The closing of forensic psychiatric hospitals in Italy: determinants, current status and future perspectives. A scoping review.

Claudio Di Lorito[1], Luca Castelletti[2], Ilaria Lega[3], Barbara Gualco[4], Franco Scarpa[5] and Birgit Völlm[1]

[1] Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham, Nottingham NG7 2TU, United Kingdom.

[2] REMS Nogara (VR), Aulss 9, Veneto Region, 37054, Italy.

[3] Italian National Institute of Health, Viale Regina Elena 299 – 00161, Rome, Italy.

[4] Department of Health Sciences, University of Firenze, Largo Brambilla 3, 50134 Firenze, Italy.

[5] Local Health Unit Centre of Toscana, Viale della Piazzuola 56, 50133 Firenze, Italy

Corresponding author: Claudio Di Lorito, Room A10, Institute of Mental Health, Innovation Park, University of Nottingham, Triumph Road, Nottingham NG7 2TU, United Kingdom. Email: claudio.dilorito@nottingham.ac.uk. Phone: (+44) 7453717277

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Abstract

Introduction. Italy is the only country in the world to have closed forensic psychiatric hospitals and converted to fully-residential services. The international interest around this reform has not been matched by research. This scoping review aims to report the determinants of the reform, the most updated information on how the system operates, its benefits and its challenges. We further aim to discuss the implications for policy, research and practice.

Methods. 1. Selection of relevant sources through electronic search on four databases, Google, relevant printed materials and personal communication with practitioners currently working in REMS. 2. Study quality monitoring. 3. Data extraction onto NVivo 4. Data synthesis through content analysis.

Results. 43 papers were selected for inclusion in our review. Two main themes were identified: 1. Historical chronology of the closure of forensic psychiatric hospitals; 2. The current model of residential forensic psychiatric care.

Conclusions. The closing down of Italian forensic psychiatric hospitals represented a fundamental step for human rights. Further work is required to improve the current service, including potential reforming of the penal code, improved referral/admission processes and consistent monitoring to reduce service inequality across regions. Further research is crucial to test the effectiveness of the Italian model of care against traditional ones.

1. Introduction

The total closure of forensic psychiatric hospitals (OPG) in Italy and the conversion to a residential model of care based on secure residential units in the community (Residenze per l'Esecuzione delle Misure di Sicurezza - REMS) was a long and tortuous journey. The origins of the reform can be traced back to the early 1970s (Margara, 2011), but the process of conversion was only brought to full completion in January 2017, with the closure of the last OPG, lasting more than 40 years.

This revolutionary reform was inspired by the protest movement of the late 1960s and laid out by the representatives of the anti-asylum movement led by psychiatrist Franco Basaglia, who received the initial support of those sectors of Italian society which were more sensitive to human rights considerations, such as university law professors. However, the reform would have seen no light without the shared vision and commitment to change of political leaders and common citizens (Crepet & De Plato, 1983).

The conversion to REMS has made Italy the first and only country in the world to have followed through the principles of the de-institutionalisation movement to such extent as to abandon a hospital-based model of forensic psychiatric care in favour of residential units, which only employ clinical personnel (Carabellese & Felthous, 2016).

However, given that the process has just very recently been completed, we were unable to retrieve any literature review synthesising the existing evidence around the reform and reporting the most up-to-date information on the status of the Italian forensic psychiatric system.

Given the interest that this reform has gained at the national and international level, and the relevance that it may have to inform and promote debate, policy and practice, within and well beyond Italian borders, we deemed it timely to bridge this gap in research.

This scoping review therefore aims to:

(i) Illustrate through a historical chronology, the socio-cultural, political and legislative determinants of the total closure of forensic psychiatric hospitals in Italy and the conversion to REMS;

(ii) Describe how REMS currently operate and highlight some of the benefits and challenges that the system is experiencing at this initial stage of implementation.

We also discuss ideas on further reform of the system and the implications for policy and practice at the national and international level.

2. Methods

2.1. Search strategy

Our search strategy was based on the PICO (Patient, Intervention, Comparison, Outcome) framework, which is widely used to define search strategies for literature reviews (Sackett, Richardson, Rosenburg & Haynes, 1997).

We carried out literature searches on four electronic databases from different disciplines relevant to our review: Embase (for medicine and psychiatry), Psycinfo (for psychology and mental health), the International Bibliography of Social Sciences (for social sciences) and Web of Science (inter-disciplinary).

Given our aim to report on the current status of REMS, we ran two consecutive searches, in September 2016 and again in February 2017, to ensure we captured the most up-to-date information. The references of all relevant sources we retrieved through the searches were hand-screened to identify further literature for our review.

