THE CLOSING OF THE ITALIAN FORENSIC HOSPITALS: SIX MONTHS LATER. WHAT WE HAVE LEARNED AND WHAT WE NEED

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In April 2015, after a long period of silence and hard work, law 81 (31 May 2014) ordering the closing of Italian Forensic Hospitals finally took effect. This law was made possible by the jointed effort not only of politicians, but also of the Italian Society of Psychiatry (Società Italiana di Psichiatria, SIP). It can be considered as a relatively unusual event in Italy that is, however, in line with other movements and psychiatric organisations that have endeavoured to combine two seemingly antithetical types of structures. On one hand, this guarantees the rights of each individual, independently of one's judicial status, to take full advantage of health services provided by the community. On the other, it guarantees the rights of a larger society to be protected from any criminal action, regardless of whether this is wholly or partly attributable to the altered mental state of the offender.
Six months after its introduction, we believe that it is possible to make an initial assessment on how well the law is working and on some additional needs that have arisen. For the first point, both good and bad aspects can be highlighted. One of the few good aspects is that concerns and alarmism about Forensic Hospitals discharging psychiatric offenders were decidedly unwarranted: the number of beds initially planned for Residential Services for the Execution of Security Measures (RSESM) have been demonstrated to be grossly excessive considering current needs. In the case that Departments of Mental Health (DMH) have the minimum requisites needed, in various regions in Italy, which have only partially adopted the new law, the entry points of patients into the DMH from a Forensic Hospital have proven to be generally achievable without substantial risks or changes to clinical routines of the DMH. From this initial experience, it can be concluded that the transfer of Forensic Hospital patients to community psychiatric services has been a positive experience overall. Thus, the law is not good only on paper, but it's also good and feasible in routine practice, given the availability of the necessary facilities.
There are, however, some pitfalls. The first is that the services available for patients discharged from a Forensic Hospital vary greatly: while various regions have more or less addressed the structural problem stipulated by law 81, other entities have continued as if nothing had changed. This patchy distribution of qualitative services and quantitative specialist interventions is unacceptable and can be considered discriminatory. Such a deadlock cannot be overcome by simple invitations and recom-

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mendations that have no real message: it will take a strong government stance that results in legal sanctions in the case of on-going inadequacies.
A second shortcoming, related to the first, is that too many regions, and consequently too many DMH, continue to focus debate on the RSESM, as if these structures were the key problem for overcoming Forensic Hospitals. This constitutes a slightly revised and somewhat incorrect version of the facts, and in reality the situation is much different. Moreover, as already mentioned, even if used correctly the valuable option of RSESM can only fulfil the needs of a minority of patients who are discharged from Forensic Hospitals. A third limitation is the fact that in spite of the repeated promises and assurances of Law 81, the majority of DMH have still not utilised the additional funding they were provided. During the closure phase of Forensic Hospitals, many DMH have been operating on much the same resources. However, as everyone knows, it is very hard to operate efficiently on a shoestring budget.
As for additional needs that have emerged, it must first of all be stressed that a small but not insignificant proportion of magistrates have continued to consider Acute Inpatient Psychiatric Services (AIPS) as a sort of surrogate for Forensic Hospitals. Paradoxically, there are judicial orders for psychiatric admission to AIPS for offenders awaiting psychiatric evaluation or for those whose medical conditions do not require psychiatric hospitalisation. In these situations, there is a clear conflict of interest between the magistrate who is ordering admission and the psychiatrist who, as a result of the magistrate's order, must carry out a task that is clearly custodian in nature. In addition, as a hospital bed is forcibly and improperly "occupied", admission of patients who have full rights during a phase of strong psychopathological decompensation must be deferred. Therefore, the formalisation of continuous and close dialogue between magistrates and psychiatrists, with a view to develop shared guidelines to address these issues and the diversity institutional roles, can no longer be postponed. The development of guidelines that are shared between magistrates and psychiatrists is also necessary to define the most appropriate placement of people who, whether or not previously discharged from a Forensic Hospital, commit new crimes because of their altered mental state. The choice to use former Forensic Hospitals, at least as long as they remain active in some way and provide psychiatric care in prisons or in structures related to the DMH, is not trivial and requires complex and careful planning that can substantially slow down the process of their final closure. The experience gained in the months immediately following the implementation of Law 81 has also clearly shown that some other issues initially placed at the periphery of the closure process of Forensic Hospitals are in reality central to the success of the operation. These include the overall organisation of psychiatric care in prison, redefinition of the concept of social danger and adequate review of psychiatric reports.
Considering organisation of care in prison a first premise seems necessary: even today, in many cases, psychiatric care in prison is implemented according to a dominant logic of psychiatrization of prison. In fact, psychiatrists working in correction facilities are often involved in tasks, such as mere psychological support, that are not theirs. They must work in a context that is unavoidably governed by rules that are frequently incompatible with those of standard psychiatric practice. These include things such as reduced safety standards, insufficient flexibility of guaranteed levels of monitoring, provision of most care by unqualified professional operators, lack of routinely available treatment options and reduced involvement of addiction services, despite the abnormally high rates of substance-related disorders among inmates. To overcome these problems, thorough screening of de novo psychiatric pathologies is needed to separate genuine cases from 'non-cases' represented by offenders who use psychiatry as a shortcut to obtain secondary benefits. Unfortunately, this is not the only priority for intervention. It is equally necessary to plan a complex set of other interventions that include, among other things, transfer of diagnostic and therapeutic guidelines used in DMH to prison life. In addition, interventions dedicated to specific themes such as psychomotor agitation and aggression directed towards oneself and/or others, stronger monitoring of adherence to therapy, the more systematic use of long-acting injectable drugs, inclusion of courses on psychiatric rehabilitation, a multidisciplinary approach to double diagnoses, ad hoc training of prison staff and adaptation of prison spaces to structural and safety standards typical of psychiatric care must be addressed.
In turn, redefining the concept of social danger is a prerequisite for the application of the law to overcome Forensic Hospitals. In fact, the attribution of a 'socially dangerous' label is sufficient to identify individuals intended for RSESM or, more in general, patients who require higher levels of surveillance. At the same time, however, it also appears increasingly clear that the current construct underlying the defi-

