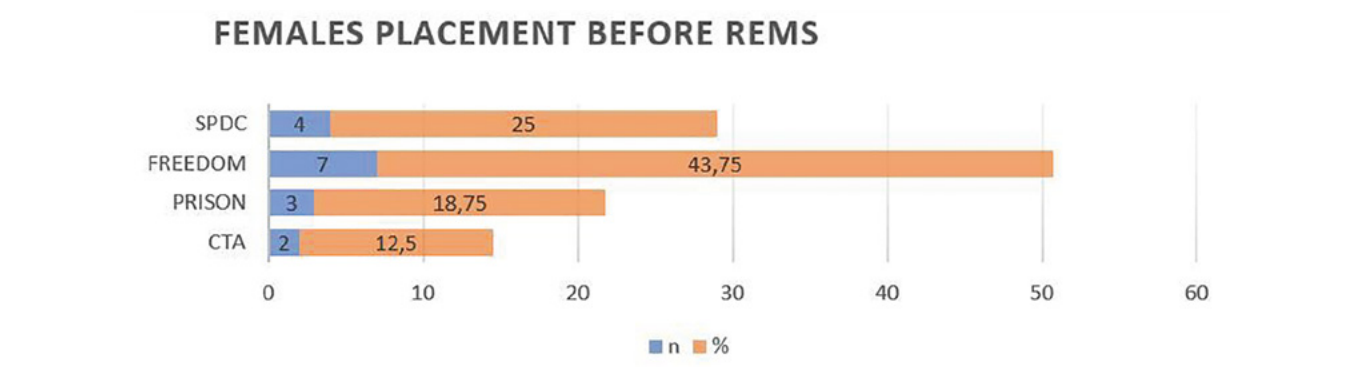

FIGURE 4. *Placement before REMS admissions of n = 16 female patients discharged from Caltagirone REMS.*

TABLE III. *DSM-5 diagnosis of the n = 16 female patients discharged from the Caltagirone REMS between the opening, in March 2018, to 31, October 2020.*

Female patients diagnosis	N.	%
Schizophrenia Spectrum and other psychotic disorders	7	43.75%
Unspecified Personality Disorder	3	18.75%
Schizoaffective Disorder	3	19%
Borderline Personality Disorder	1	6.25%
Bipolar Disorder	1	6.25%
Conduct Disorder	1	6.25%

bidity with other disorders only in two patients out of sixteen (12.5% of our female sample).
In general, we can establish that of the 46 male guests discharged from the Caltagirone REMS from the opening in April 2015 to October 31, 2020, eighteen (39.13%) are still nowadays situated in CTA, eight are on probation (17.39%), seven are in housing facilities (15.22%), six are in prison (13.04%), six are free (13.04%), one has been readmitted to the Caltagirone REMS (Fig. 3).
After being discharged, from the opening in March 2018 to the 31st of October 2020, nine patients have been sent into CTA (56.25%) and are at date in these structures. Four guests (25%) have been discharged from the Caltagirone REMS to be admitted in different REMS situated in their area of origin: three are still in these structures, one of them being transferred to a CTA, while the other one is free. Two patients (12.5%), both free nowadays, had been discharged and located in housing facilities. Only one patient has undergone a displacement in a prison once discharged from the Caltagirone REMS, just to be readmitted into it shortly after (Fig. 5).
Nowadays, ten patients (62.5%) live in CTA, three (18.75%) are free, two (12.5%) are still serving their sentences in their respective territory's REMS, one (6.25%) has been readmitted to the Caltagirone REMS (Fig. 6).
It has been possible to discover the current employment status of two former guests of the Caltagirone REMS, who are at date: one patient is an office worker, the other one is attending university.
It has not been possible to find out the data regarding the TSO that the guests have been subjected to once they have been discharged from the Caltagirone REMS, because of the scattering of information given by the different origins of the subjects.

Discussion

The aim of this study was to analyse socio-demographic, diagnostic profiles, current clinical state and any other information about the reintegration into mainstream civil society of patients with mental disorders who have committed criminal offense and that were admitted to Caltagirone's REMS, from the opening of each compartment to October 31, 2020. Having such information, it would be useful to identify both strengths and weaknesses of the Forensic Psychiatry health service management in

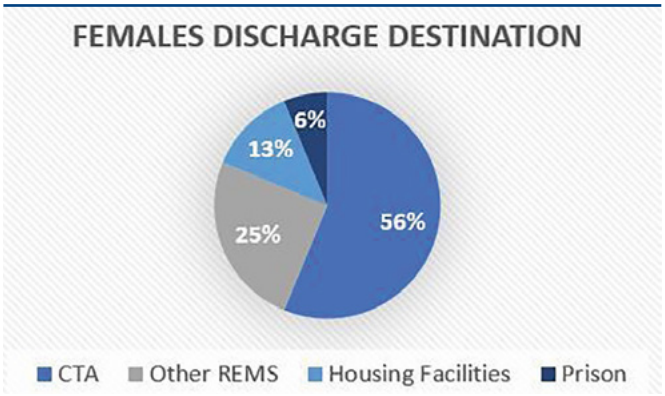

FIGURE 5. *Current situation of n = 46 male patients discharged from the Caltagirone REMS.*

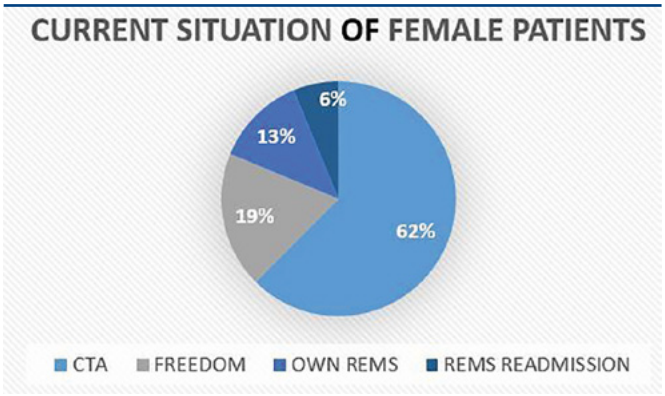

FIGURE 6. *Current situation of n = 16 female patients discharged from the Caltagirone REMS, from the opening in March 2018 to October 31, 2020.*

Sicily. Collected data on the pathway toward recovery and independence of Caltagirone's REMS population confirm the evident need to scientifically monitor the local psychiatric services system's or the REMS's work in order to improve the Italian forensic psychiatric health service management. We found an average middle-aged male population of 42.86 years and an average middle-aged female population of 43.31 years. The male sample was more numerous than the female one: in fact, the female compartment was opened only in 2018, three years after the male one. The most frequent psychiatric diagnosis was Schizophrenia in both the female and male samples: other studies reported Schizophrenia as the most frequent diagnosis in Italian REMS population [14,15]. We found that the second most frequent diagnosis was personality disorders. Infact, a longitudinal study conducted in 2019 has reported personality disorder as a frequent diagnosis (32.0%) in a sample of 730 patients admitted into Italian REMS between June 2018 and June 2019 [10]. Unspecified personality disorders diagnosis was rather common and reflected the clinical complexity of our sample. Therefore, we reported scarce information about the real presence of antisocial traits and psychopathy: in our sample, most male patients were affected by bipolar spectrum disorder (15.22%) and only one male patient was affected by antisocial personality disorder. The heterogeneous distribution of different diagnosis in Caltagirone's REMS reflected one of the most problematic aspect in the therapeutic and rehabilitative program management in Italian REMS: in this particular clinical context, personalized care is not completely applicable and this aspect limits the prevention of aggressive behaviour. The mixing of psychotic, bipolar and borderline-antisocial patients, without specific and clear admission criteria, could cause the necessity of an urgent custodial intent, with high risk for the safety of both patients and REMS workers [16-18]. However, the therapeutic model adopted by Caltagirone's REMS, which offers pharmacological prescriptions, psychotherapy, rehabilitation, motor and daily life activities, and psycho-educational programs, is quite effective. In fact, from April 2015 to October 31, 2020, after leaving the REMS once having served their sentence, 7 male patients were admitted, and now live, into special communities called *Comunità Alloggio*, 13 are now released or in a condition of supervised release, and 8 are regularly working. From March 2018 to October 31, 2020, after leaving the REMS, 3 female patients are now released: one currently studies at University, and one is regularly working. All these patients were able to enjoy progressive independence while maintaining an essential link with local psychiatric services. These data promote the application of criteria required by the Italian Decree of October 1, 2012, which stresses the importance of doctors, educators, psychologists and social and health workers in REMS. Moreover, the organization of the work must be based on the principles of clinical governance and the presence of these professional figures may help reducing the risk that REMS become essentially "smaller OPG" [19]. We found encouraging results about duration of residency in REMS: less than one year for the female sample and less than two years for the male one. Further studies are needed in order to investigate how gender can impact on the duration of treatment in REMS, on the kind of crime committed, on the judgment of social dangerousness and on the kind of security measure established. In fact, there are often gender differences in aggressive behaviour and sociocultural aspects, and biological factors and hormonal differences have been suggested for some specific pathological personality traits [20,21]. We also found that 18 former male patients and 9 former female patients live in CTA (Comunità Terapeutiche Assistite – Assisted Therapeutic Communities) which are residential communities with constant clinical services. This aspect reflects the problem of the "isolated asylum" of forensic psychiatric patients and their difficult full reintegration into the Italian society for lack of ambulatory services once the REMS security measure ends [4]. A combination of different factors, such as legislative aspects (for example, the meaning and the judgement of social dangerousness) and personal history (for example, family relationship, financial status and the presence of drug abuse) influences prognosis and a reasonable reintegration into civil society. However, the local psychiatric service called *Dipartimento di Salute Mentale, Mental Health Department* (DSM) can find rapid solutions for forensic psychiatric patients at the end of REMS security measure: in fact, the link between Caltagirone's REMS and Catania's DSM is important to avoid the "ergastoli bianchi" problem and the extension of the duration of residency in REMS.

Unfortunately, we could find information about TSO, once REMS security measure ends, only for male patients. This can be explained by the problematic aspect of the principle of territoriality for women. There are few suitable structures for women in Italy: for this reason, they are temporarily placed in REMS that are far their region [6]. This is the cause for the loss of follow-up data. Caltagirone's REMS has a separate structure for women and this is a very meaningful aspect of strength: in fact, different gender therapeutic programs are possible by avoiding mixed solutions, which are barely applicable.

Finally, we found that five former male patients are waiting for a new admission into a REMS for other crimes and new security measures. Further studies are required to define which diagnostic, social and environmental factors can influence outcome of therapeutic and rehabilitative programs in REMS.

Conclusions

Our study focused on the follow-up of patients admitted in Caltagirone's REMS once the security measure ends, in order to detect critical issues and strengths in the transition from OPG to REMS in Sicily. The multidisciplinary model adopted by Caltagirone's REMS is successful, although additional improvements are needed in order to enhance psychiatric ambulatory services and to monitor information about forensic psychiatric patients once the security measureends.

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Across the walls. Treatment pathways of mentally ill offenders in Italy, from prisons to community care

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SUMMARY

The process of deinstitutionalization of psychiatric care in Italy has recently included also the care of psychiatric patients who committed offences. This happened following a set of laws enacted since 2008. The Departments of Mental Health (DMH) belonging to the public National Health System (NHS) are now providing care along the whole psychiatric system, from the treatment of inmates in prisons to care plans in the community. This change requires new cultural paradigms and organizational models. Some DMHs have set up Forensic Psychiatry Units (FPU), dedicated to providing care of such patients with specific treatment pathways both inside and outside the places of detention. The DMH of Bologna set up a FPU dedicated to offer mental health care in prison, juvenile prison and secure residential unit for "not guilty by reason of insanity and socially dangerous" offenders (Residenza per l'Esecuzione della Misura di Sicurezza, REMS).

According to this model, mental health in penitentiary settings is warranted by a multidisciplinary team comprising psychiatrists, psychologists, nurses and psychiatric rehabilitation professionals. Addiction treatment staff closely cooperate with the FPU in the treatment of dual diagnosis inmate patients. FPU aims to ensure continuity of care for inmates with mental health issues, from their access (or from the onset of the psychiatric disorder) up to community care under any form of release.

FPU has further expertise areas, supporting Community Mental Health Services in developing and monitoring therapeutic pathways for psychiatric patients under judicial order. This include assessing violence risk at the request of the supervisory courts, and working closely with courts and expert witnesses in developing tailor-made prescriptions for offenders sentenced to the safety measure of probation.

In view of the complexity of these cases, in which the needs of care, control and reintegration into the social fabric are intertwined, we consider mandatory to widespread specific skills regarding offenders assessment and treatment, relying whenever possible on evidence-based tools.

Key words: therapeutic pathways for forensic patients, mental health services in prison, forensic psychiatric hospita, Forensic Psychiatry Unit

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Conflict of interest
The Authors declare no conflict of interest

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Introduction

The relationship between mental illness and violent or criminal behavior has always been one of the most debated and controversial topics in psychiatric literature. Italy is renowned for its Psychiatric Reform of 1978 that brought to the closure of all mental hospitals and the implementation of a radical community care system. Less discussed is the fact that the management and treatment of the mentally ill offenders remained till recently in the hand of the penitentiary system and outside the general mental health care system.

Italian Government decided not to include in the deinstitutionalization process the Forensic Psychiatric Hospitals, which were only renamed as Judicial Psychiatric Hospitals (Ospedali Psichiatrici Giudiziari, OPG) [1], probably in order not to overload the National Healthcare System and its Mental Health Service [2]. The price for this was an institutional and cultural mismatch between psychiatry and justice, which has seriously hindered the development of a shared practice concerning the areas of joint intervention [3]. This gap has only been addressed since 1999 with fluctuating trends and minor adaptations rather than with organic reforms [4-7]. Still today many procedural and welfare problems in prisons and mental health services need to be addressed.

The transition of Penitentiary Medicine (and psychiatric care with it) to the NHS was set up with a Presidential Decree of 2008 (DPCM 1 April 2008) [8], which was inspired by some pilot experiences of deinstitutionalization such as the "Antares" Project in Emilia Romagna and the "Eracle" Project in Tuscany (D.lgs 502/92, n. 2593, 30 December 1999 Emilia Romagna; D.lgs 230/99 Tuscany). One epidemiological study provided reliable data on the population of OPGs and suggested that such a Reform was feasible with due investments. Among other things, it showed that 72% of the in-patient population was affected by non-affective psychosis and 60% was already cared for by the Community Services before the commission of the crime [9]. More recent data have substantially confirmed these findings since in current psychiatric-forensic facilities 60.7% of patients are affected by a Schizophrenia spectrum and other psychotic disorderswhile an even higher proportion of forensic patients (82%) were already in care by mental health services at offense time [10].

After a transition period, only in 2015 the OPGs were closed and DMHs started do display a range of management and treatment options, from mental health care in prison settings to community care, from mental health residential communities for the acquitted (Residenze per la Esecuzione della Misura di Sicurezza, REMS) to diversion schemes to ordinary residential settings.

In Emilia-Romagna, a region of 4.4 million inhabitants in Northern Italy with the capital in Bologna, the progressive overcoming of the OPGs was based on three strategies, which were accompanied by substantial financial investments: 1) reduction of admissions through the provision of diversion schemes to community-based alternatives to inmate care; 2) during detention: careful assessment, planning of prison-to-community pathways, establishment of observation wards mostly hosting inmates fallen ill in prison; 3) increase in discharges through assertive community-based care programs by the Local Mental Health Centers (Centro di Salute Mentale, CSM) including residential rehabilitation services.