The search strategy consisted in combining terms from the following two domains:

- The "country" domain, with terms such as 'Italy' and 'Italian'.
- The "institution" domain, with terms such as 'Forensic', 'psychiatr*', 'REMS', 'OPG', 'Ospedali Psichatrici Giudiziari', 'Residenze per l'Esecuzione delle Misure di Sicurezza', 'psychiatric hospital*', 'asylum*', 'Mental health service*', 'Mental Hospital*', 'Community mental health', 'institution*', 'de-institutionalisation'.

Word truncation, marked by the asterisk (*), allowed to search for any variations in the suffix of terms, thus maximising sources retrieval. The search strategy was kept as consistent as possible across different databases, although minor variations were made to respond to the different characteristics of databases.

Owing to the inevitable delays caused by the peer-review process in the publication process, the sources we retrieved through the databases did not necessarily report the most up-to-date information about the reform. Therefore, in addition to the database searches, we ran a Google search to retrieve updated information, by inspecting the first 100 hits. This strategy ensured we also captured grey literature, relevant policy documents from governmental

bodies (e.g. the latest half-yearly report by the special commissioner for the closing down of OPG), as well as sources from charity/third sector/lobbying organisations such as StopOPG, which played a crucial role in the reforming process.

In addition, to gather enriched historical data and supplement data from the electronic sources, we consulted the library catalogue of the University of Nottingham and hand searched relevant documents and textbooks.

Finally, we engaged in email communication with Italian practitioners currently working in the system of REMS, which enabled us to capture detailed data, such as the percentage of patients who benefit from temporary leaves, which would have been otherwise missed.

2.2. Study selection and appraisal

The sources retrieved through the electronic and Google searches were screened by the first author (CDL), who dismissed those not relevant to the scope of the review. The remaining sources were checked for eligibility against the inclusion criteria by two authors (CDL and LC).

Inclusion criteria:

- Study is on Italian forensic psychiatry;
- It addresses one (or more) of the following:

    - Historical, legal, cultural, political and/or social determinants of the total closure of forensic psychiatric hospitals in Italy.
    - How REMS operate.
    - The benefits of REMS.
    - The innovations of REMS.
    - The challenges following the reform.
    - The debate on how to further reform the service.
    - The implications of the reform.

- No restrictions on language and date of publication were applied.

In relation to study appraisal, the first author (CDL) carried out quality screening using the Critical Appraisal Skills Programme (CASP) checklist for qualitative research. The tool provides prompts for the systematic assessment of key areas impacting on the quality of the

source such as: Clear statement of the aims of the research, appropriateness of methodology, appropriateness of research design, rigorousness of data analysis, clarity in the reporting of findings, and value of the research in contributing to knowledge.

Although we did not exclude any article on the grounds of quality, given the relevance of all sources retrieved, this assessment further ensured the suitability of the sources for our review.

2.3. Data extraction and analysis

We carried out a directed content analysis of data, which is a suitable methodology when preliminary evidence about a phenomenon exists, but it requires further research (Hsieh & Shannon, 2005). As per the principle of the directed approach to content analysis (Potter & Levine-Donnerstein, 1999), we derived content themes directly from our two research questions.

We extracted relevant data from the sources, imported them onto NVivo, Version 11 (QSR International Pty Ltd., 2012) and coded them into the relevant theme. During the coding process, given the generous amount of data, we also generated sub-themes, in order to organise our findings in an orderly fashion. The information collected for each theme and sub-theme was then synthesised for optimisation of data reporting. Finally, we gave themes and subthemes titles which best described their content.

3. Results

The database searches yielded 1,655 results. Ten additional sources were retrieved through the Google search. Of the 1,665 records, 1,597 were excluded upon title and abstract screening, as they were clearly ineligible for review. The remaining 68 were checked against the inclusion criteria. A final number of 43 sources were selected for inclusion in our review. The selection process is fully illustrated in Figure 1 through a PRISMA 2009 Flow Diagram (Moher et al., 2009).

The articles were published in different countries, including the United Kingdom, the United States of America, Germany, Argentina, Denmark and Italy. This shows the interest that the Italian reform has generated also at the international level. Of all the studies we retrieved, none was empirical, reflecting the paucity of scientific evidence-base in this area. Our searches also evidenced the lack of any review synthesising the existing literature, confirming the timeliness of our work.

In terms of publication year, eight of our sources (one in five) were published within the last 12 months (2016/2017), and 19 after 2010, demonstrating that our review reports the most up-to-date information about the status of REMS.