nition of social dangerousness is moving decisively towards strong and unfairly defensive psychiatry. Albeit with plenty of due caution, social dangerousness must be redefined by emphasising two key points. The first is that allocation of social danger for psychiatric reasons is not based on certainties, but rather on probabilistic forecasts that are often broad in nature and fairly transient as they are based on many external variables that cannot be fully controlled. The second is that the boundary between social danger inherent to a mental disorder and that associated with a "free choice delinquent" is often very thin, as indicated, for example, by the frequency with which the label of antisocial personality disorder is applied in the context of prison care.

These considerations introduce a third hot topic that requires urgent intervention: remodelling of psychiatric consultation. With adequate preparation and the right advice it is possible to fraudulently direct psychiatric consultation to one's own advantage. This affirmation becomes even more true as consultation moves away from the golden rule of a constant reference, almost spasmodic, to the medical history of the subject. Unfortunately, even today many technical consultants do not rely exclusively on clinical logic, and as a consequence draw conclusions that are highly inferential and not supported by evidence. The risk of inferential conclusions is even more remarkable given that much of the textbook guidance in routine use is obsolete, unconnected with the tools routinely used in clinical practice, and therefore unable to sufficiently support probative expert conclusions. Despite these obvious limitations, many judges rely too much on psychiatric consultations, giving them much more weight than they actually deserve. In addition, it is increasingly clear that some concepts typical of technical consultations, such as temporary mental disorder, as often cited by media sources, are events that are quite rare and therefore not applicable to the vast majority of cases.

For all these considerations, involvement between judges, lawyers, forensic doctors and psychiatrists seems to be, once again, the instrument of choice to ensure expert opinion that is genuinely respectful of clinical reality. This would be an achievement of substantial ethical value as it would finally allow a transition from justice that is sometimes based on medico-legal squabbles towards justice that is more fair. However, considering reform of psychiatric care in prison, the concept of social danger and specialised technical expertise are not just the structural core elements to ensure adequate closure of Forensic Hospitals, they are also the starting points for a broader process of revising the primary regulations governing clinical and medico-legal governance that can be applied to all offenders suffering from a specific mental disorder. The awareness that we have many irons in the fire should call for the opening of an exhaustive debate. *Evidence-based Psychiatric Care* will strongly encourage that this takes place.