Since then, social dynamics of greater marginalization, the closure of the OPGs and the increase in the application of judicial orders, have produced an increase in the population belonging to the penitentiary system, causing a transformation of the epidemiological situation within prisons, which today face complex populations and uncertain boundaries, which are difficult to frame in diagnostic categories [11], whose common denominator is often early traumatic experiences that seem to contribute to violent behavior, as evidenced by the extensive scientific literature on the outcomes of traumatic experiences [12-14]. The same social dynamics and the overcoming of the OPGs have also led to a substantial increase in judicial orders that require care by Community Psychiatric Services.

These epidemiological and institutional changes call for specific skills by health professionals at the interface between Psychiatric Services and the judiciary system (e.g.: second level assessments and with the use of clinical and design assessment tools).

Forensic Psychiatry Units (FPU) within Departments of Mental Health (DMH) is one possible response to these new needs, as far as they can provide for alternative treatment pathways for offending patients to ensure an adequate care supply chain. FPUs are already operating in various DMHs (e.g.: Bologna, Parma, and Brescia) and ensure psychiatric care in prison, manage REMS, and above all support CSMs and other DMH facilities in drafting and managing clinical and psychosocial pathways for judicial patients, in continuity between the penitentiary institution and the community.

At the DMH of Bologna, an FPU has been set upand is currently directed by one of the authors (F.B.). It covers the following areas of expertise:

- organization and management of the REMS "Casa degli Svizzeri";
- organization and management of the psychiatric service at the Bologna Prison and consultancy at the Juvenile Prison;
- monitoring of all intra-departmental individual care pathways pathways for psychiatric patients under judicial order;
- collaboration with expert witnesses and judicial authorities either in the early phases of evaluation and planning of care for mentally ill offenders or when mental illness breaks out while in prison;
- training, technical support, consultation, and consultancy activities for the Community and hospital structures of the DMH;
- collaboration with the Risk Management and Legal Medicine Unit;
- collaboration with public administrations and users/carers associations about guardianship and supported decision-making procedures.

FPU team comprises 4 doctors, 3 psychologists, 1 social worker, 3 nurses, and all the care staff (nurses, educators, and psychiatric rehabilitation therapists) to manage the REMS. Care for inmates with substance abuse and psychiatric care of minors are not provided by FPU, but by different specific DMH Units for addiction and Child and Adolescent Mental Health care. We are aware that in other DMHs these activities fall within the responsibilities of FPUs.
Clinical and psychosocial pathways comprise also 4 "rapid access from prison" beds by the "Arcipelago" Intensive Treatment Residence, for patients with judicial orders for observation and treatment in the acute phase.
Most of the staff of these facilities have undertaken challenging and complex training courses on the topics of forensic psychiatry, criminology, psychotraumatology, transcultural psychiatry and psychiatric clinic in institutional settings. This constitutes a professional investment that so far has censure stability to the working group and coordination between the various Units involved.
Currently, there are about 80 out-of-prison pathways of offending patients monitored by Bologna FPU and managed together with CSMs. Work with the judiciary and penitentiary institutions requires daily contacts and court decisions are rarely taken without having consulted the DMH. Professional and financial commitment required by establishing these care pathways for offending patients has increased considerably over the years and the trend seems to be for further increases.

Mental health care in prison

Prisons are a very specific setting in which to provide mental health care. The practice stands on an intrinsic contradiction of having to develop pathways to health within an institution which by its nature maintains an afflictive function, albeit modulated by the re-educational needs and recovery introduced by the 1975 reform.
The transition of penitentiary medicine to the NHS is relatively recent (2008) and there are relevant regional organizational differences. So far we have only a few valuable experiences and a few steering documents as references.
According to the paper [15] released by the "National Construction and Development Committee of the PDTA", a prerequisite for working in the penitentiary field is the establishment of a multidisciplinary team comprising psychiatrists, nurses, psychologists, and professionals dedicated to addictions and possibly psychiatric rehabilitation staff.
One common problem is the lack of vocations to work in prisons. As a result, there is frequently a high turn-over of staff, often lacking specific skills and with a high risk of burn-out. This is a major weakness both for therapeutic continuity and for the development of specific skills. It is, therefore, necessary to ensure adequate resources, duly trained and working "across the walls", i.e. in prison and the community. Under this respect, FPUs can contribute to the development of specific skills, which can be used both in the intra- and in the extramural setting.
Patients have a right to continuity of care from their access into prison (or from the onset of the psychiatric disorder, in the case of patients who develop the first episode during detention) up to community care under any form of release.
It is therefore important to identify patients who show psychiatric symptoms in progress, a history suggestive of psychopathological vulnerability and those already cared for by psychiatric services, or those who simply are under psychopharmacological treatments, also to avoid abrupt withdrawals or inappropriate changes to therapies already in progress at the time of admission to prison. Psychiatric history must be immediately investigated, for example by providing physicians who make a first general medical assessment with structured screening tools or by providing a psychological interview for all newcomers. Early link with CSM is highly recommended.
Once the presence of a clinically significant psychiatric disorder is ascertained, the patient is taken in charge by the team: key workers are identified for each case, in order to promote continuity of care, therapeutic and rehabilitative interventions, planning of following controls. Once the acute phase has been overcome, follow-up is continued consistent with the interventions implemented, maintaining periodic visits to promptly intercept any exacerbations.
Another possible critical moment is that of release [16], not only due to the inmate's expectation and anxiety to return to freedom, which can be so strong as to cause a feeling of estrangement and extreme concern for the situations he will face "out "(the so-called "Vertigo of the exit"), but also due to the need to build a connection with the local services (CSM, and Social Services above all) for the continuation of treatment.It is useful to implement a "discharge" protocol according to which the Penitentiary Administration reports to FPU, as early as possible, the imminent release from prison to allow Community services to be informed and ensure continuity of care, even with specific paths for the most fragile; such projects should also take into account social needs, which often constitute risk factors for relapse into crime far more relevant than mental disorders.

Intramural facilities

Currently, 16 prisons are equipped with Psychiatric Observation Units (POU) and 35 with the Mental Health Care Units (MHCU), specialized sections characterized by higher levels of psychiatric assistance.

POUs are responsible only for a second level differential diagnosis and for the evaluation of the appropriateness of placement in prison. In the penitentiary context atypical and difficult to classify clinical and behavioral picturesoften appear, both for the frequent comorbidities and risk factors, and the relative frequency of fictitious or deliberately simulated disorders to access less afflictive forms of punishment.
MHCUs, on the other hand, host inmateswhose illness has not been brought to acquittance or whose detention in the ordinary sections of the prison is not appropriate due to "supervening mental illness". In these units, although located within the prison, work mainly health staff belonging to the NHS. They carry out both assessments and therapeutic treatments, including long-term ones. When managed by FPUs within the DMHs, their work ensures again continuity across the walls.

The acute phase of illness

The treatment of psychiatric acute disorders in prisoners, especially when there is a high risk of self-harm, is a complex challenge. Prisons are highly containing environments that imply at the same high control and monitoring of "risky" behaviors, and severe stresses that often trigger psychiatric disorders, behavioral problems and other risks for health and life [17].
Hospitalization is sometimes appropriate if intensive care of an acute condition is enhanced by a safe distance the patient from the pathogenic context. However, these hospitalizations put several problems both from the point of view of the ward and from that of the Penitentiary Police which, unless otherwise ordered by the Magistrate, must guard him at the place of treatment.
On the hospital ward side, logistical problems arise: the patient and his guards must be placed in a room for them alone, ordinary work of staff is changed, tension may arise with other patients. Stigma against offenders may add to the stigma against psychiatric patients.
On the prison staff side, agents often complain about the shortage of resources for ensuring single man guarding in the hospital setting, when shifts in prisons are difficult to cover.
Having "rapid access from prison" to a psychiatric residence (as it is in the case for FPU in Bologna at the RTI "Arcipelago") or to a psychiatric ward equipped to host and care for inmates, is a highly valuable resource to overcome most of these problems.
Once the acute phase is overcome and the patient returned to prison, the psychiatrist assesses the inmate, reviewing the psychopharmacological therapy and appropriate prison section, in order to achieve better psychological conditions and minimize the impact of returning to prison after the period spent in the more comfortable healthcare environment. During the post-acute phase, into account the increased vulnerability to new episodes of psychopathological and behavioral decompensation, psychiatric visits are generally more frequent and drugs are taken under nurse supervision, in order to ensure a better compliance and reduce the risk of harmful use of covertly accumulated drugs. Psychological and psychoeducational interventions are focused on illness awareness, therapy management and recognition of early warning signs.

Stepping out. Care in the community

Law 81/14 transferred responsibility for the therapeutic and rehabilitative pathways of psychiatric patients who have committed crimes to the DMHs and established that treatment outside prison walls should be the norm. Detention of the acquitted in specific REMS should be residual and transient, mental health and risk reduction must be sought through treatment in ordinary DMHs units, with specific plans for the mentally ill offenders.
These pathways provide, in most cases, some form of probation, the prescriptions of which are customized by the Magistrate to reduce "social dangerousness".
Therapeutic programs of psychiatric offending patients are proposed by the expert, ordered by the Court, planned, monitored, and financed by the DMHs. The penitentiary system follows up the program through a specific extramural unit (Ufficio Esecuzione Penale Esterna, UEPE). The Post-sentence authority periodically checks the outcomes both in terms of health and risk, gathering information from DMHs and UEPE. Players are multiple and responsibility must be shared. Common language and agreement about standards, methods, and procedures are crucial.
The FPU in Bologna provides support to community psychiatric services, mostly for medico-legal advice and risk assessment procedures, to help them in ensuring real therapy and a safe interface with Justice (experts and magistrates).
Taking charge of an offender patient presents various critical issues. Crime generates stigma [18], which hinders the recognition of such patients as a person in need of care rather than containment and segregation. The complexity of needs in this population requires large use of resources, in a context that already suffers from a chronic lack of staff and funding. However, the intensive care of such patients appears scientifically rational, for example in the light of the Risk-Need-Responsivity model [19]. According to this model, the level of intervention must be proportional to the relapse risk (Risk Principle: the greatest resources should be invested precisely in the most "difficult" cases), it should focus on the patient's needs to minimize risk factors (Need-Principle), using evidence-based customized based on individual characteristics (Responsivity-Principle).

Finally, professionals may be concerned about the responsibility and legal implications of such taking charge, though it is acknowledged that good care constitutes the best protection for the patient, for society and the professional himself.
In most cases, psychiatric-forensic patients are entrusted to mental health centers with the safety measure of probation, which provides for specific prescriptions ordered by the Post-sentence Magistrate, aimed at reducing the risk of new crimes. The prescriptions must be sufficiently containing to protect society from the risk of new crimes, but also allow those therapeutic, rehabilitative and social reintegration activities that in the medium and long term can lead to the progressive reduction of risk. The Magistrate can gradually modify the prescriptions concerning the clinical conditions and the rehabilitation project.
For these reasons it is useful to design and monitor these pathways with the use of structured professional evaluation tools, such as the Structured Professional Judgment, SPJ [20,21], and the HCR-20 v3 [22]. Since these tools require both an in-depth knowledge of the patient and of the social context in which he lives, as well as psychiatric-criminological skills, professionals of the FPU and those of the Community Services should work together with the development and project monitoring.

The residential setting

The development of rehabilitation projects graduated according to clinical needs and risk level requires often the access to community residential facilities with a rehabilitation vocation that has skills and organization suitable for psychiatric-forensic patients. In many Italian regions and Emilia-Romagna in particular, there is a network of residences (Therapeutic Rehabilitation Residences and Group Apartments) that underwent training for hosting and caring for mentally ill offenders. These facilities contribute to progressive social inclusion programs, within a sort of supply chain that includes NHS units and private accredited ones, ranging from the most "restraining" settings for patients acquitted who still have significant risk (REMS), for inmates who have yet to pay off their debt with justice (POU and MHCU), to settings of care that are gradually more open and suited to social inclusion where to offer rehabilitation to return to society as "free men".

Conclusions

The regulatory reforms that led to the closure of the OPGs and the birth of the REMS, have imposed a new mandatory responsibility of the Psychiatric Services in the treatment of offenders with mental disorders.The complexity of these cases, in which the needs of care, custody and reintegration into the social fabric are intertwined, requires wide dissemination within the psychiatric services of skills regarding the psychiatry-justice interface and the development and monitoring of specific therapeutic-rehabilitation projects for offenders. Forensic Psychiatric Units are teams specifically established to take care of restricted patients in prison settings (REMS and Prison) and to assist community services in taking care of psychiatric patients who benefit from alternative measures to detention. Monitoring the outcomes of their work and patients pathways over time will make it possible to further refine the treatment model to encourage increasingly effective and efficient treatments.

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Original article

Violence in forensic psychiatric facilities. A risk management perspective

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SUMMARY

Violence against healthcare workers is a global phenomenon. Psychiatric settings are among the places at greatest risk of being a victim of aggression. Several strategies aimed at preventing violence in healthcare settings and implement protective measures have been proposed. Nevertheless, forensic psychiatric settings have been poorly investigated from the point of view of clinical risk management, especially in Italy. The recent process of deinstitutionalization of forensic psychiatric patients in Italy, with the replacement of former forensic psychiatric hospitals with small regional-based community structures (REMS), deserves particular attention in terms of clinical risk management. We propose in the following contribution a methodology that allows to measure the risk of violent behavior in different psychiatric forensic settings, from the point of view of clinical risk management. This includes a proposed adaptation of the Modified Overt Aggression Scale (MOAS) for the specific purpose. The use of such approach, including the calculation of a structure's "risk score" could allow comparisons between different facilities as well as the implementation of strategies aimed at minimizing the frequency of violent acts, as well as activating the most suitable measures to prevent them.

Key words: violence prevention, REMS; MOAS, clinical risk management, forensic psychiatry

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Violence in healthcare settings

Violence perpetrated against healthcare workers, often by patients, their relatives or less often by visitors, is a ubiquitous phenomenon and one that has increased in frequency over the last few years. The American National Institute of Occupational Safety and Health (NIOSH) defines violence in the workplace as *"the act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty"* [1].

Acts of violence in healthcare setting are rarely fatal, most often they consist of physical or verbal aggression or threats. The rate of incidents involving hospital workers is equal to 9.3 per 10.000 [2].

A recent systematic review and meta-analysis of the literature has shown that of 333,000 participants included in the review, 61.9% reported experiencing at least one violent episode in a health care setting, 42.5% of these were not physical and 24.4% were physical. Verbal abuse was the most common form of non-physical violence (57,6%), followed by threats (33.2%) and sexual assault (12.4%) [3].

According to the World Health Organisation, violence in healthcare settings is a global phenomenon. Between approximately 8% and 38% of healthcare workers are subjected to physical violence over the course of their career and the country with the largest number of violent episodes is India [4]. As such, it has been necessary to try to prevent violence in health-

care settings and implement protective measures with the objective of creating a safer workplace, increasing awareness of the need for political action in this area and facilitating the exposure and reporting of violence in the workplace [5].

The situation in Italy is not different to that in the rest of the world, a survey conducted in 2018 found that of 1280 doctors surveyed around 65% had been the victim of workplace violence. This was even more prevalent in the regions of the south of Italy (72.1%). Of those interviewed, 66.2% reported that they had suffered verbal aggression and 33.8% physical aggression. Looking at the location of these incidents more closely, it was found that 34.1% occurred in psychiatric facilities and 20.3% in emergency rooms [6].

This evidence is consistent with that of Magnavita et al. who through medical surveillance of workers exposed to risk in 2005-2011 found that on average, every year one healthcare worker in ten was physically abused and one in five suffered verbal abuse. In this case also, the locations of increased risk were found to be psychiatry (11.1-59.6%) and accident and emergency (3.8-20.5%) [7].