Based on our research questions, we identified two main themes:

- Historical chronology of the closure of forensic psychiatric hospitals
- The current model of residential forensic psychiatric care

3.1. Historical chronology of the closure of forensic psychiatric hospitals

This theme outlines the historical, legal, political, cultural and social processes that led to the forensic psychiatric reform and which trace their origin in the mid-1850s. Looking retrospectively was deemed a crucial exercise to give context to the reform, to understand its origin and to better appreciate the current challenges and benefits.

3.1.1. Biological positivism and the Italian school of anthropological criminology

Modern Italian psychiatry evolved from the positivistic theories of the 19th century, based on Biological Darwinism, which attempted to transfer scientific rigour to human behaviour (Gibson, 2002).

Human behaviour that deviated from societal norms was interpreted through the lenses of degeneration theory, which supported the idea that abnormal behaviour was caused by the inheritance of genetic traits acquired by the parents during their lifetime and passed on to the offspring (Dowbiggin, 1985). A classic example illustrating social degeneration theory is offered by Benedict Morel, a renown psychiatrist in the Rouen Asylum, in his work "Treatise on degeneration of the human species" (1857).

Morel observed that exposure to stimulants and pollutants in the first generation would cause epilepsy and hysteria in the second generation and mental illness in the third. Positivist theorists further argued that criminal behaviour also was caused by the genetic make-up of the individual, rather than mediated by free will (Gibson, 2014). Positivists found themselves in open disagreement with the enlightenment theories of classical social philosophy inspired by the writings of Cesare Beccaria, who emphasised the rein of free will on human behaviour (Beccaria, 2003; Gibson, 2014).

Positivism was also highly influenced by the studies of physiognomy (the assessment of a person based on outer appearance) (Lavater, 1775) and phrenology (the assessment of a

person based on measuring the skull) (Gall, 1798), which contended that inclination to criminal behaviour could be systematically determined by measuring the biologically innate traits of the person (Gibson, 2014). It followed that offenders could be easily identified from law-abiding citizens through these physical assessments (Gibson, 2014).

Positivistic tenets found fertile ground among numerous psychiatrists of late 19th century Italy, who gathered around the figure of physicist Cesare Lombroso, widely acknowledged as the father of anthropological criminology, the science of crime based on the study of humans (Gibson, 2014). Given his prestige and power in the medical and political world of early-days unified Italy, Lombroso's theories exerted great influence on the long-term discourse around forensic psychiatric care, which to some extent is still noticeable today (Babini, 2014).

In the second edition of the "The criminal man" (1878), his most influential work, Lombroso argued along the lines of degeneration theory that criminals presented biological and genetic (i.e. inherited) traits typical of an earlier evolution stage of the human species, which rendered them born-savages or atavistic beings, with incontrollable impulses toward crime (Villa, 1985).

Among Lombroso's disciples was the criminologist Enrico Ferri, who bridged the gap between anthropological theories and forensic practice by outlining the role that the state should play in relation to born-criminals (Frigessi, 1985). Ferri acknowledged the impossibility to treat and rehabilitate these individuals, given their congenital inclination to offend, and advocated for the creation of asylums, which would fulfil a mission of social defence, by secluding offenders from society (Walsh, 2015).

3.1.2. The Zanardelli code and the birth of asylums

In 1889, the Parliament passed the first Italian penal code, named after the then Minister of Justice, Giuseppe Zanardelli. At this time, Italian forensic psychiatry was split in two separate schools, the justice system, relating to Beccaria's classic stance of social philosophies, and the medical world, influenced by Lombroso's anthropological criminology (Gibson, 2014). Given the power of jurists in policy development, the Zanardelli code mostly abode by the principles of the classical school (Gibson, 2014).

Based on the mission of social defence, Italian psychiatrists started a pressing campaign for the development of asylums (Lombroso, 1872). These would represent a fair compromise between prisons, which would otherwise perpetrate unjust inhumane punishment against individuals who had committed crime out of will, and the need to isolate dangerous

individuals from the public (Paolella, 2011; Martucci & Corsa, 2006). The new institutions would be inspired by the English model of Broadmoor Hospital (Bongiorno, 2013; Tamburini, 1873).

Broadmoor Hospital was the first secure institution built by the British government in response to the overcrowding and poor quality of care caused by the lack of adequate psychiatric provision at the national level (Allderidge, 1974). The hospital, which was fully operative by 1864 and had a capacity of 500 beds, offered a highly-specialised service to address the complex needs of forensic psychiatric patients, while ensuring the execution of security measures (Allderidge, 1974). In fact, such was the quality of care offered in the institution, that a patient named James Kelly, who had absconded Broadmoor in 1888, requested to be taken back in 39 years later (Allderidge, 1974). The reputation of the hospital crossed national borders; in Italy, the new asylum system was measured up against the gold standard set by Broadmoor (Tamburini, 1873).

The first Italian asylum for the mentally insane was opened in 1876 in Aversa near Naples, followed by institutions in Montelupo Fiorentino (1886) and in Reggio Emilia (1897) (Gibson, 2014). Despite the mission of treatment envisioned for these institutions, statistics from the Ministry of Interior (ISTAT, 1884-1914) evidenced that asylums soon became quasi-militarised environments, mostly managed by security rather than clinical staff. The main criterion for admission, as per the Mental Health Law (Law 36/1904), was dangerousness to society, further proving how the genuine mission of asylums was containment rather than treatment (Paolella, 2011; Stocco, Dario, Piazzi, & Fiori Nastro, 2009).

3.1.3. Fascism and the Rocco Penal Code

Following the death of Lombroso (1909), the debate between the classic and positivist schools subsided (Gibson, 2014). However, with the advent of Fascism in 1922, positivistic ideas made a comeback, as they became instrumental in fighting the “socially dangerous”, which in most instances were “personae non gratae” to the fascist regime, rather than severe psychiatric cases (Gibson, 2014; Babini, 2014). In 1930, the parliament passed a new penal code, named after the then Minister of Justice Alfredo Rocco (Law 1398/1930), which for the first time included elements inspired by positivistic ideas (Stocco, Dario, Piazzi, & Fiori Nastro, 2009). The code has substantially remained unaltered throughout the 20th Century and is currently still in use (Scarpa, Castelletti, & Lega, 2017).

For the first time, the Rocco code introduced "security measures", which allowed the precautionary incarceration for a maximum of ten years of individuals who the Court deemed dangerous to social order, even if they had not committed a crime (Law 1398/1930). In order to respond to the increasing demand of internment caused by the tighter security grip on the population, the fascist regime opened three new asylums throughout the peninsula, in Naples - Campania (1925), Barcellona Pozzo di Grotto – Sicily (1925) and Castiglione delle Stiviere - Lombardy (1939), including the first institution for women (Schettini, 2004).

The Rocco Code also attempted to reconcile the split between classical and positivistic stances by conceiving the so-called 'dual track' (doppio binario), according to which offenders who were deemed capable of free will would access the penalty track (i.e. trial, sentencing and imprisonment), while those who were mentally incapacitated and/or socially dangerous would be admitted to psychiatric settings (i.e. asylums) (Pelissero, 2008).

3.1.4. Republican years and the de-institutionalisation movement

After the fall of fascism and the proclamation of the Republic in 1946, Italian forensic psychiatric law and practice remained mostly unaltered throughout the 1950s and 1960s (Babini, 2014). The administration of asylums, called Ospedali Psichiatrici Giudiziari (forensic psychiatric hospitals) (OPG) from 1975 onward, was retained by the Ministry of Justice, which maintained the traditional emphasis on containment over recovery (De Vito, 2014). The sole exception was represented by the OPG in Castiglione delle Stiviere (Mantua, Lombardy), which from the 1980s on employed health care staff and distinguished itself from the other OPG by its higher standards of quality (Calogero, Rivellini, & Stratico', 2012; Andreoli, 2002).

The process that eventually led to the closure of OPG was fuelled in the early 1960s by international sociological ethnographic research in psychiatric institutions, such as the 1961 "Asylums: Essays on the Condition of the Social Situation of Mental Patients and Other Inmates" by Erving Goffman (1961). This type of research, which inspired the development of the anti-psychiatry movement (Davidson, Rakfeldt, & Strauss, 2010), proposed the social-constructionist concept of psychiatric hospitals as "total institutions", systems in which its agents, staff and patients, are forced into predefined roles of "guards" and "captors" by rigid social and cultural conventions and practices, which aim to perpetrate the status quo (Goffman, 1961). Such system leaves no room for manoeuvre to patients, who remain deeply institutionalised (Weinstein, 1982).

The concept of institutionalisation was reflected even in the sinister architectural features of psychiatric institutions, as conveyed with very effective imagery by the British Health Minister Enoch Powell in his famous "Water Tower" speech of 1961:

"There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside—the asylums which our forefathers built with such immense solidity to express the notions of their day"

The anti-asylum movement, which developed during the 1960s based on the ideas of American Psychiatrist Thomas Szasz (1960), as well as by those of Husserl and other phenomenologists, and which was framed in the protest movement of the late 1960s, denounced the inhumane treatment, the poor hygienic conditions and the lack of any therapeutic programme in the asylums (Basaglia, 1968; Basaglia & Tranchina, 1979; Bruzzone, 1979; Parrini, 1978; Venturini, 1979).