A further survey of nursing staff was conducted in Italy in 2017 [8]. 61.1% of the sample interviewed declared that they had been attacked or threatened by service users and that trend is on the increase compared to a similar survey in 2013. 48.1% of the nurses reported having experienced verbal aggression and 6.4% physical aggression. 45.5% said that they had experienced both physical and verbal aggression. Another national survey conducted with more than 15,000 nurses supported this, bringing Italian healthcare workers in line with those in other countries in this respect [9].

Legislative framework

The increase in violence in healthcare settings has prompted a change in the law and for the Italian Ministry of Health to give more attention given to this matter. Consequently, in 2007, it issued a recommendation for the prevention of acts of violence towards healthcare workers [10]. In so doing, such events were accorded the status of *watch list events* (i.e. "a patient safety event that results in death, permanent harm, or severe, temporary harm") [11].

The objective of this recommendation is to prevent acts of violence against healthcare workers through the implementation of measures that allow for the elimination or reduction of conditions of risk and allows for training of the workforce in evaluation and management of such events when they occur. It should be the Health Service to identify risk factors to its personnel and to put in place the most effective strategies [12].

In the last ministerial report of *watchlist events*, violent acts against healthcare workers made up 8.6% of the total number of events reported. However, 50% of the doctors interviewed as part of the 2018 survey stated that they were not aware that these aggressions constituted *watchlist events* which should be reported not only to the Director of the local healthcare trust, but also through the SIMES system (a monitoring system for reporting *watchlist* events) for which an investigation of the event is obligatory [12]. This suggests that the true number of violent events could be significantly higher than indicated by the ministerial figures, which has also emerged as part of a prior investigation [13].

In Italy, from a legislative perspective, presidential decree number 547/1955 is the first step towards adopting workplace safety measures and making them obligatory, whereas the current point of reference for health and safety measures in the workplace is legal Act number 81/2008 which represents the legislative elaboration and evolution extended to all occupational sectors and every type of risk [14].

In the light of the increase of violent episodes in healthcare settings and the growing public awareness of it, two recent laws have been enacted which are particularly relevant for the prevention of the risk of violence in healthcare settings. Law number 113/2020 sets out the "*Arrangements with regard to the safety of those working in the medical professions and community healthcare*" and it establishes severe punishments for aggression towards healthcare professionals which can mean up to a 16 year prison sentence and fines of up to € 5,000 for verbal threats. Moreover, it expects the institution to establish working procedures with police support to guarantee timely intervention. The 113/2020 law also provides for the National Centre for the Safety of those working in the Medical Professions and Community Healthcare [15].

Law number 24/2017 sets out the "Arrangements with regard to safety of care and of the person being cared for, and also the professional responsibility of those who exercise healthcare professions" and has brought about pertinent changes in the conception of safety of care both in terms of its culture and application, ring-fencing it as a "constitutive part of the right to health" [16].

The management of clinical risk, therefore, means a crucial coming together in healthcare settings of actions aimed at identifying risks and formulating clinical/administrative countermeasures as well as planning surveillance mechanisms, prevention and management of errors. Essentially, with law number 24/2017 all healthcare workers are expected to contribute to activities regarding the prevention and the management of risk that are connected to providing a healthcare service. Moreover, they should be able to intervene in an active or proactive manner in the event of an adverse event. Given that violence in healthcare settings is a *watchlist*

event and one of the most frequent negative events, it would seem logical that healthcare organisations are required to provide the means for containment of these events for all the reasons detailed above.

Violence in mental healthcare settings

The identification of risk factors for workplace violence according to setting has brought to light the fact that level of risk varies according to the type of setting and the characteristics of the patients treated there; in fact the risk of violence is higher in mental health settings, in accident and emergency, in paediatrics and in surgery and in particular during night shifts [17].

According to the United States Justice Department, the second highest annual average of episodes of workplace violence is in mental healthcare settings. The total rate for episodes of verbal aggression was 0.60 and for physical aggression 0.19 [18].

Saeki et al., whose data come instead from Japan, confirm that the possibility of a doctor meeting with a WRAV (work-related aggression and violence) is once every 3.5 years which is about 10 times over the course of a career. The highest incidence of WRAV is found in those who work in mental health care facilities, especially in hospital [19].

Nurses are the first and moreover the most frequent target for aggression by psychiatric patients [20]. Ridenour et al. [18] found that almost 20% of psychiatric nurses had suffered physical aggression, 43% had been frightened by physical aggression and 55% were verbally assaulted at least once during the equivalent of a single work week.

There is a limited number of studies that examine the frequency and characteristics of violent behaviours experienced by workers in psychiatric care settings [21-22.] Most of the studies have focussed on hospitals (SPDC, psychiatric intensive care units), moreover, there are few studies of violent episodes taking place locally, in community healthcare settings [23-24.] It is worth noting the work of Magnavita & Heponiemi [25] who looked at all the healthcare workers employed in the Civitavecchia area (hospital and community healthcare) over a 12-month period and found that 9.2% of healthcare workers experienced physical aggression, 19.6% verbal aggression and 5.5% reported having been stalked. The author had conducted similar studies at different times (2005,2007, 2009) and concluded from a comparison of the data that the percentages showed a stable trend. Almost half of the violent episodes took place in two settings: psychiatry and emergency. In particular, the risk of physical violence for those that work in mental health services appeared 22 times higher than the average.

Among the few Italian contributions to the field is the research of Catanesi et al. [13] which involved a survey sent to all Italian psychiatrists, from the responses which numbered more than 1200, it emerged that experiencing verbal aggression over a lifetime was very common (90%) and the percentage of psychiatrists who reported physical aggression (64%) was also noteworthy. Moreover, working in the psychiatric intensive care unit was among the main risk factors.

Essentially, the literature suggests that working in a psychiatric setting is a risk factor for victimisation [19,26-28]. The evidence for this seems to derive from a convergence of various complex systems, for example, individuals may become violent or aggressive as a direct consequence of psychotic symptoms and/or the abuse of psychotropic substances able to alter the perception of reality, state of consciousness or behaviour [29]. Aggressive or violent behaviour can occur as a reaction to restrictions and requirements of the hospital environment and can become an expression of anger, retaliation or desire to assert one's status [30]. There is evidence to suggest that violent behaviour comes more readily to those who have behaved violently in the past [21].

Taking all this into consideration, it is important to ask oneself what the effect of chronic exposure to a protracted climate of apprehension and fear is upon psychiatrists, nurses and healthcare workers. How prepared do psychiatrists and other staff feel to deal with violence in the workplace? How much does violence, stress and fear of violence affect the health of healthcare workers or the quality of the service? Catanesi et al.'s study [26] reported that almost all the Italian psychiatrists who participated felt that they were professionally underprepared in this area and argued strongly for more training (97%). This is even more important today given the fact that community healthcare workers are forced to work with criminal psychiatric patients due to the closure of secure hospitals.

Violence perpetrated against workers in forensic psychiatry units

Forensic psychiatry units represent a very particular type of workplace context. The international literature details research on similar target populations in hospital departments [31], in high secure forensic psychiatry settings [32] or secure environments [33] which are far from the community-based model which is used in Italy. A recent work by Kelly [31] explored, for example, a group of workers (n = 348) employed caring for patients in a forensic psychiatry hospital. These workers reported that verbal conflict with patients was "very common" (99%) and they described as "high" the incidence of experiencing physical aggression in the last twelve months (70%) [31].

In Italy, there has been a process of deinstitutionalization of the forensic psychiatry system which has in-

volved the Department of Mental Health taking responsibility for the treatment of psychiatric patients who have committed crimes and are considered a danger to society. This has meant the closure of the old psychiatric secure units and the creation of new community structures present over the entire country. These are known as Residences for the Execution of Security Measures (REMS) [34].

Residences for the Execution of Security Measures (REMS)

REMS are residential psychiatric detention centres. Judicial authorities send patients who suffer from mental disorders to these centres, the patients have usually committed violent crime and have been judged to be a *danger to society.* Moreover, an expert has usually established that they are likely to reoffend. In order for a patient to be admitted to a REMS, the level of *danger to society* needs to be considerable, where that level is lower the Judge may decide upon less restrictive measures which do not involve detention. This could mean probation with conditions set for rehabilitation (for example, attending a residential therapeutic community).

Inside the Italian REMS, the patients are treated using a model of individualised rehabilitative therapeutic programmes which are defined by the psychiatric team in the patient's residential region (Mental Health Centre – Centro di salute mentale, CSM), under the auspices of the Department of Mental Health (Dipartimento di salute mentale, DSM) [35]. Inside the REMS, security is wholly managed by the mental health teams, according to Italian Law (L. 17.02.12 n.9, art. 3-ter) "Management of the psychiatric structure is delegated to the Psychiatrist Medical Director" [35]. There are no prison officers present inside the REMS, there are, however, security guards who by law can – but do not have to – become involved exclusively in "activities involving perimeter security and external surveillance" [35].

The REMS were conceived to be located regionally and each one of them holds a maximum of 20 patients. Currently, there are 31 REMS in Italy. A recent observational investigation by Catanesi et al. of all the REMS [36] described the clinical, criminological and treatment characteristics of the patient population. For the most part, cases involve patients with schizophrenia spectrum disorders(60.7%) who are already in the care of the mental health services (82.2%) have long clinical histories (11.5 years) and often a difficult course of disease characterised by hospital admissions (71.1%, 4 or more admissions 13.3%) and compulsory health treatment (54.8% and more than 4 compulsory hospitalisations 7.9%). In the general population of 730 patients, personality disorder was diagnosed in 32.3%, that is almost one patient in three, associated disorders relating to substance abuse are seen in 27.5%, that is one in four patients. It is possible to say therefore, that the REMS have, in fact, absorbed the same target population of patients that were at one time sent to secure hospitals, that being patients with multiple problems in which along with a long term psychotic disturbance, personality disorder and substance abuse disorder is often associated. This means, difficult patients with a long history of treatment failure who have committed violent crimes (one in four has committed homicide or attempted homicide and one in two violent acts against others) and for which an expert has estimated that it is probable that the patient will reoffend.

Given the evidence detailed herein, it is clear that the characteristics of the patients admitted in the REMS mean significant consideration needs to be given to the correct management of risk and security due to the fact that in such structures it is necessary to guarantee high standards in the clinical management of patients as well as the security of healthcare workers [36].

REMS are defined as places requiring highly complex management. The appropriate management of the patients, considering the specific characteristics of the healthcare personal who work with them, should proceed recognising the behavioural risk factors associated with each one of the psychiatric patients inside the structure. This is necessary in order to manage the patients appropriately and to guarantee both security and the specific care required [37].

In total, the 31 REMS in Italy can guarantee about 612 beds. This limited number of places has meant that a waiting list has been drawn up by the Ministry of Justice which does not take into consideration the evaluation of clinical risk.

From a legislative perspective, the most relevant Law is number 81/2014, which sets out "Urgent arrangements regarding the replacement of secure hospitals" and which signalled the definitive replacement of secure hospitals; structures which had the highest level of security. Regional legislative autonomy over the organisational structure of the REMS in each region has resulted in regional differences both in the number of patients admitted (form a minimum of 2 in the REMS in Friuli, to the pluri-modal structure in Castiglione delle Stiviere which has 8 modules with 20 patients each) and the level of security guaranteed. Some are classified as structures with a medium level of security and some with a lower level of security [38,39].

In 2012, through a legislative decree, the Ministry of Health, together with the Ministry of Justice, identified the minimum structural, technological and organisational requirements of the REMS. The full details can be found in the text, however, here we highlight that it

refers to 'minimum requirements" that each local health authority is duty bound to adopt in order to allow "that the health and rehabilitation objectives are reached by those who are placed in their care, through the adoption of therapeutic rehabilitation programmes and social inclusion practices proven to be efficacious". It is also specifically required that "in consideration of significantly variable psychopathological profiles [omissis] implementation is adequately diversified also in structural, organisational, security and external surveillance terms as well as in levels of protection, with the ability to respond to diverse psychopathological characteristics and their evolution".

Setting aside, for now, our views on the role potentially played by the structures themselves, here we limit ourselves to that which concerns the personnel that should make up the multi-professional team of the setting. According to the legislation cited, the team should consist of at least 2 full-time psychiatrists available day and night and during public holidays, 1 psychologist, 12 nurses, 6 community healthcare workers, 1 educator or a mental health professional. There are significant differences in this regard between each individual region. A regional comparison between such different structural and organisational norms would naturally provide precise indications about the preventative efficacy of the choices made.

The institution of the REMS has meant that the National Health Service has taken full responsibility for psychiatric patients who have committed criminal acts and are dangerous to society, introducing, therefore a further level of complexity into the course of their care. The judgement of being a danger to society is the responsibility of the Judge, but the Health Service and particularly Psychiatric Services are responsible not only for the strictly health related aspects – care and rehabilitation of the perpetrator of the crime, but also for protection of society in general (prevention of reoffending). All in a healthcare management setting under the auspices of the Department for Mental Health.

Risk score for violent behaviour: instrument and methodology

During the transfer of patients who are mentally ill and a danger to society from the justice to the health system, it is important to identify and establish in a preventive and proactive way the level of security necessary for each patient. This is important to guarantee good clinical outcomes and adequate levels of protection for healthcare workers. With the introduction of the legislation detailed above, the function of risk management as well as being dictated by clinical logic has acquired a form of legislative obligation. In fact, all healthcare workers are expected to contribute to prevention activities and the management of risk connected to the delivery of healthcare and are duty bound to intervene in any process which could lead to an adverse event.

Violence perpetrated against healthcare workers is, moreover, a *watchlist* event; an adverse event of particular gravity, which it is an obligation to report. As has been said before, in the psychiatric setting, aggression is one of the most frequent adverse event. It is therefore necessary for healthcare organisations have with instruments to manage aggression towards healthcare workers. This offers a new perspective on the evaluation of risk of violence to healthcare workers.

The first step, in our opinion, is to identify an instrument which will be useful in quantifying a risk score for violence against healthcare workers in psychiatric settings and this is a prerequisite to prevention activities. The use of a proactive instrument in the management of clinical risk would represent a departure point also for future statistical elaborations which are necessary to evaluate how much the factors which are at the fundamental base of care (the characteristics of the population in care, type, composition and number of healthcare workers, logistical and organisational elements) can influence risk score and therefore different levels of security for healthcare workers.

The risk score (*R*) is defined by this formula:

$$R = P \times I \text{ (Risk score = Probability x Impact)}$$

Applied to the problem of violence experienced by healthcare workers in psychiatric settings, *P* indicates probability, that is the frequency with which a violent event occurs, while I indicates the extent of the damage, that is the consequences of the events.

Adhering to the recent scientific evolution in terms of security and management of clinical risk, in Italy the obligation of evaluation of workplace risk has been inserted into the Text on Health and Security at Work (Law n. 81/2008). The directions to be followed supplied by the specific rule of law on the evaluation of risk are contained in the risk evaluation document for workers. In this document the scale of probability (P) refers to the existence of a noted correlation between the type of activity under consideration and/or the negative effects which could arise from any damage.

The scale of probability (P) that results from this, classifies the events from "improbable" to "highly probable" on a scale of 4 values in relation to the noted risk of the occurrence of the event in question, as is succinctly noted in this table from the Institute for Prevention and Safety at work (Tab. I).

The scale for extent of impact (I) in the risk evaluation document refers to the consequences (in terms of injury

TABLE I

P = 1: improbable	The noted risk could cause damage in conjunction with other unlikely events There have not been other noted episodes Damage resulting from this would cause disbelief
P = 2: unlikely	The noted risk could cause damage only in an unfortunate circumstances Previous episodes are very rare Damage resulting would cause great surprise
P = 3: likely	The noted risk could cause damage, even if not automatically and directly Dame has followed some episodes of this risk Damage resulting from this would cause moderate surprise
P = 4: Highly probable	There are correlations between the noted risk and damage Damage has resulted from this same risk in the same business or similar businesses or in similar working environments Resulting damage would not cause any surprise

TABLE II

I = 1: light	Injury or episode of acute exposure with a rapidly reversible effect Chronic exposure with rapidly reversible effects
I = 2: medium	Injury or episode of acute exposure with reversible effects Chronic exposure with reversible effects
I = 3: serious	Injury or episode of acute exposure with partial invalidity Chronic exposure with irreversible effects and/or partial invalidity
I = 4: very serious	Injury or episode of acute exposure with lethal effects or total invalidity Chronic exposure with lethal effects and/or total invalidity

or exposure) produced by the event in question and to their reversibility whether total or partial. The classification, also on a scale of 4 levels, is from "light" (injury or episode with rapidly reversible effects) to "very serious" (injury or episode with effects which are either lethal or lead to serious invalidity), as in the following Table II.

The evaluation of the level of risk (R) brings with it the adoption of preventative and protective measures in proportion to the risk value, according to this Table III.

In order to apply the concepts listed above in residential structures for the mentally ill who have also committed crimes, it is necessary to understand not only the frequency (P) of the violent episodes that occur in these settings, but also the consequences, both physical and mental that result from them. Currently, we do not have reliable data, given that the data presented are generic, referring either i) to exclusively clinical psychiatric contexts where the population in question is clinically different, or in a different clinical phase; or ii) to forensic settings but with organisation, security levels and more which are not comparable. Neither is it possible to use data for accidents registered with The Italian National Institute for Accidents at Work because it is well known that the number of reports of violent incidents at work is decidedly lower than the episodes that occur daily in psychiatric settings. This is because Italian psychiatrists manage violence as part of the therapeutic relationship [26].

Therefore, we need, data which shows the true number of episodes of violent events that healthcare workers in the REMS deal with daily.

To collect such data, an instrument is needed which has as part of its internal structure characteristics that coin-

TABLE III

R > 8	Corrective actions without delay	Priority 1
R = 4-7	Urgent corrective actions to be planned	Priority 2
R = 2-3	Corrective actions and/or improvement measures to be planned for the short/medium term	Priority 3
R = 1	Improvement measures to be planned no immediate intervention required	Priority 4

cide both with the definition of frequency and also the severity of events. One of these, in our opinion, is the *Modified Overt Aggression Scale* (MOAS) [40].

We consider the MOAS to be suitable because it is an instrument which is very simple to use and which is recognised both internationally and in Italy [41], it is already used in psychiatry for the evaluation of episodes of aggression in the hospital context [42]. The MOAS registers – on a scale – both the episodes of aggression (physical and verbal) and their severity [41]. Therefore, it is able to determine both the frequency and severity of violent behaviours.

The scale has four sections (verbal aggression, physical aggression towards objects, physical auto aggression and physical hetero aggression) each of these contains descriptions of actions which allow, in relation to the seriousness of the event, the scoring of points from 0-4 (where 0 means no aggression and 4 is a serious aggressive act). A coefficient of increasing value (1x, 2x, 3x, 4x) is applied to each raw score per category in each of the four sections, with verbal aggression having the lowest score and physical aggression the maximum. As an example, the threat of violence towards others is value 3 of section 1 (raw score 3 x coef.1 = 3), physical aggression towards others that produces serious injuries is value 4 of section 4 (raw score 4 x coef.4 =16).

The four categories of aggression (verbal, towards objects, auto- and hetero-directed) express therefore, considered overall, a weighted score between 0 and 40 which indicates the "seriousness" of the behaviour. However, regarding this, we believe that some methodological adjustments are necessary.

A superficial reading could take the maximum score to be an indication of maximum severity which is true, but not sufficiently fine-grained from the perspective of risk management. A maximum score of 40 is only reached, infact, by calculating the sum of the 4 categories (verbal violence max 4 points; violence towards objects max 8 points, violence against oneself max 12 points and violence against others max 16 points). This would be a very exceptional event. Physical aggression against a healthcare worker which results in serious injury is certainly very significant but obtains a score of only 16.

From the perspective of safety of personnel, it is also evident that showing aggression towards oneself or towards objects is one case of affairs, showing aggression towards other people is quite another. From our point of view, even if we accept that all of these behaviours are expressions of aggression, some of these are certainly more important than others.

Moreover, an objectively less serious episode, like the threat of violent action towards a healthcare worker, is evaluated to have a relatively low score (3 or 4), but if said behaviour is repeated systematically towards a single worker, it can have profound consequences for their mental health.

We do not believe that the raw MOAS score, therefore, can be used as a definitive indicator with the objective of managing clinical risk. It only becomes relevant when analysed by each single category (verbal, against objects, against oneself and against other people) and above all this needs to be evaluated in relation to the episode frequency.

This leads on to our second point. On hospital wards, the MOAS is usually used to register violent behaviour in single patients. This is also done with the aim of assessing how a patient's behaviour responds to the therapy given and how well the patient adapts to the new context. In this way, it is possible to obtain signs of tendency to aggressive behaviour for each patient. This has helped us to understand, for example, that more aggression and therefore more risk is observable in the first days of hospitalisation, with a tendency to reduce or normalise over the course of a week [41].

The REMS, however, are typically a context of long-term care, where patients are resident for periods which range from many months to more than a year. In Italy, the clinical management of any acute phases of illness are typically delegated to the Psychiatric Intensive Care Units within which is it possible to initiate compulsory health treatment. In the REMS, violent behaviour in patients, which can become acute without warning, is for the most part chronic/habitual.

However, longitudinal evaluations are necessary, and we believe that for this particular care setting the MOAS should be used on a weekly basis. On the other hand, in the original paper, the author of the MOAS scale, Kay [40] evaluated patient behaviour with a retrospective survey of five consecutive days, there are number of different studies that support the use of the MOAS in this way [42,43].

We suggest that data collected in the REMS using the MOAS proceeds as described here. The MOAS points related to each single episode should be noted for each patient on a weekly basis, see the example below (Tab. IV).

The weekly total, 16 in this example, results in a daily value of 2.28 (16:7 days) only for verbal aggression. This calculation should be made for each of the four categories of the MOAS (verbal, against objects, against oneself and against other people). The following examples relate to the three forms of physical aggression. The patient manifested two episodes of physical aggression without serious consequences (raw weekly score 12, daily 1.71), no episodes of self-harm (0 points), damage to objects on two occasions (raw weekly score 6, daily 0.85) and these over and above the number of verbal aggressions stated earlier (Tabb. V-VII).

Making the calculation in this way will give a result which is a comprehensive assessment of the level of aggres-

TABLE IV

Verbal aggression - week 1	Score	Weekly frequency	Raw score	Coeff.	Total
Screaming with rage, mild cursing or personal insults	1	5	5	1	5
Cursing with violence, serious insults with the aim of provoking anger	2	2	4	1	4
Threatens violent actions with rage against other people or against themself	3	1	3	1	3
Repeatedly threatens violent actions against other people or against themself	4	1	4	1	4
Tot = 16					

sion in the patient and indirectly, therefore, the risk that the healthcare workers could face while working with them. If this is repeated for a period of 3 months (therefore a total of 12 MOAS per patient) it could be said to be reasonably indicative both of the risk score for each patient and the change over time. Consequently, this could also give an indication of susceptibility to treatment. The objective is, of course, to bring this number as close to 0 as possible (Tab. VIII).

The average of the sum of the scores for all the patients in a certain setting will be indicative of the collective risk for the entire structure as it contains those specific patients.

As stated, however, not all aggressive behaviour is of equal risk to the safety of personnel.

Using the MOAS as suggested would provide the clinical risk expert with enough data to obtain distinct values of frequency (P) for verbal aggression (certainly more common) and physical aggression (less common). The evaluation of the frequency of these behaviours would make it easier to correlate them with the consequences of exposure to this risk. These will certainly depend not only on the seriousness of the conduct but also on its repetition over time.

Limiting the evaluation of these consequences only to those that result in physical compromise, which are im-

TABLE V

Aggression towards objects - week 1	Score	Weekly frequency	Raw score	Coeff.	Total
Slams doors with rage, tears clothes, urinates on the floor	1	0	0	2	0
Throws objects to the floor kicks the furniture, ruins the walls	2	0	0	2	0
Breaks objects, breaks the windows	3	2	6	2	12
Starts fires, hurls objects violently	4	0	0	2	0
Tot = 12					

TABLE VI

Auto aggression - week 1	Score	Weekly frequency	Raw score	Coeff.	Total
Pinches themself or pulls at their skin, pulls their hair, hits themself without causing injury	1	0	0	3	0
Hits their head against the wall or punches the wall, throws themself to the ground	2	0	0	3	0
Gives themself minor cuts, burns, grazes or bruises	3	0	0	3	0
Harms themself seriously or commits suicide	4	0	0	3	0
Tot = 0					

TABLE VII

Aggression towards others – week 1	Score	Weekly frequency	Raw score	Coeff.	Total
Pushes people, grabs their clothes	1	1	1	4	4
Pinches, kicks, scratches, pulls hair (without causing injury)	2	2	4	4	16
Attacks others causing light injury (e.g. contusions, distortions or bruises)	3	0	0	4	0
Attacks others causing serious injury (e.g fractures, breaking teeth, deep wounds, loss of consciousness etc.)	4	0	0	4	0
Tot = 20					

TABLE VIII

Category – week 1	MOAS average daily score
Verbal aggression	2.28
Aggression toward objects	1.71
Auto-agression	0
Aggression towards others	2.85
Total	**6.84**

portant but not the only consequences, is not possible. It is also necessary to shed light on the psychological effects on healthcare workers themselves. Once again, to achieve this it will not be enough to use the data regarding the *accidents* registered with The Italian National Institute for Accidents at Work. For the reasons stated above, a clinical evaluation of all the workers is necessary, which can pick up levels of psychological suffering measurable using the DSM-5 criteria and those below the surface which present a risk in the medium term. In order to do this, we recommend using simple instruments such as the Beck Depression Inventory (BDI) [44], State-Trait Anxiety Inventory (STAI) [45] e General Health Questionnaire (GHQ) [46].

Having obtained these results, we will be able to make a substantial scientific contribution to the techniques used to predict risk in Clinical Risk Management, contributing to the creation of a risk score which is reliable in the psychiatric-judicial sphere.

Systematic registration of all of the episodes of aggression by patients in a REMS within a predetermined period of three months, allows for the calculation of a risk score, both of the single patients (useful for the choice of containment measures) and in a general sense to determine the structure's risk level in order to fully understand the measures necessary to protect the people who work there.

From safety to wellbeing

Safeguarding the mental and physical health of those who work inside REMS does not end by addressing the problem of workplace violence, nor by the simple calculation of a risk score, but it does offer a starting point. Without studies that can define seriousness and frequency of adverse events, not only in REMS, but also in community structures that take patients who have committed crimes, it is not possible to put preventative measures in place that can be said to be considered and proportionate.

We know, however, that other factors (type of population, structural and environmental conditions, organisation models, therapeutic and rehabilitation protocols) are potentially able to condition the patients' behaviours and they themselves can become risk factors for violent acts [42]. These also, therefore, should be the object of further study. As mentioned before, however, the objective is not only to reduce the frequency of violent acts to the minimum, activating the most suitable measures to prevent them, but also to return the healthcare staff who work in these settings to a state of wellbeing [47].

Working in a climate of fear and worry, not being sure that all of the necessary security measures are in place, not having delineated procedures for the management of violence all represent risk factors and at the same time sources of stress. We must not undervalue the effect that these stressors may have on workers. This is the same for those that are victims of violent episodes or single traumatic incidents and those that live day after day with the fear of becoming a victim (chronic stress), or even those who fear being called to testify to violent acts committed by a patient or for that which a patient could have done after leaving the REMS [48].

A perception of safety does not arise only from low values on the risk score. The subjective conviction that the context is organised and protective, as much as possible, and that a worker would receive feedback and acknowledgement in the advent of an adverse event

also helps to increase the perception of safety. In the management of clinical risk, the levels of safety can be implemented in a continuously monitored *virtuous cycle* of identification, evaluation and dealing with risk. This is important because it is not the reporting of risk that improves safety, but the response to it that brings change [49,50].

This is even more true in relation to how much psychiatrists and staff feel prepared to deal with violence in the workplace. Indeed, the subject of training is bound up definitively with organization and structure. In the investigation by Catanesi et al. [26] a few years ago almost all of the Italian psychiatrist who participated in the study (97%) reported that there was insufficient training in this area. The psychiatrists asked forcefully for training strategies. We imagine that this is even more pertinent today, as community mental health teams have been forced to deal with criminal patients since the closure of secure hospitals.

Without data, it is hard to develop effective preventative measures, unsound to think of reducing the risks, difficult to inform and train workers and therefore create good clinical practices and reliable guidelines.

In REMS, worker safety must be based on an analytical and systematic collection of empirical data.

This need also derives from the absence of historical data and strictly comparable forensic psychiatric systems on an international level.

We are hopeful that soon we will be able to provide the first results of our research in the field, and also be able to offer a working protocol.

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Original article

Domestic violence: critical issues on Intimate Partner Violence (IPV) primary prevention strategies

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SUMMARY

Background

Domestic violence is one of the most critical issues worldwide, often reported in newspapers and faced with prejudices and clichés. Violence against women in particular continues to be an obstacle to reaching equality, development, peace and the achievement of respect for women human rights. Primary prevention strategies aim to increase awareness and critical capacity of the phenomenon in the general population. They are therefore not only a clinical challenge, but also a social, cultural and political one.

Objective

The objective of this literature review is to identify primary prevention programs and interventions related to interpersonal violence

Methods

A literature search was conducted through major databases: MEDLINE/PubMed, PsycINFO/PsycLIT, Excerpta Medica/EMBASE, Scopus, Web of Science (ISI), Cochrane Library. National data were collected from, the ISTAT website, the Ministry of Health and the Interior and the Institute of Health.

Conclusions

The analysis of primary prevention programs highlighted two elements of criticality: insufficient involvement of the perpetrators of the violent behaviour (men) compared to the involvement of women, and lack of attention to specific risk and protective factors for each level.

Key words: domestic violence, interpersonal violence, intimate partner violence, violence against women, primary prevention, prevention strategies

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Introduction

Domestic violence (DV) represents a serious social, cultural and public health problem worldwide [1]. DV includes intimate partner violence (IPV), defined as *"physical, sexual, stalking and psychological violence (including coercive tactics) by a current or previous intimate partner"* [2], and also violence within families (children and elderly abuse). The Intimate partner violence (IPV), and in particular violence against women and girls (VAWG), is one of the most widespread, persistent and devastating human rights violations in our world, largely unreported because of the stigma and the shame that surround it. The United Nations World Conference defines violence against women as "… *any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life*" [3]. In 2011, the States members of the Council of Europe signed the Istanbul Convention which established the main objectives of preventing and combating violence against women and domestic violence [4]. This

Convention recommends the promotion of changes in the socio-cultural behaviour of women and men, the adoption of adequate legislative measures, the implementation of adequate awareness campaigns aimed at the general population, the inclusion of school educational programmes, the strengthening of the education of involved professionals, as well as the establishment of preventive and treatment programs, the involvement of public and private sectors and prevention programs for violence against women should therefore be built according to these general principles and be tailored to the specificities of the territory and population to which they address. Prevention strategies for violent behavior encompass different variables related to the intrinsic characteristics of this complex phenomenon, including its multifactorial and multi-determined nature (e.g. the overlapping of biological, psychological, psychiatric, social, cultural and circumstantial risk and protective factors) [5]. Primary prevention is the leading prevention strategy, which aims to adopt interventions and behaviors in order to avoid or reduce the onset and development of a disease or an unfavorable event. The aim is therefore to prevent a disease from occurring in healthy individuals and to reduce risk factors which could lead to an increased incidence of the disease. Examples of primary prevention strategies are represented by awareness/information campaigns addressed to the general population and promoted by governments.