In Italy, at the beginning of the 1970s the anti-asylum movement, gathered around the leading figure of psychiatrist Franco Basaglia, acquired centrality in the debate around reform of the psychiatric sector (Foot, 2014). Having been imprisoned in 1944 in Venice as opponent to fascism, Basaglia developed strong feelings against any form of seclusion, discrimination and abuse.

Through its organisation Psichatria Democratica (Democratic Psychiatry), the movement campaigned to de-legitimatise psychiatric institutions among mental health professionals and the public (De Vito, 2014). Its successes culminated in 1978 with the promulgation of the Psychiatric and Health Act, best known as Basaglia Law (Law 180/1978), which included directives for the prospective closure of mental hospitals nationwide. These would be replaced by community mental health services (Ferrannini et al., 2014; Barbui & Tansella, 2008). In addition, Law 180 removed "social dangerousness" as criterion for referral to Italian mental health services for the first time, 75 years after its introduction in the Mental Health Law 36/1904.

3.1.5. Towards the closure of forensic psychiatric hospitals

Despite the success in closing down general psychiatric hospitals, the six existing forensic psychiatric hospitals passed untouched by the reform, as they remained under the jurisdiction of the Ministry of Justice and separated from all other health services, which were by this

time included in the new-born Servizio Sanitario Nazionale (SSN) (National Health Service) (De Vito, 2014).

This determined a marked gap in quality between a community mental health service among the most advanced in Europe (Burti, 2001) and a forensic psychiatric service based on a nineteenth century model (Fioritti & Melega, 2000). Throughout the 1980s and 1990s, financial pressures made the inclusion of forensic psychiatric services in the SSN a low priority for the Ministry of Health. This led to further procrastination over the reform of the sector (De Vito, 2014).

Another consequence of the financial difficulties was reflected in the cuts that the OPG were subject to toward the end of the 1990s, which resulted in further degrading of service quality (Scarpa, Castelletti, & Lega, 2017). A national study carried out by the Italian National Institute of Health (Istituto Superiore di Sanita') to investigate on the status of OPG, reported that by 2012, 17% of the patients in OPG were not offered any rehabilitation treatment, and that only one patient out of six was granted treatment for at least eight hours a week (Lega et al., 2015; Lega et al., 2014). The inadequate service provision within OPG generated the phenomenon of the so-called "Ergastoli Bianchi" (White life-sentences), which saw lifetime confinement, based on the grounds of social dangerousness, of many patients, for lack of alternative accommodation and ineffective treatment plans.

A major shift in policy occurred in 2008, when an Act of the Presidency of the Council of Ministries (DPCM, 2008) finally incorporated forensic psychiatric services into the SSN, to ensure continuity with community mental health services and reiterate the need for the "sanitarizzazione" (emphasis on health care rather than on containment).

Given that SSN services were provided at the regional level, forensic psychiatric services became aligned to the logic of localism, the distribution of patients based on geographical proximity to their place of origin (DPCM, 2008). Accordingly, the Act prescribed that every Region should develop forensic psychiatric services for their catchment areas. The separation of forensic psychiatric services from the Justice System was also enacted through the suspension of article 148 of the Penal Code, which allowed referral of offenders/prisoners who had developed mental incapacity while in custody (DPCM, 2008).

Despite the improvements envisioned by the legislators, a parliamentary investigation of 2010 exposed the widespread degrading conditions of the OPG, the lack of clinical staff and the frequent use of restrictive measures, meaning conditions were more akin to a prison than

a recovery culture. The then president of the Republic, Giorgio Napolitano, denounced the inacceptable conditions of OPG by defining these institutions "Horrifying and unworthy of a civilised country" (Rizzo, 2015).

The investigation was followed by a warning of violations of human rights issued by the Council of Europe (Barbui & Saraceno, 2015). These events pushed the government to immediate action and pass Law 9 of 2012.

3.2. The current model of residential forensic psychiatric care

This theme provides updated information (to February 2017) about the development of Italian REMS since Law 9 of 2012, their innovations and benefits and their critical issues.

3.2.1 Development of REMS following Law 9

Law 9, which prescribed the total closure of OPG, was followed by Law 81 of 2014, which made it mandatory for each of the 20 Italian regions to develop secure residential units in the community (Residenze per l'Esecuzione delle Misure di Sicurezza) (REMS) by 31st March 2015.