In view of the above, it is possible to affirm that the prevention of IPV is a multifaceted challenge, which must consider a wide range of circumstances not only related to the perpetrators, but also to the characteristics of the victims and the context.

Violence against women is an obstacle to achieving equality, development, peace and the achievement of respect for the women human rights. The consequences of IPV on mental and physical health produce further damage in the medium to long-term, at individual level and also at the community and society level, with significant direct and indirect costs. Primary prevention strategies for IPV are mainly based on prevention through awareness campaigns that aim to increase awareness of the phenomenon in the general population and to raise critical capacity of the general population with respect to the phenomenon of gender-based violence. They are therefore not only a clinical challenge, but also social, cultural and political.

Epidemiology of IPV

Studies on intimate partner violence (IPV) have revealed mixed findings about its prevalence across gender. Some past studies pointing to a tendency for men to under-report suggesting that this discrepancy may be releated to gender differences in reporting styles and culture (e.g. excusing, normalizing as an expression of love, dependence, self-blaming) [6-9] or lack of existing measures (e.g., the Conflict Tactics Scales; CTS) to assess the context, motives, causes, and consequences of IPV [10]. Results from the WHO multi-country study on women's health and domestic violence [11] confirm the pervasiveness and high prevalence of violence against women by an intimate partner in a wide range of cultural and geographical contexts. The reported lifetime prevalence of physical or sexual partner violence, or both, in women aged 15-49 years, varied from 15 to 71%. In all settings except one, women were more at risk of violence by an intimate partner than from any other perpetrator. Women who suffered physical or sexual partner violence were substantially more likely to have severe constraints placed on their physical and social mobility: they reported significantly more acts of controlling behaviours by their partners than women who had not suffered partner violence. The pattern of violence might be different in settings of high violence and low empowerment of women, compared with more industrialised settings. Three quarters of all violence against women is perpetrated by domestic partners, with poor women disproportionately affected. The authors provide empirical support for a causal relationship between relative work conditions for women and violence. These findings suggest that in addition to more equitable redistribution of resources, policies that serve to narrow the male-female wage gap also reduce violence and the costs associated with it gender wage gap [12].

Historical issues

Although special attention has historically been paid to violence against women, violence against men has also been documented. Anthropologists report that men's violence against women is widely documented in history, often linked to jealousy and fear of rejection dynamics, but also aimed at restoring a position of domination within the couple or as a punishment for a failure to perform a household task [13]. Violence is considered an extreme measure of a series of tactics by which men control women's freedom and authonomy. Biologists find a similarity with the phenomenon of the mate-guarding [14], behavior of control by which the female, which is crucial for the continuation of the species, does not mates with another male). Some cultural practices such as the imposition of the veil, seclusion, segregation, female genital mutilation could be part of the culturally recognized tactics of control, mate guarding [15]. From a legal point of view, violence against women has been legitimized in many cultures for a long time, when aimed at maintaining the balance deviating from the woman-property model [16]. For a long time, adultery was considered a crime only for women; the man has been recognized, by law, the right to "punish his wife" [15,17]; friends and/or family members who protected the woman, trying to

avoid husband's violence, were charged with the crime of "aiding and abetting" [18]. From the seventies onwards, considerable social and cultural changes have outlined a substantial change in the man-woman paradigm: the abrogation of laws that recognized women as "a husband's property, the laws on divorce, the abolition of honor, up to the recognition of the "legal dignity" of the crime of ill-treatment and the victim's right to protection.

Legal issues

In Italy, the introduction of the so-called "Red code" (*Codice Rosso*) is based on a perspective of higher protection for the victims. In July 2019 was introduced the Law n°69 (dated 07/19/2019), known as the "Codice Rosso", which renews and changes the discipline of domestic and gender-based violence. The purpose of the law is to make the repression of gender-based violence more effective through certain mechanisms such as: the identification of new crimes, the tightening of penalties for already existing crimes, the preparation of a prompt response from the criminal system through some changes of the Code of Criminal Procedure, the modification of investigative times (shortening of times). How much the new legislation has really affected the control of the phenomenon of domestic violence is not easily assessed. Domestic violence is a great "reservoir of crimes" of which femicide is the one with the greatest social visibility and most easily accessible to official statistics. Numerous other behaviors, mistreatment, abuse, psychological mistreatment, are easily incorporated into an underground that does not always reach official reports (Tab. I).

Clinical issues

Violence against women is now widely recognised as a serious human rights abuse, and increasingly as an important public health problem with substantial consequences for women's physical, mental, sexual, and reproductive health [11]. Women exposed to IPV have approximately 5 times higher risk of suicide than non-exposed women [19]. About 41% of women victims of IPV and 14% of men experience physical consequences of the violence. The literature highlights further consequences, such as cardiovascular, gastrointestinal, reproductive, musculoskeletal and nervous system diseases, many of which runs a chronic relapsing course [20]. Literature highlights that the association between IPV and mental health is bidirectional, such that IPV increases the risk of mental health conditions, which themselves increase vulnerability to intimate partner violence. Intimate partner violence is associated with development of anxiety, depression, and suicide attempts, which can predict subsequent intimate partner violence [21]. Psychopathological consequences of IPV include mainly depressive disorders, anxiety disorders, eating disorders and post-traumatic stress disorder (PTSD) [1,22], as well as risky behaviors such as substance abuse, alcohol, smoking and HIV-risk sexual behaviors [23]. Surveys

TABLE I. LAW 69/2019. THE "RED CODE" (Codice Rosso). Main introduced measures.

New crimes	*Art. 387 bis c.p. (Violation of the measures for removal from the family home and the prohibition on approaching the places frequented by the injured person)* *Art. 558 bis c.p. (Compulsion or entrapment to marriage)* *Art. 612 ter c.p. (Unlawful dissemination of sexually explicit images or videos)* *Art. 583 quinquies c.p. (Deformation of the person's appearance by permanent facial injuries)*
Aggravation of the existing sanctions	*Art. 572 c.p. crime of domestic abuse* *Art. 612 bis c.p. Crime of harassment (Stalking)* *Art. 577 c.p. other aggravating circumstance. life imprisonment* *Art. 609 bis c.p. Rape. Sexual abuse* *Art. 609 quater c.p. Sexual acts with a minor* *Art. 609 octies c.p. Group sexual violence*
Amendments to the code of criminal procedure	*Art. 90-ter c.p.p. Reports of evasion and release* *Art. 282-ter c.p.p. Prohibition of approaching the places frequented by the offended person* *Art. 282 quater c.p.p. Reporting obligations* *Art. 299 c.p.p. Withdrawal and replacement of measures* *Art. 659 c.p.p. Enforcement of decisions of the supervisory court*
Investigation time	*The judicial police immediately communicate, also in oral form, the crime report to the Public Prosecutor* *The Public Prosecutor obtains information within 3 days from the registration of the crime* *The judicial police must, without delay:* – *carry out the acts delegated by the Public Prosecutor* – *make the documentation available to the Public Prosecutor*

based on the general population suggest that 52% of women and 17% of men who are victims of sexual assault, physical violence or stalking by an intimate partner develop PTSD. 73% of women and 36% of men report negative feelings such as fear, anxiety and concern for their safety [24]. There are also indirect consequences on the social costs associated with the use of medical and mental health services for damage resulting from IPV, loss of paid work productivity, absence from school, need for childcare and interventions for minors, in addition to legal costs.

Objective

The objective of this literature review was to identify programs and interventions of primary prevention strategies focused on violence against women, in particular IPV, and to analyze some critical issues.

Methods

A literature search (both in English and Italian) was carried out through the main databases: MEDLINe/PubMed, PsycINFO/PsycLIT, Excerpta Medica/EMBASE, Scopus, Web of Science (ISI), Cochrane library and also on the different internet portals. For the collection of national data, the ISTAT website, the Ministry of Health and the The Ministry of Interior and the Institute of Health were checked. The results were classified on International, European and National), and on the basis of the type of prevention intervention (primary, secondary and tertiary prevention). This last distinction was based on the classification proposed by the CDC (Center of Disease Control and Prevention) and applyed in the DELTA program (The Domestic Violence Prevention Enhancement and Leadership Through Alliances Impact Program) which defines the development of global prevention strategies through a continuum of activities addressing all levels of social ecology.

Results

Documents relating to the legal context were not included in the analysis as they are not related to prevention implementation programs, but were examined as they provide information on the regulatory framework for guidelines and prevention programs. At the international level, 7 documents published by the United Nations and a WHO document (from 1979 to 2000) were included. With regard to European legislation, 13 documents published by the European Union (from 1998 to 2000) have been included. With regard to the Italian regulatory context, 13 documents were included (from 1996 to 2019) (Tab. II).

After excluding duplicates and intervention programmes that do not provide primary prevention strategies, our search identified the following International documents: 7 documents published by the United Nations, UN Women (United Nation), World Health Organization (WHO), European Commission, Council of Europe, European Institute for Gender Equality. At the national level, 7 programs were selected issued by the Council of Ministers, Department of Equal Opportunities, Ministry of Education, University and Research, Parliamentary Commission of Inquiry into Femicide, Superior Council of the Judiciary, National Research Council State Police (Tab. III).

Discussion

The World Health Organization proposes primary prevention programs through documents addressed to the general population that define the different types of violence, describe the effects of IPV on victims and provide education programs for health professionals for victim recognition [19]. In another document, the WHO addresses policy makers, programmers and public health funding bodies and related sectors, with the aim of providing them with recommendations for developing evidence-based programs for the prevention of violence against women. The Council of Europe also provides indications on primary prevention, favouring and promoting strategies for gender equality, in five priority areas including to prevent and combat gender stereotypes and sexism, violence against women and domestic violence, to ensure equal access of women to justice and a balanced participation of men and women in the political life and in public decision-making. The European Commission aims to raise awareness of gender-based violence, through co-financing campaigns conducted by national governments and supports transnational projects managed by non-governmental organizations [25]. In another document (Strategic engagement for gender equality 2016-2019) it indicates the strategies for equality between women and men, giving priority to five key areas of intervention comprising equal economic independence for women and men, equal pay for work, equality in decision making. The European Institute for Gender Equality (EIGE) has developed a way to measure the phenomenon of violence against women [26] as part of its gender equality index. The new measurement framework sheds light on the spectrum of violence against women ranging from harassment to death (femicide). It makes it possible to measure forms of violence, such as human trafficking, intimate partner violence, sexual assaults and rape. This tool can help Member States that have ratified the Istanbul Convention in their obligations to monitor and communicate the phenomenon of IPV.
At the national level, the Presidency of the Council of

TABLE II. Regulatory framework.

International	*1979, UN. Convention on the Elimination of All Forms of Discrimination against Women New York* *1993, UN. Declaration on the elimination of violence against women* *1995, UN. Platform for action approved by the Fourth World Conference on Women (Critical Area D – Violence against Women)* *1996, WHO. Resolution of the World Health Assembly "Prevention of violence: a public health priority"* *1998, UN. Resolution of the General Assembly "Crime prevention and criminal justice measures to eliminate violence against women" and "The model strategies and practical measures on the elimination of violence against women", annexed to the Resolution* *1999, UN. Summary of the Optional Protocol (signed by 72 countries on 31/7/2001) concerning the "Convention for the Elimination of All Forms of Discrimination against Women"* *2000, UN. Resolution of the Special Session of the General Assembly "Women 2000: gender equality, development and peace for the 21st century" (Introduction and critical area D – violence against women)*
European	*1986, EU, Resolution on violence against women* *1991. Recommendation 92/131/EEC of the Commission of 27 November 1991 and Council Declaration of 19 December 1991 on the implementation of the Commission Recommendation on the protection of the dignity of women and men at work, including the Code of Conduct on measures to be taken to combat sexual harassment* *1997. Directive 97/80/EC of the Council of 15 December 1997, concerning the burden of proof in cases of discrimination based on gender* *1997, EU. Group of experts appointed by the Steering Committee for Equality between Women and Men (CDEG) of the Council of Europe: Summary of the "Action Plan to Combat Violence Against Women"* *1997, EU. Resolution on the "Need to organize a campaign at European Union level for total intransigence against violence against women"* *1999, EU. Resolution on violence against women and the "Daphne program"* *2000. Directive 2000/43 / EC of Council of 29 June 2000, which implements the principle of equal treatment between people regardless of race and ethnic origin* *2000, UE. Decision N. 293/2000/CE on a "Community action program on preventive measures intended to combat violence against children, young people and women" (2000-2003)* *2002. European Council. Recommendation (2002) of the Committee of Ministers to member states on the protection of women from violence* *2011. Explanatory Report to the Council of Europe Convention on preventing and combating violence against women and domestic violence* *European Parliament resolution on the 57th session of the United Nations Commission on the Status of Women (CSW): prevention and elimination of all forms of violence against women and girls (2012/2922(RSP))* *2014. European Parliament resolution of 25 February 2014 with recommendations to the Commission on combating violence against women*
National	*1996. Law 15 February 1996, n. 66 "Regulations against sexual violence" (cp artt.609bis-octies)* *1997. President of the Council Directive "Actions to promote the attribution of powers and responsibilities to women, to recognize and guarantee freedom of choice and social quality to women and men", Official Gazette May 21, 1997* *1998. Law 3 August 1998, n. 269 "Rules against the exploitation of prostitution, pornography, sex tourism to the detriment of minors as new forms of enslavement"* *2001. Law 5 April 2001, n. 154 "Measures against violence in family relationships"* *2006. Law 9 January 2006, n. 7, "Provisions concerning the prevention and prohibition of female genital mutilation practices", of the Presidential Decree May 30, 2002, n. 115 "Consolidated law on legal expenses"* *2009. L. 23 April 2009, n. 38, Urgent measures regarding public safety and the fight against sexual violence.* *2013. Law 27 June 2013, n. 77, Ratification and execution of the Council of Europe Convention on preventing and combating violence against women and domestic violence, done in Istanbul on 11 May 2011* *2013. The so-called law on femicide (d.l. 14 August 2013, n.93, converted into Law 15 October 2013, n.119, on the fight against gender-based violence)* *2015. Art. 24 of Legislative Decree 15 June 2015, n. 80 "Leave for women victims of gender-based violence"* *Law 19 July 2019, n. 69, "Amendments to the Criminal Code, the Criminal Procedure Code and other provisions regarding the protection of victims of domestic and gender-based violence"*

UN: United Nations; WHO: Wolrd Health Organization; EU: European Union; EEC: Economic European Community

TABLE III. Primary prevention interventions and programmes.

International	
UNDOC-UN Women	*Blue Heart Campaign": raising awareness about the problem of human trafficking and inspiring decision makers to make the change happen*
WHO, 2010.	*Preventing intimate partner and sexual violence against women. Taking action and generating evidence*
WHO, 2013	*Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines, 2013. Definition of forms of violence, sequelae and effects on the health (both organic and mental) of victims of violence*
European Commission, 2015	*Strategic engagement for gender equality ,2016-2019*
European Institute for Gender Equality (EIGE), 2017	*Gender Equality Index: we cannot be silent about violence*
Council of Europe, 2018. Gender Equality Strategy, 2018-2023	*Gender equality strategy*
European Commission, 2018	*Ending gender-based violence. Actions combating gender-based violence, research and campaigns, statistics on gender-based violence*
National	
Presidency of the Council of Ministers, 2015	*Extraordinary Action Plan Against Sexual and Gender Violence (pursuant to article 5, paragraph 1, of the decree-law of 14 August 2013, n.93, converted, with amendments, into the law of 15 October 2013, no.119)*
Department for equal opportunities, Presidency of the Council of Ministers, 2017	*Communication and awareness campaigns*
Department of equal opportunities in agreement with the Presidency of the Council of Ministers, 2017	*Inter-institutional agreements, for the implementation of educational initiatives in the school environment for the implementation of the "Extraordinary action plan against sexual and gender- based violence"*
Presidency of the Council of Ministers and State Regions Conference and of the Unified Conference, 2017	*National Strategic Plan on Male Violence Against Women, 2017-2020*
Parliamentary commission of inquiry into femicide, 2018	*Investigations on the dimensions and causes of femicide, understood as the killing of a woman, based on gender and, more generally, of all types of gender-based violence*
State Police, 2018	*Information and awareness-raising initiatives to combat gender-based violence in the bud*
The Institute for Research on Population and Social Policy - National Research Council (IRPPS – CNR), 2019	*Treatment Programs for Violence Offenders*

Ministers, in the Extraordinary Action Plan Against Sexual and Gender Violence (Article 5, paragraph 1, of Legislative Decree no. 93 of 14 August 2013, converted into Law 119 of 15/10/2013) emphasizes the levels of intervention, including primary prevention through the promotion of a change concerning attitudes, gender roles and stereotypes that make male violence against women acceptable. The Presidency of the Council of Ministers, in agreement with the Department for Equal Opportunities, also promotes communication and awareness campaigns aimed at public opinion to increase their awareness of the phenomenon of male violence against women, in order to promote correct culture of the man-woman relationship at all ages. The Department for Equal Opportunities in agreement with the Presidency of the Council of Ministers, implements primary prevention programs whose objectives concern: 1. the realization of educational initiatives in the school environment, including education for equality and respect for differences; 2. collaboration with the Ministry of Education, University and Research to combat gender stereotypes; 3. the agreement with the Institute of Advertising Self-

discipline (IAP) which establishes the rules that advertising and commercial communications must respect. In Italy, the State Police has also promoted information and awareness-raising initiatives to combat gender-based violence in its infancy, expressed in education programs in schools and training courses for social workers and health structures to improve the first reception. The Parliamentary Commission of inquiry on femicide, as well as on all forms of gender-based violence (March 5, 2018) reserves a space for the promotion of cultural change as a prevention of gender-based violence, without however providing any guidelines. Greater space for primary prevention is offered in the National Strategic Plan on male violence against women, 2017-2020 of the Presidency of the Council of Ministers and State Regions Conference and of the Unified Conference (December 2017), where a line of intervention is envisaged through educational plans and communication, as well as training for operators in public and private sectors. The only program that explicitly focuses on primary prevention carried out on perpetrators was published by the Institute for Research on Population and Social Policies – National Research Council (IRPPS – CNR), based on the agreement with the Department for equal opportunities for the Presidency of the Council of Ministers. The "Treatment Programs for Violence Offenders" reserve specific resources for the support of prevention programs for violent men to encourage the adoption of non-violent behaviour in interpersonal relationships. The aim is to increase the levels of empathy, responsibility and motivation for a change in the perpetrator.

The first observation resulting from this analysis is that, the majority of primary prevention programs, both internationally and nationally, mostly target victims, i.e. women or children, not including the perpetrators (in this specific case men). This appears to be a significant limitation in the methodology of primary prevention mechanisms. In fact, according to the Istanbul Convention, among the general obligations of prevention are the following: "*The Parties adopt the necessary measures to promote changes in the socio-cultural behavior of women and men, in order to eliminate prejudices, customs, traditions and any other practice based on the idea of the inferiority of women or on stereotyped models of the roles of women and men*" (Art. 12, point 1) and "*The Parties shall take the necessary measures to encourage all members of society, and in especially men and boys, to actively contribute to the prevention of all forms of violence (…)*"(Art. 12, point 4). Primary prevention interventions focused on the offender should therefore provide with an adequate awareness of the male gender on the types of violence (e.g. emotional, psychological, economic), and for direct and rapid access also for men to adequate information on how receiving support (e.g. listening centres, self-help groups, psychology services). They further must provide men with information on legislative measures, both punitive and for rehabilitation. It would also be appropriate to promote campaigns focused on male attitudes towards prejudices, customs, role stereotypes and traditions that encourage gender-based violence. Such campaigns should include the active contribution of men and the promotion of non-violent solutions for the management of interpersonal conflicts.

A second observation is that included prevention programmes do not put enough emphasis on risk and protection factors on which primary prevention could act. The strategies and approaches included in the recommendations of the DELTA program [27] seem to approach the resolution, at least partially, of this problem. They represent different levels of social ecology, with efforts aimed at changing individual behaviors, relationships, families, schools and communities that influence risk and protective factors for IPV. Although there is less evidence of what works to prevent IPV than in other areas of violence, such as youth violence or child maltreatment, a growing research base shows that the interconnections between different forms of violence suggest multiple opportunities for prevention [28-32]. A comprehensive approach that simultaneously targets multiple risk and protective factors is key to having a broad and lasting impact on interpersonal violence.

In view of the above, our suggestion is that an adequate primary prevention program should focus on reducing some risk factors attributable to the general population and which, according to the current scientific literature, could predispose to IPV. These include individual risk factors, such as attitudes and beliefs that support IPV, isolation, a family history of violence, relational risk factors [33]. There are also community risk factors, the contexts in which social relationships are incorporated; and finally risk factors related to society, macro-factors, such as gender inequality, systems of religious or cultural beliefs, social norms and economic or social policies. In addition to risk factors, some protective factors associated with a lower likelihood of perpetration of violence or victimization have been identified. These include a high level of empathy, good academic performance, high IQ, a positive relationship with one's mother, and attachment to school [34]. Less is known about protective factors at community and social levels, but research is emerging indicating that environmental factors such as lower alcohol access density [35] and community norms that are intolerant of violence [36] can be protective. Although more research is needed, there is evidence to suggest that greater economic opportunity and housing security may be protective [37-39]. Understanding these factors, at different levels, can help to identify adequate

prevention opportunities, also through the enhancement of protective factors in programs and awareness campaigns targeted on specific issues and aimed at the general population.

Conclusions

We analysed several programs for the prevention of IPV and highlighted two critical issues at the level of primary prevention. Insufficient involvement of the perpetrators of violent behavior (men) compared to the involvement of women in education/information/awareness campaigns, and insufficient attention to risk and protective factors specific to each different level. In fact, it is essential that there can be an integration in the specificity of the stakeholders, who must include both the victims and the perpetrators, but also the socio-economic cultural context within which the violence occurs. IPV is a public health priority and health policy response must be structural and not emergency-type. It is necessary to promote systematic interventions aimed at the education of the general population in order to recognize the signs of violence in its infancy.

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Original article

The application of new social determinants in forensic psychiatric practice: the vital poverty

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SUMMARY

Vital poverty is a novel concept which concerns a form of impoverishment that is not only economic or material, but rather relational, value, affective.

The vital poverty, although not regardless of the material and economic aspects, mostly represents the subjective moral, spiritual, social and empathic dimensions of the life of individuals. To this regard, we hypothesize that the vital poverty is a new social determinant of mental health and preliminary data suggest that the level of vital poverty can mediate the development of psychopathological disorders. A typical example of vital poverty is bullying and in general many forms of antisocial behavior can be linked to this form of vital impoverishment. The application of the concept of vital poverty to forensic psychiatry can concern various fields, such as femicide and interpersonal violence, stalking, the evaluation of parenting skills. Therefore, studying the "level" of vital poverty may be particular helpful in forensic psychiatric practice. In this article, we will present a clinical case in which we will analyze and demonstrate the usefulness of investigating this new social determinant, the vital poverty, in order to establish a possible causal link between this condition of psychopathological vulnerability and abnormal behavior.

Key words: forensic psychopathology, socio-economic status, vital poverty, poverty, psychopathy

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Introduction

Mental health and most common mental disorders are shaped by the social, economic, and physical environments in which people live [1].

An increasing number of historical contributions investigated the link between poverty and mental health, especially the effects of poverty on children's cognitive and emotional development [2,3].

Numerous studies document an impact of poverty on brain development in childhood [4]. In particular, there is evidence that adverse socio-environmental conditions during pregnancy cause inflammatory responses that negatively affect the brain development of the unborn child [5]. Furthermore, social inequalities and the environmental factors related to them may induce changes in neuronal development [6,7].

However, it's increasingly clear that the link between poverty and physical and mental health is not only economic.

The updated literature is shifting the focus of its attention from the mere economic income to other variables, such as the level of social inequality within the same country, or cultural and social variables [8]. Today, modern mental health studies are replacing the traditional concept of economic poverty (socio-economic status) with the concept of Social Determinants of Mental Health [9,10]. Social determinants of mental health represent a broader container of factors than merely economic and income related [11]. Research on social determinants focuses on the environmental and social

circumstances in which people live and within which their health is affected [12].

In this regard, we have suggested the introduction of a new social determinant of mental health, the vital poverty [13,14]. The vital poverty represents a broad concept, which includes cultural, moral, relational and emotional aspects. Preliminary data show that the vital poverty is a social determinant that correlates with the individual's resilience independently of material economic factors [15].

In this article, we investigate the possible application of the concept of vital poverty to forensic psychiatry. The application of the concept of vital poverty to forensic psychiatry can concern various fields, such as femicide and interpersonal violence, stalking, the evaluation of parenting skills.

Therefore, studying the "level" of vital poverty may be particular helpful in forensic psychiatric practice. In this article, we will present a clinical case in which we will analyze and demonstrate the usefulness of investigating this new social determinant, the vital poverty, in order to establish a possible causal link between this condition of psychopathological vulnerability and abnormal behavior.

The concept of vital poverty

The traditional definitions of poverty (absolute poverty and relative poverty) refer to purely statistic factors, in which the main criterion is related to deprivation or lack of resources, in absolute terms or in relation to the others. As mentioned, a person's well-being is a wider phenomenon that goes beyond the greater or lesser economic availability.

Referring to childhood, UNICEF in 2007 established general indices of well-being among which the economic aspect is only one of the elements to be considered [16]:

- material well-being: percentage of children living in conditions of relative poverty;
- health & safety: health level in the first year of life (index of mortality and low birth weight); presence in the context of services of preventive medicine (vaccinations); child safety (number of deaths from accidents and injuries);
- educational well-being: scholastic obligation up to 15 years;
- family and peer relations: family structure, family relationships (percentage of families whose children eat the main meal with parents at least once a week, percentage of children who report that their parents spend time with them to "talk") and relationships with friends;
- behaviors: health risk behaviors (smoking, alcohol, cannabis, number of unexpected pregnancies in adolescence) and experiences of violence suffered;
- subjective well-being: percentage of children who define their health as "good" or "bad", percentage of children who love to go to school.

In order to overcome the conceptual limits deriving from the mere economic definition of poverty, absolute or relative, we introduced a new concept, the "vital poverty", which considers not only material deprivation, but also restriction of relational, emotional, value and moral capacity. The concept of vital poverty can help us to understand in deeper the non-material dimension of poverty.

The vital poverty, in fact, although theoretically conditioned by economic poverty, is a broader concept, which refers an impoverishment of general qualities and human resources of the individual, to a social involution incapable of having long-term perspective. This condition is characterized by a feeling of inner emptiness and a lack of meaning of one's life.

Poverty of relationships, emotional poverty, meaninglessness, loss of values, loss of moral and religious sense are the indexes of this new form of poverty. which we called "vital" and constitute a risk factor, a substrate of vulnerability. psychopathological.

Anxiety, depression, adaptation disorders, some psychotic reactions can find in vital poverty not a causal element, but a psychopathological vulnerability factor due to the conditions of general weakening of the individual's resources.

A typical example of vital poverty is bullying. Bullying is an ancient phenomenon, but in post-modern society acquires new characteristics as it mixes the use of social networks, the viral diffusion of videos and photos with the aim of humiliating the victim. The bully becomes a hero of the web, his performance may be emulated by the other friends [13,15].

The hypothesis that we put forward concerns the possibility of connecting bullying to vital poverty, considering that vital poverty (a moral, emotional and relational impoverishment) can constitute the psychological basis of aggressive behavior against the other [14].

Statistics on the spread of bullying in schools do not indicate any causal link between the type of school and the class social affiliation and violence [17].

It is striking that the aggressive action is experienced by the bully without feelings of guilt or empathy. On the contrary, the aggression against the other seems to increase a feeling of pleasure in the bully. The experience of bullying could be explained according to the general impoverishment of institutions and schools in our society. To this regard, it may be related to the hypothesis of the vital poverty, Modernity implies the crisis of symbolic figures (eg, teachers) and the inability of the subjects to assume a symbolic mandate. Moreover, young people frequently don't trust in the law; as the philosopher Zizek argues, they see obscene enjoyment *(jouissance)* in the Great Other of the Law, a form of sadism and repression by social and political institutions [18]. If moral and political authorities are stained with obscene and abusive

enjoyment, why should young people respect them and the law? The decay of the symbolic authorities and the more and more frequent manifestations of violence towards the others may be correlates of the vital poverty.
Another example of vital poverty is the actual spread of the fake news across western societies. With the explosion of the Internet and social networks, it is now much easier to spread these fake news.
"The flu vaccine facilitates contagion with the new coronavirus", "Ayurvedic treatments fortify and therefore protect me and do not make me ill with COVID-19", "The beard exposes to a greater risk of becoming infected with the new coronavirus", "Drinking methanol or ethanol protects against new coronavirus infection", "Children are not at risk of being infected with the new coronavirus" are some examples of most common fake news during this period of COVID-19 pandemic in Italy [19]. The fake news may easily develop on the fertile ground of the passion for ignorance and simplification typical of the post-modern age [20]. The passion for ignorance and vital poverty share many aspects in common, such as the refusal of moral and scientific authorities, the search for the enemy and easy simplification.

The application of the vital poverty to forensic psychiatry

Some typical aspects of vital poverty, such as, for example, the rejection of moral values, emotional indifference, the attention to material rather than ideal aspects, represent a fertile ground for the development of antisocial or deviant behavior.
For this reason, we have tried to investigate the possible application of this concept in forensic psychiatry. In this article, we will show the case of an offender who underwent a psychiatric evaluation. He completed a self-report questionnaire to assess the level of vital poverty (Siracusano and Ribolsi, unsubmitted). We will report some extracts of the psychiatric forensic assessment in order to discuss the possible correlation between vital poverty and forensic psychopathological evaluation.

Clinical history

The patient C. is 23 years old. When he was four years old, the parents divorced for unclear reasons. He describe his mother as a present and overall affectionate woman; the father is described as a severe, often violent man ("he hit me with his belt when I was disobedient"). During the second half of childhood when, a series of dysfunctional behaviors began to emerge ("I was often aggressive with my peers"). He obtained his lower secondary school certificate and subsequently, after several failures during his high school studies, he left his studies at the age of about 18aa.
Currently, C. consumes medium amounts of cannabis (3-4 times a week); in the past he used MDMA and cocaine. He was evaluated several times during childhood and adolescence. In particular, a diagnosis of "oppositional defiant disorder" was made when the patients was 14 years old. At the age of 17, following persistent episodes of emotional dysregulation and psychomotor agitation (not better described by the patient), he was admitted to the SPDC at the OSP. San Camillo de Lellis: he was discharged with a diagnosis of Antisocial Personality Disorder.
In 2014 he started a romantic relationship with a girl he met through social networks. A few months later, the girl became pregnant. In the meantime, he started to be aggressive towards the girl (*"I behaved badly, I was very jealous"*): after several quarrels, he received a complaint for stalking.