However, on the deadline set by Law 81, only the region Emilia Romagna had REMS ready for new admissions. On 19 February 2016, the Council of Ministers appointed a special commissioner, Franco Corleone, who had previously held responsibility as guarantor of prisoners' rights, to monitor closely on the implementation of the reform and on the progress of the six remaining regions which still failed to offer REMS (Abruzzo, Calabria, Piemonte, Puglia, Toscana e Veneto) (Cecconi, D'Anza, Del Giudice, Gonnella, & Zappolini, 2016; Conti, 2016).

In the same period, as mandated by Law 81, all six OPG suspended admission, with the sole exception of OPG Castiglione delle Stiviere (Mantua, Lombardy), which received a deadline extension, having been evidenced in the Parliamentary investigation of 2010 to offer more favourable conditions for the patients (Scarpa, Castelletti, & Lega, 2017).

The insufficient number of REMS to accommodate new patients and the suspension of admissions in the old OPG soon caused an emergency in the availability of beds. Throughout 2016, the REMS in Castiglione delle Stiviere ran consistently beyond its maximum capacity of 160 beds, hosting an average of 200 patients at any time (Corleone, 2017). By January 2017, the emergency was overcome all over the national territory, as the regions eventually

complied with the new regulation. The process of discharging patients from old OPG had taken 22 months to be completed, from April 2015 to January 2017. Following risk assessment, most of them had been transferred to community mental health services located in their own catchment area, while the remainders had been either relocated to private accommodation or referred to REMS.

On 27-28 January 2017, with the discharge of the last patients at the OPG Barcellona Pozza di Gotto, Italy officially became the first country worldwide to close forensic psychiatric hospitals. This historic event was officially celebrated in Trieste, an emblematic city for Italian Psychiatry, as it was the place in which Basaglia managed to close the local asylum and first conceived of regional psychiatric services in the 1970s (Corleone, 2017).

3.2.2. Updated information on the system of REMS

At present (February 2017), 30 REMS are operational all over the national territory, but the number is fluctuating, as some REMS are provisional while others are being developed (Corleone, 2017). Overall, the three regions with the largest catchment areas, Lombardy, Lazio and Campania, have the largest capacity to accommodate patients, with 120, 91 and 68 beds respectively (Scarpa, Castelletti, & Lega, 2017). The region Umbria has stipulated a legal agreement with the adjacent region Tuscany to share REMS. Similar agreements are in place for the regions Molise and Abruzzo, and Valle d'Aosta and Piedmont (Corleone, 2017). Full details on the capacity and the number of patients of each REMS by Italian region are reported in Table 1.

Since their inception in April 2015 until February 2017, 950 patients have been admitted to REMS and 415 have been discharged, showing a patients' turnover which was unprecedented in Italian forensic psychiatry (Corleone, 2017). In February 2017, REMS held 624 patients all over the national territory, compared to 1,015 patients accommodated in the old OPG in their last year of operation (Lega et al., 2015). The difference roughly amounts to a 40% reduction in the number of patients between the two systems. In February 2017, however, there were 235 patients who had been referred to REMS, but who were still waiting to be admitted (Corleone, 2017). These were temporarily held in jail, followed by community mental health services or staying at home, depending on the level of risk to themselves and society. An updated count of the number of patients waiting to be admitted to the REMS is currently being undertaken at the national level (personal communication from member of staff, July 14, 2017).

3.2.3. Innovations and benefits of the system of REMS

The structural characteristics of REMS are set by law to achieve four main goals: 1. Security measures; 2. Individualised care; 3. Recovery in a community setting; 4. Small scale units (Scarpa, Castelletti, & Lega, 2017).

To ensure high-quality standards, each REMS are limited to a maximum of 20 beds and must employ only clinical personnel, with a staff-to-patient ratio of 0.9:1 (Scarpa, Castelletti, & Lega, 2017). At least two psychiatrists, one psychologist, two occupational therapists, one social worker, 16 nurses and 10 nursing assistants (Operatori Socio-Sanitari) must be employed in each REMS (Scarpa, Castelletti, & Lega, 2017).

To emphasise the change from the old system of OPG, REMS should be located either in brand-new buildings or in pre-existing buildings, which were previously used for community-based rehabilitative tasks (Scarpa, Castelletti, & Lega, 2017). OPG should not be readapted for use in the new service. The sole exception is represented by the region Lombardy, whose current six REMS are using the same premises of the old OGP in Castiglione delle Stiviere, because, as discussed in section 3.1.5, the hospital had already converted to the ethos of REMS before the reform (Corleone, 2017). This temporary arrangement will partly be rectified, as per the regional plans, by the development of two new REMS with 20 beds in Lambiate.

Every patient is accommodated in single or double-occupancy rooms, compared to the overcrowded dormitories of OPG. In contrast with traditional risk-based approaches typical of other countries, the bedrooms in the REMS tend to reflect a therapeutic culture emphasising “normalcy” and personhood. The rooms are unlocked throughout the day, granting access in and out, and the patients are encouraged to adorn their private spaces with personal items and to make them as homely as they wish (Scarpa, Castelletti, & Lega, 2017).

Security personnel can act as additional staff in the presence of a safety emergency; otherwise security measures only include a fenced perimeter, CCTV and locked doors (Scarpa, Castelletti, & Lega, 2017). Should the patients experience acute crisis episodes, they can be transferred for immediate treatment to general psychiatric hospital acute wards, which are usually located near each REMS (Scarpa, Castelletti, & Lega, 2017).

The development of REMS drew inspiration from the experience of community mental health services and from the cultural heritage of the anti-institutionalisation movement. REMS were developed to be a service provided by the national health system, rather than the Ministry of

Justice, to emphasise their mission around the care, rather than containment of mentally disordered offenders (De Leonardis & Emmenegger, 2012).

Given this mission, admissions should be kept to a minimum and limited to patients who require specialised treatment and security which are not available in community mental health services (Scarpa, Castelletti, & Lega, 2017). Admission can only occur via compulsory referral mandated by the Court (Magistrato di Sorveglianza or Giudice delle Indagini Preliminari) (Scarpa, Castelletti, & Lega, 2017). In line with the ethos of the United Nations Convention on the Rights of Persons with Disabilities, Law 81/2014 prescribes that a patient cannot stay in a REMS for a period longer that a prison sentence for the same index offence, to prevent the phenomenon of unnecessary long-stay.

Owing to the recovery model of forensic psychiatric care guiding practice at the REMS (Drennan et al., 2014), restrictive practices are strongly discouraged and hardly resorted to. Instead, the mission of the service is to address the patients' individual psychosocial and treatment needs to favour socially-integrated lifestyles (Scarpa, Castelletti, & Lega, 2017). For this reason, REMS place great emphasis on social community-oriented vocational and recreational activities (Corleone, 2016).

In the REMS of the Abruzzo region, for example, an extensive programme of outdoor activities has been implemented. This includes: the "Clean Air Project" (Progetto Aria Pulita), which aims to improve physical and emotional wellbeing by offering patients group trekking in the Apennine mountains; a theatre laboratory, whereby the patients collaborate with a community-based company in the production of theatre shows to promote self-agency and empowerment; Christmas markets and the Epiphany fair, in which the patients take part as a means to promote a sense of belonging to the community and its traditions, in a period of the year where the absence of families may trigger feelings of loneliness and alienation (Corleone, 2017).

In order to promote community re-integration, patients who are deemed suitable upon clinical evaluation are granted accompanied leaves. At the REMS Castiglione delle Stiviere, over a month period, around 35-40% of the 120 patients are granted at least one leave of up to six/eight hours; around 20% obtain a leave of one or more days (personal communication from member of staff, February 24, 2017). In addition, 32 patients have permission from the magistrate to organise their own leaves in agreement with the clinical team (personal communication from member of staff, February 24, 2017).

Temporary leaves, in line with research evidencing how community-focused care and a social framework to treatment can generate positive recovery outcomes (Furlan, Zuffranieri, Stanga, Ostacoli, Patta, & Picci, 2009), have been reported by patients at the REMS Castiglione delle Stiviere to incentivise their commitment to recovery (Di Lorito et al., 2017). In turn, community-oriented activities promote socially-integrated lifestyles, which is reflected in the rare occurrence of serious incidents the REMS Castiglione delle Stiviere have experienced since their inception (personal communication from member of staff, February 24, 2017).

Although this may reflect that few patients with antisocial personality disorder/psychopathic traits have been referred to these specific REMS, the trend may also be explained through the social-constructionist perspective of Goffman (1961) discussed in section 3.1.4, suggesting how in highly restrictive settings individuals may internalise a captive prisoner's self-identity and behave aggressively. On the contrary, when the patients are treated truly humanely, they escape the traditional dynamic of "guard versus prisoner" and tend to refrain from anti-social behaviour.

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 (Scarpa, Castelletti, & Lega, 2017). The care pathway is shared with mental health community services, as per the directives of Law 81, to encourage proactive engagement/collaboration in the prospect of future release.