Extacts from the "forensic psychiatric assessment":
"From the evaluation carried out it emerges very clearly that the patient is affected by a personality disorder with prevalent traits of borderline disorder, a pervasive pattern of instability in interpersonal relationships, mood and impulsivity characterized by labile and precarious affectivity, marked reactivity of the mood, irritability, difficulty to control impulses, poor frustration tolerance and involvement in potentially harmful activities such as in particular substance abuse, mixed with antisocial aspects. These characteristics appear stable in the patient since the late adolescence. There are mood swings of the depressive type and more frequently hypomanic which have frequently characterized, as illustrated above, the clinical history of the accused. Surely the temperamental characteristics of the subject are in close causal connection with the behaviors such as the one for which he is accused, causing a decrease in the ability to understand the unfairness of certain actions and in particular to curb impulsive behaviors related to frustrations, in particular those related to relationships.
[…] The patients is a socially dangerous person in forensic psychiatric terms".

Conclusions: the application of the vital poverty concept to the forensic assessment

In order to quantify the level of the vital poverty we have created a self-report scale. The Vital Poverty Scale (VPS) consists of four dimensions: a material dimension, a value dimension, a relational dimension, an affective dimension (Siracusano and Ribolsi, in preparation).
C. has compiled the VPS for the assessment of vital poverty. The score achieved is 21/32. It is higher than the average score we verified in a transdiagnostic sample with a psychiatric diagnosis [15]. In particular, this patient

showed high scores in the value and relational dimension, while the score in the material dimension was low. This data confirms the possibility of applying the concept of vital poverty in forensic psychiatric practice. C. has a high level of vital poverty in line with the psychiatrist's assessment. In particular, the high scores in the value and relational dimension correlate with antisocial, impulsive behaviors.
The forensic psychiatric assessment reported:

"decrease in the ability to understand the unfairness of certain actions and in particular to curb impulsive behaviors related to frustrations".

Such a difficulty to recognize the rules and consequences of one's actions represents a characteristic element of vital poverty, in particular of the affective and relational dimensions.
An essential element of this patient's story is the educational poverty. As can be deduced from the clinical history, this patient had severe school difficulties. The lack of adequate cultural and cognitive stimuli represents a "vital" impoverishment different from the economic one, although obviously in many cases there is a correlation between these two forms. Today many authors speak more and more often about this form of educational poverty [21].
The story of this patient indicates traumatic events in childhood (divorce of parents, abusive father) and it is likely that these elements represent a risk factor for the development of deviant psychopathological behaviors and high levels of vital poverty. The poverty of ideals, the low value of the paternal figure (violent father) represent forms of non-economic impoverishment. As we said in the previous paragraphs, vital poverty is related to the symbolic crisis of moral authority and the consequent absence of remorse and feelings of guilt.
Future research is needed to correlate living poverty and levels of psychopathy. Psychopathy is a socially devastating personality disorder defined by a constellation of affective, interpersonal, and behavioral characteristics, including egocentricity, manipulativeness, deceitfulness, lack of empathy, guilt or remorse, and a propensity to violate social and legal expectations and norms [22-24].
In the future, it will be necessary to study in an wider forensic sample the ability of the vital poverty level to predict psychopathy and deviant behavior.

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Original article

Aggressiveness in bipolar illness: from stigma to reality

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SUMMARY

Objectives

Many studies over the years have searched for an association between violence and psychiatric diagnoses, though not providing a unanimous and confirmative result. We have sought to extend and deepen the evidence on this topic, focusing on a specific diagnosis and its particular phases of illness and looking for correlation between psychiatric co-diagnoses and outpatients' visits adherence. Considering the clinical importance of violent acts and the social stigma related to them, we analysed different aspects of aggressivity: those undoubtedly violent acts and aspects like irritability or agitation that are frequently alarming and contribute to maintaining the social stigma towards psychiatric patients.

Methods

Over a 12-month period we recruited 151 consecutively admitted bipolar type I inpatients. We studied their presenting complaint, past medical and family history; we collected information about lifetime hetero- or self-aggressive behaviours, irritability, agitation, suicide attempts, alcohol, or substance abuse. Every patient was evaluated for personality disorders through SCID-5 for Personality Disorders (SCID-5-PD).

Results

The overall aggressivity in our sample resulted in 11.92% of cases, while the number of aggressive episodes during euthymia decreased to 2.64%, a level that is nearly close to that of the population without a lifetime psychiatric disorder. Personality disorders and alcohol abuse appeared to be the main risk factors for irritability (Fig. 1); substance abuse, above all cannabis and cocaine, for both irritability and hetero-aggressive behaviour (Fig. 2). We observed how subjects who displayed more compliance to psychiatric and psychological visits exhibited a significant lower aggressive behaviour than less adherent subjects. Our data disconfirms the common conception that links psychotic features to violence and shows how the great majority of patients displaying symptoms like irritability or agitation (often alarming as aggressiveness) do not display any violent action.

Conclusions

Studying aggressive behaviours in a population with a diagnosis of bipolar disorder we observed how the rare episodes of aggressiveness were mainly condensed in the active phases of the illness and mainly related to alcohol or substance abuse, while violent acts during long periods of wellbeing appear in line with those of the general population. We are confident our data might be helpful in deconstructing stigma that a psychiatric diagnosis equals violence, and that violence could somehow be justified by a disease.

Key words: bipolar disorder, aggressive behaviour, aggressivity, violence, stigma, mental illness, substance abuse, personality disorder

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Introduction

One of the most compelling hardships for health professionals is to help patients face a social milieu that still today strongly stigmatizes people

with mental health disorders. The trending topic of prejudice and discrimination is violence, as mainly perpetrated by mental illness subjects.
A US nationwide survey showed that as many as 75% of the public considered people with mental illness as violent [1]. This evidence appeared to increase over the years: in 2000 a report found that the number of Americans who viewed people with mental illness as violent and socially dangerous doubled with respect to the number of people who reported the same opinion back in 1950 [2]. How come so many people link mental illness to violent behavior?
There is no univocal answer. Amid all the factors contributing to stigma there is the media and how they report episodes of violent crimes. Not only in the news, but also in the entertainment industry, connecting mental disorders to violent behaviors and, vice versa, justifying violent behaviors because of a mental disorder**.** The general population finds it reassuring and easier to accept that violent crimes are committed by "different" or "sick" people. The institutional care system and lastly the scientific community are also in part of responsible: so far they have failed to provide the population with a unanimous and confirmative result about this topic. Not only are scientific studies often discordant and poorly detailed, but also seldom updated [3-6].
As a matter of fact, most psychiatric patients are not dangerous and only a minority of individuals affected by psychiatric conditions presents lifetime aggressive behavior. Conversely, they are likely to be victims of other people's violent acts [7-9]. From literature data it appears that the main psychiatric populations accountable for aggressive behaviors are schizophrenic and bipolar disorder subjects [10]. Going deeper in this topic, it seems that disease-specific aspects contribute to higher prevalence of violent behaviors among psychiatric patients than among the general population. One may question that the relative weight of comorbidity is actually relevant, where main co-occurring (and presumably precipitating) disorders are alcohol or other substance abuse, and personality disorders; other minorly impacting factors are learning disability and presenting with acute mania rather than mixed episodes, depressive episodes or other non-affective psychosis. For example, bipolar I and II disorder patients are reported to have committed aggressive behavior in 25.34 and 13.58% of cases, *versus* 0.66% in the general adult population. A previous report of aggressiveness in "pure" bipolar patients, with either a bipolar I or II diagnosis, was of 2.52 and 5.12%, respectively [11]. On the other hand, those patients with a diagnosis of alcohol abuse or substance abuse disorder behaved aggressively in 7.22 and 11.32% of cases, respectively [11]. In the same year Fazel et al. observed aggressive behavior (or its proxy, "trouble with the police or the law") in 12.2% of individuals with the diagnosis of bipolar disorder, 8.2% with alcohol abuse, 10.9% with drug abuse and 1.9% with no disorder [12]. Probably, due to the selection of patients and to the sample size, the data is not comparable. Considering the lack of univocal evidence further studies are desirable.

Aims

Bipolar disorder seems quite convenient to our goal, since it is one of the most likely to lead to violent behavior, most frequently related to psychiatric comorbidities (e.g., substance and alcohol abuse, personality disorders), and it is characterized by acute illness episodes and an inter-critic period of wellbeing.
We have set three goals in this article:

- considering the lack of univocal, recent and disease-specific data available in literature, we seek to extend and deepen evidence on this topic, focusing our attention on whether aggressive episodes occur during acute illness phases or also in euthymic periods;
- we focused on the relationship between violence and the presence of co-diagnoses as personality disorders, alcohol or substance abuse, and continuity to outpatients' visits;
- considering the clinical importance of violent acts committed by psychiatric patients and the social stigma related to them, we tried to innovatively analyze different shades of aggressivity: those undoubtedly violent acts like self- or hetero-aggressive behaviour and aspects, like irritability or agitation, that are not overt violence, but contribute to maintain the social stigma towards psychiatric patients.

Definitions

Aggression is an overt behavior intended to cause harm, pain or damage of various degrees. It can be subdivided in verbal aggression, aggression against objects, against self, and against others [14]. It is heterogeneous in its determinants and no standardized biological markers are available.
Violence describes aggression towards other people. Very often violence and aggression are interchanged, but violence preferentially refers to criminous context.
Agitation is characterized by excessive and disorganized motor or verbal activity.
Irritability is an unpleasant mood state independent of depression or anxiety; decades ago, descriptive psychopathology pointed out how this term had been introduced in clinical reports paired with aggressivity, or hostility without a specific definition [15].

Materials and methods

Participants

The present study was designed as a retrospective,

naturalistic study conducted over a 12-month period at the Mood Disorders Unit of San Raffaele Hospital in Milan. At the time it served an urban catchment area with a total population of 1,378.689 people.
The inclusion criteria for this project were > 17 years of age, fulfilling the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria for Bipolar Disorder type I (manic, mixed or depressive episode), completion of the assessment for personality disorders, using SCID-5 for Personality Disorders (SCID-5-PD). We excluded patients with a diagnosis of schizophrenia, other psychotic disorders or intellectual disability.
From 1st January to 31st December 2019, 151 consecutively admitted bipolar type I inpatients were recruited. During hospitalization the presenting complaint, past medical and family history were collected in detail by a psychiatrist through daily clinical interviews. Based on common clinical practice and available literature data that have reported impulsivity and aggressivity to be significantly higher in bipolar disorder patients with comorbid personality disorders [13], we usually perform SCID-5-PD to every bipolar inpatient. To ensure absence of any active depressive and manic symptoms at the time of the assessment of personality, the Montgomery-Asberg Depression Rating Scale (MADRS) and the Young Mania Rating Scale (YMRS) were used.
All patients were treated with adequate pharmacological, somatic and chronobiological approaches, according to clinical judgments. At discharge every patient had an appropriate mood stabilizer treatment and underwent regular follow-up visits.
We collected socio-demographic clinical characteristics and cumulative rates of lifetime acute mood episodes (depressive, mixed and manic). As binary variables, we assessed the presence or absence in lifetime of self-aggressive behaviours, suicide attempts and Alcohol Use Disorder. We created multiple categorical variables collecting lifetime data of hetero-aggressive behaviour (verbal aggression, aggression against objects and against others), irritability/impulsivity, agitation, Substance Use Disorders (cannabis, cocaine, others) and Personality Disorders.
The study, approved by the Ethical Committee of the Hospital, was conducted in accordance with the Declaration of Helsinki. A written informed consent was obtained from all participants.

SCID-5-PD

SCID-5-PD is a semi-structured clinical interview, performed by trained psychologists and used in research and clinical settings in order to evaluate the presence of one out of the 10 personality disorders described in DSM-5. As a novelty from the previous edition, SCID-5-PD allows us to make a categorical or a dimensional diagnosis of personality disorders [16].

Statistical analyses

To investigate overall group differences in clinical and socio-demographic variables, we performed a Student's t-test and chi-square for continuous and categorical variables, respectively.
To investigate the possible relationship between self- or hetero-aggressive behaviour, irritability, agitation, personality disorders and substance or alcohol abuse, we created contingency tables and performed Pearson's chi-squared or Fisher-Freeman-Halton test, where appropriate.

Results

Clinical and socio-demographic data are displayed in Table I.
The overall aggressivity in our sample resulted in 11.92% (18/151). Stratifying it for the subtype of aggressive behavior we obtained: 9.27% (14/151) for verbal aggressivity, 1.32% (2/151) for aggressivity against objects, 1.32% (2/151) for aggressivity against others.
The number of aggressive episodes during euthymia resulted in 2.64% (4/151). Then, stratifying it for the subtype of aggressive behavior, we examined if some correlations existed with known risk factors.
We obtained significant correlation by the Fisher-Freeman-Halton test, for alcohol and substance abuse, but not for personality disorders (PD) [Irritability: no alcohol 4.22% (6/142) *vs* alcohol 22.22% (2/9); verbal aggressivity: no alcohol 1.41% (2/142) *vs* alcohol 11.11% (1/9); aggressivity against objects: no alcohol 0.70% (1/142) vs alcohol 0% (0/9) (Fig. 1); X^2 9.918 p = 0.019. Irritability no substance 2.15% (3/139) *vs* substance 41.67% (5/12); verbal aggressivity no substance 0.72% (1/139) *vs* substance 16.67% (2/12); aggressivity against objects no substance 0% (0/139) *vs* substance 8.33% (1/12) (Fig. 2); X^2 63.151 p < 0.001. Irritability: no PD 3.50% (8/114) *vs* PD 10.81% (4/37); verbal aggressivity: no PD 1.75% (2/114) *vs* PD

TABLE I. *Clinical and demographic characteristics of the sample.*

CHARACTERISTICS	
Gender (F/M)	97/54
Age, years mean ± sd	56.36 ± 13.42
Lifetime episodes, mean ± sd	12.08 ± 9.916
Current episode duration, days mean ± sd	24.47 ± 10.42
Current depressive/manic/mixed episode	150/29/15
Psychotic features (Y/N)	11/140
Personality Disorder co-diagnosis (Y/N)	37/114
Alcohol Use Disorder co-diagnosis (Y/N)	9/142
Substance Use Disorder co-diagnosis (Y/N)	12/139

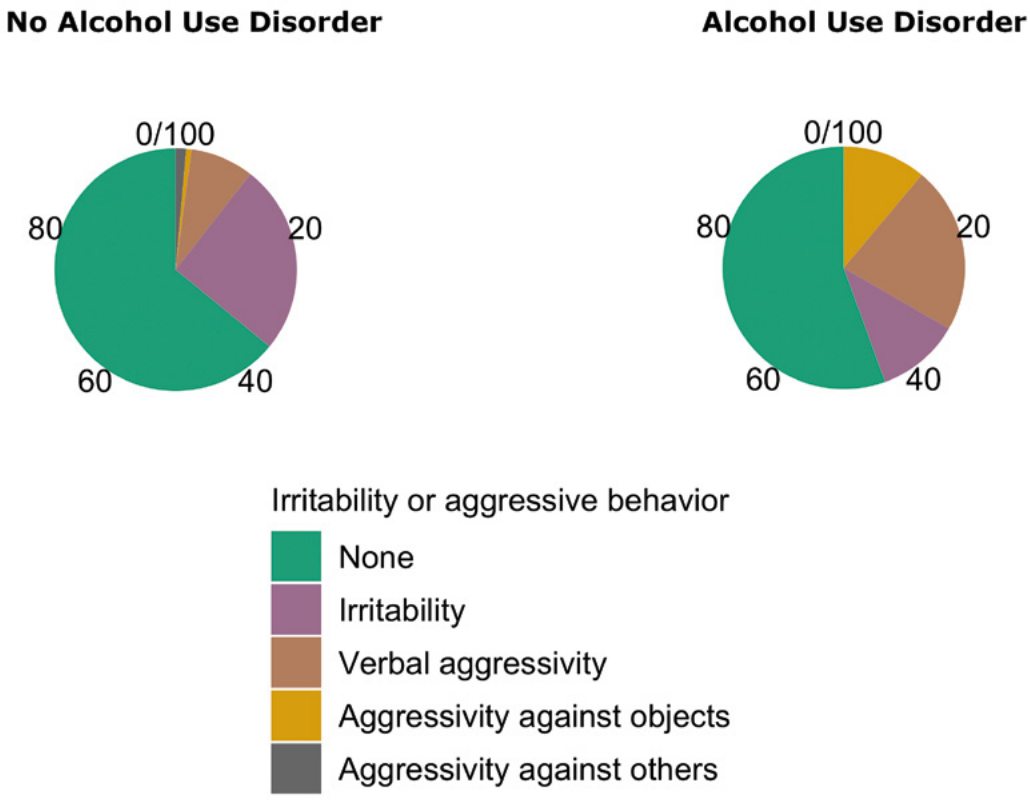

FIGURE 1. *Percentage of irritability and aggressive episodes in the bipolar I sample. Left graph: non-alcohol use disorder patients, right graph: alcohol use disorder comorbid patients.*

2.70% (1/37); aggressivity against objects: no PD 0% (0/114) *vs* PD 2.70% (1/37); X^2 6.838 p = 0.094].

Calculating the number of patients who displayed aggressivity during active phases of illness and stratifying it for the subtype of aggressive behavior, we obtained significant correlation by the Fisher-Freeman-Halton test for alcohol and substance abuse, but no significativeness was obtained by chi-square test for personality disorders (PD). [Verbal aggressivity: no substance 7.91% (11/139) *vs* cannabis 25% (2/8) *vs* cocaine 33.33% (1/3); aggressivity against objects: no substance 0% (0/139) *vs* cannabis 8% (0/8) *vs* cocaine 66.66% (2/3); aggressivity against others: no substance 1.44% (2/139) *vs* cannabis 0% (0/8) *vs* cocaine 0% (0/3); X^2 105.318 p < 0.001 (Figure 2). Verbal aggressivity: no alcohol 8.45% (12/142) *vs* alcohol 22.22% (2/9); aggressivity against objects: no alcohol 0.70% (1/142) *vs* alcohol 11.11% (1/9); aggressivity against others: alcohol 1.41% (2/142) *vs* alcohol 0% (0/9) X^2 9.277 p = 0.026 (Figure 1). Aggressivity: no PD 10.52% (12/114) *vs* PD 16.21% (6/37); X2 0.861 p = 0.353].

Searching for correlations between patients who displayed irritability and psychiatric co-diagnosis we obtained no significative results by chi-square test for personality disorders X^2 0.948 p = 0.330 and alcohol abuse X^2 0.266 p = 0.606; no significative results by Fisher-Freeman-Halton test for substance abuse: no substance 34.53% (48/139) *vs* cannabis 50% (4/8) *vs* cocaine 100% (3/3); X^2 6.66 p = 0.084.

We examined gender distribution of aggressiveness in our sample and found no statistical significance neither in the acute phase of illness (female 12.37% *vs* male 11.32%, X^2 0.036 p = 0.850) nor in inter-critic periods (female 1.03% *vs* male 5.66%, X^2 2.830 p = 0.093). Then, we calculated the relative percentage change of aggressivity from acute episode to inter-critic period: in the whole sample it was 77.78%, stratified by gender it was in females 91.67% and in males 50%.

The mean age in those who exhibited aggressive behavior was significantly younger than those who were not aggressive (47.39 ± 12.90 years old *vs* 57.68 ± 13.06 years old, p = 0.002).

There was no significant correlation between aggressive behaviour and mean duration of hospitalization (24.52 ± 10.62 days *vs* 23.94 ± 9.04 days, p = 0.821).

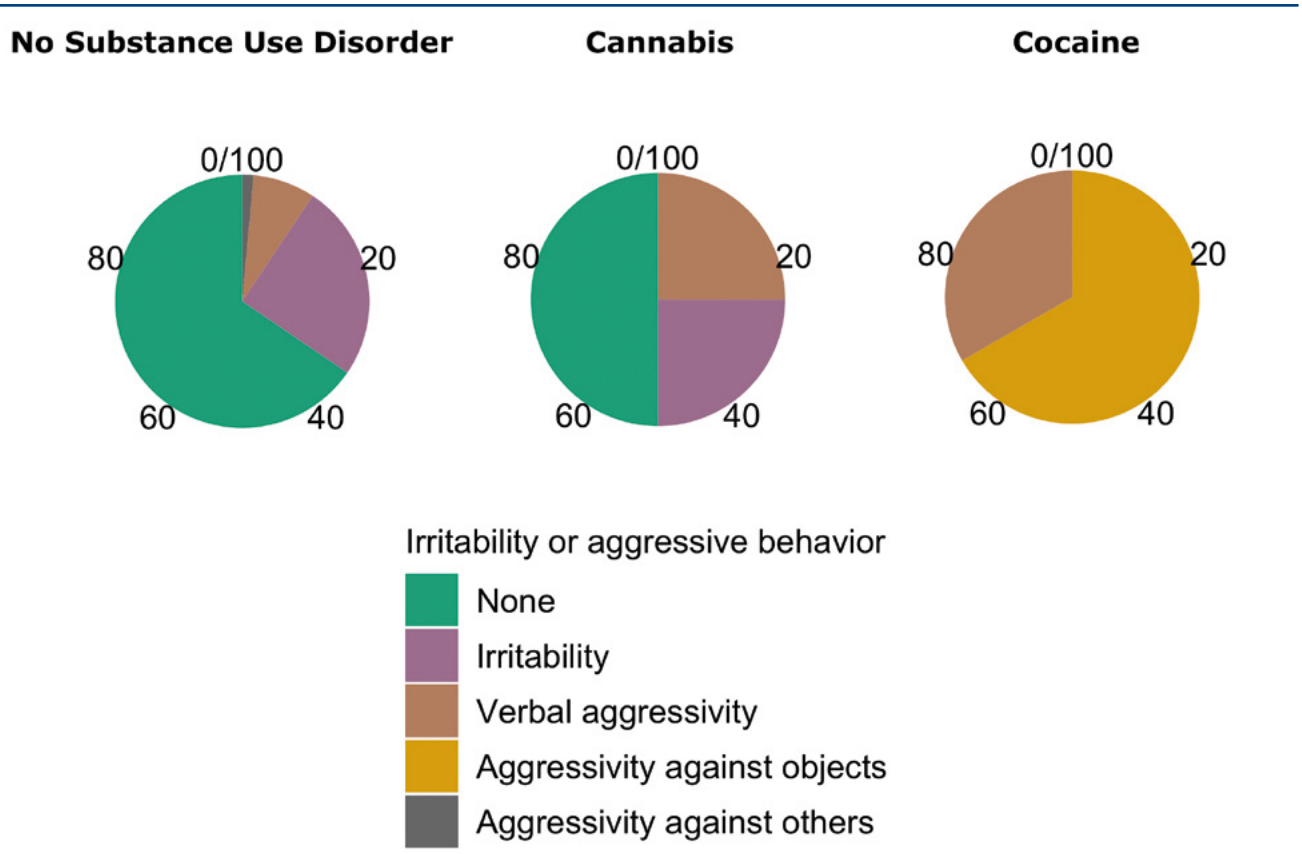

FIGURE 2. *Percentage of irritability and aggressive episodes in the bipolar I sample. Left graph: non-substance use disorder patients; middle graph: cannabis abuse; right graph: cocaine abuse.*

We found a statistically significant correlation by the Fisher-Freeman-Halton test between aggressive behaviour and outpatients visits adherence (VA): [Verbal aggressivity: no VA 13.33% (4/30) *vs* VA 8.40% (10/119); aggressivity against objects: no VA 0% (0/30) *vs* VA 1.68% (2/119); against others: no VA 6.67% (2/30) *vs* VA 0% (0/119), X^2 9.325 p = 0.025].

Studying patients who presented psychotic features at time of admission, it resulted that none of them had a lifetime history of violent behaviour.

Calculating the number of patients who displayed irritability (55/151), we found by chi-square test a statistically significant difference between those who showed also aggressivity or not (32.73 *vs* 67.27%, X^2 35.67 p < 0.001]. Finally, calculating the number of subjects who had psychomotor agitation episodes (31/151), we found by chi-square test a statistically significant difference between those who also showed aggressivity or not (35.48 *vs* 64.52%, X^2 20.628 p < 0.001).

Discussion

We opened this article with a question: are people with a diagnosis of bipolar disorder more dangerous to society than the rest of the population?

We analyzed data from a 12-month period of bipolar type I inpatients to explore the relationship between violence and the presence of a psychiatric diagnosis. In order to do that, we considered different characteristics of bipolar disorder and the most frequent comorbidities to identify *believable* risk factors of violence. Moreover, we decoded the general term of aggressiveness trying to deepen which behaviors are more tightly bound to social stigma.

Considering the overall aggressivity in our sample, our rate of 11.92% is lower than what has been described by the latest studies on the topic by Grant and by Corrigan, who wrote about 25.34% and 12.12%, respectively [11,12]. Stratifying it for the type of aggressive behavior, a new in the field and therefore missing corresponding references in other clinical populations, we obtained that our patients were verbally aggressive in 9.27% of cases, aggressive against objects in 1.32% of cases and finally 1.32% of them acted against others.

Conscious of the particular and natural clinical course of bipolar disorder, characterized by recurrent and com-

plete recovery, the first goal of our retrospective study was to examine if aggressive behaviours were timely concentrated or a kind of constant phenomenon throughout a patient's life. In order to do that we divided the occurrence of aggressive behaviour between acute phases versus inter-critic periods: we observed a drastic reduction of aggressive behavior during euthymia from 11.92 to 2.64%, respectively. Our data reaches levels nearly close to those of the general population: about 1-2% [11-12,22]. It must be highlighted that our percentage comprehensively refers to all types of aggressiveness (where our sample showed only verbal aggressions or against objects, without violent episodes against people). The available literature data always considers violence towards people, but only rarely does it consider other types of violence.

It was noteworthy to observe that aggressive behavior during euthymia was almost always correlated to the presence of a co-diagnosis. Some of the well-known risk factors from literature are personality disorders, alcohol and substance abuse [27]; in our sample PD and alcohol appeared to be the main risk factors for irritability ($p = 0.094$ and $p = 0.019$, respectively) and substance abuse for both irritability and hetero-aggressive behaviour ($p < 0.001$). This finding is concordant with previous reports [17-20]. Another recognized risk factor for aggressivity is male gender [21]: however, in our research, it was moderately associated with aggressiveness during euthymia (female 1.03 *vs* male 5.66%, $p = 0.093$) rather than intra-episode, as we obtained no gender differences in acute episode violence actions (female 12.37 *vs* male 11.32%, $p = 0.850$). We then calculated the differential rates in aggressive behavior from acute episodes to intercritical periods, finding a decrease for both genders alone (females 91.67, 50%) and for the whole sample (77.78%). This finding concords with previous population-based investigations reporting an increased relative risk of committing violent crimes for bipolar women compared to female controls [25,26].

Regarding age, our sample showed a mean age of 56.36 ± 13.42 years at admission: patients who did not show any aggressiveness were 57.58 ± 13.07 years old, while those who carried out some kind of aggressiveness were significantly younger (47.39 ± 12.09 years old, $p = 0.002$), in accordance with previous literature data [10,23-24]. Focusing on aggressivity during active phases of the illness to examine and manage any possible risk or predictive factor, we stratified our sample for personality disorders, alcohol or substances abuse. The results suggest that patients with a co-diagnosis of alcohol abuse show a significant increase in aggressivity compared to non-alcoholic patients ($p = 0.026$) (Fig. 1). Notably, all reported episodes concerned verbal aggressivity, doubling those who have no alcohol abuse. Regarding substance abuse, above all cannabis and cocaine, we observed an increased irritability from 34.53% in non-abusers up to 50% in the cannabis abuser sample and 100% in cocaine abuser sample ($p = 0.084$) (Fig. 2). With regards to hetero-aggressive behavior, we found increased verbal aggressivity 7.9% in non-abusers to 25% in cannabis abusers and 33.33% in cocaine abusers, with a strong statistical significance ($p < 0.001$); aggressivity against objects from 0% in non-abusers and cannabis abusers, reaching 66.66% of cocaine abusers (Fig. 2), in accordance with previous literature which highlights substance abuse as a major risk factor for impulsivity, aggressivity and violent crimes [17-19,27]. Despite the fact that subjects with a co-diagnosis of personality disorders seem to act violently more frequently in raw data, our analysis shows no statistical significance, neither for hetero- nor self-aggressivity in the subsample. We may argue that the relatively small sample size and relative count of personality disorder bipolar patients are accountable for this outcome.

A finding of our study that has a practical consequence regarding the clinical management of our bipolar patients is that subjects who display more compliance and regularity to psychiatric and psychological visits exhibited a significant lower aggressive behavior (verbally, against objects or people) than less adherent subjects (χ^2 9.325 $p = 0.025$). It is still to be explored if continuative adherence to visits could constitute a protective factor from acts of violence or vice versa, those who have more aggressive behaviour have higher drop-out rates.

Last but not least, we addressed the stigma associated with violence in psychiatric patients. The ordinary image about psychiatric patients and violence stigma relies on psychotic features, as they are perceived as equivalent to worse aggressivity. We explored this issue in our sample: our data disconfirms the common conception. We observed no aggressive events in our psychotic-feature presenting patients. We suppose that psychotic-feature presenting patients are more likely to be "pure bipolar" and present less alcohol and substance abuse and less personality disorders lowering their intrinsic risk of displaying aggressive behavior. We presume that lack of statistical significance is due to relatively low counts of psychotic-feature presenting patients in our sample.

Stigma becomes evident in everyday life when people are used to consider as crimes, not only real violent acts, but also many other symptoms of psychiatric illness like psychomotor agitation, restlessness and irritability, as intrinsically equivalent to overt aggressivity. To investigate these typical symptoms that are so often alarming as aggressive behaviour, we innovatively considered the common idea of violence as a spectrum, subdividing it into different shades: those undoubtedly violent acts like self- or hetero-aggressive behaviour and aspects, like irritability or agitation, that are not overt violence, but con-

tribute to maintain the social stigma towards psychiatric patients. In our analysis, it is true that the greatest part of aggressive patients was also agitated and irritable, but over 60% of agitated patients (X^2 20.628 $p < 0.001$) and nearly 70% of irritable ones (X^2 35.670 $p < 0.001$) did not display any violent action. Not only are they not aggressive toward objects or people, but we also did not find any evidence of verbal aggressivity.

Conclusions

Studying aggressive behaviours in a population with a diagnosis of bipolar disorder, we observed that the rare episodes of aggressiveness were mainly condensed in the active phases of the illness and mainly related to alcohol or substance abuse; the percentages of violent acts during long periods of wellbeing appear in line with those of the general population.

Notable was the finding that typical symptoms of manic phases, frequently alarming as violent acts, just in a great minority of cases evolve in overt violence: on the bright side, the majority of our patients, who might be agitated or irritable, were never aggressive.

We are confident our data might be helpful in deconstructing stigma that psychiatric diagnosis equals violence, and that violence could somehow be justified by a disease.

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