The effort within the system of REMS to improve service quality has received preliminary positive feedback from the patients, as reported in a recent case-study on five patients aged over 50 years old residing in the REMS Castiglione delle Stiviere (Mantua, Lombardy) (Di Lorito et al., 2017). The study comprised two phases: (i) An assessment of whether the patients' needs are met/unmet in relation to daily living, treatment, health, and support; (ii) qualitative interviews around service satisfaction. Both were administered to all five patients.

Results from the assessment of needs found that on average 73.3% of patients had their needs met, a rate comparable to that reported in a study by Futeran and Draper (2012) on patients aged 50 years and over with mental illness treated in community mental health services (77%). The qualitative interviews reflected high levels of satisfaction around accommodation arrangement, health care assistance and social opportunities and daily activities (Di Lorito et

al., 2017). These include "Kitchen groups", whereby patients who are able cooks and who are deemed suitable to the task, compile food shopping list, prepare meals and distribute them to the other patients; assignment of housekeeping tasks or jobs based on individual skills; access to gym facilities and soccer/volleyball fields, supervised by clinical members of staff and gym teachers; availability of leisure rooms, with ping-pong tables, board games, cards and TV; regular cultural and educational programmes including foreign language schools, film festivals, arts/music/theatre workshops, and book and newspaper reading groups; access to computer rooms (with no internet access), where patients can use their own devices (Corleone, 2017).

Despite the limited generalisability of this case study, given its small, non-random sample at only one single REMS, it nonetheless gathers preliminary evidence that the efforts made to improve forensic psychiatric care may be generating positive outcomes.

3.2.4. Critical issues of the system of REMS

Given the recent development of REMS, the system is affected by some limitations that need addressing (Bronzi et al., 2015). One of these pertain to the process of referral and admission. At present time, magistrates refer patients to REMS based on the appraisal of forensic experts (SIP, 2016; Ciccone & Ferracuti, 1995). However, these experts usually have very little contact with forensic psychiatric services to ascertain whether they can address the patient's treatment needs (Casacchia et al., 2015). 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 (Scarpa, Castelletti, & Lega, 2017).

The situation is exacerbated by the fact that, although by law REMS should be considered as a last resort as per the principle of *"extrema ratio"*, magistrates often refer patients to REMS provisionally, while more suitable accommodation in community mental health services is being found (Casacchia et al., 2015). These provisional measures, called "urgent referrals", represented the largest source of new admissions in the REMS in a study by Scarpa (2015).

As denounced by the Psychiatric National Society (Societa' Italiana di Psichiatria), indiscriminate referral poses great challenges to service provision, as REMS currently accommodate a heterogeneous population crossing all diagnostic axes, from cases suitable for community mental health services to severe comorbid cases of personality disorders and substance addiction (Casacchia et al., 2015).

A 2005 sentence from the Italian Higher Court (Corte di Cassazione) has established that individuals with severe personality disorders can be referred to forensic psychiatric services and this has contributed to maintain the number of these patients consistently high. Lega et al. (2015; 2014), in their study "Assessment of Italian Forensic Psychiatric Hospitals" carried out to report on the psychiatric morbidity of a sample of 473 patients out of the 835 present in the six Italian OPG, found that 20% had any personality disorder. This finding reflected an increase compared to previous investigations (Andreoli, 2002; Fioritti et al., 2001; Morosini et al., 2001).

In addition, the persisting use of article 89 of the penal code, which prevents imprisonment for offenders with partial capacity, including those with personality disorders, introduces individuals with marked antisocial traits into forensic metal health services (Scarpa, Castelletti, & Lega, 2017). Other than the potential security issues for the staff, who have manifested their concerns about the absence of any security personnel within REMS, these patients may pose tangible threats to community safety, once released to outpatient services.

Another limitation of the current system is the disparity in the quality of service provision between the regions where the old OPG operated and those where they did not. The former group is experiencing great limitations in the process of referral and admission because Courts and experts still operate within the pre-reform forensic psychiatric culture (Scarpa, Castelletti, & Lega, 2017). In this sense, it appears quite crucial, as explained by the special commissioner for the closing down of OPG Franco Corleone, that structural changes in policy and practice are accompanied by efforts to challenge societal culture in its stigmatic approach toward the psychiatric offender (Corleone, 2017).

Instead, in those regions working for the first time with security measures, more successful efforts have been taken to make the processes of referral and admission more adequate (Scarpa, Castelletti, & Lega, 2017). In Veneto, for example, the region is currently co-ordinating collaboration between psychiatrists and magistrates to evaluate single cases that may be referred to REMS (Scarpa, Castelletti, & Lega, 2017).

Regional divide is also evident in the availability of beds. Given the high referral rates from the magistrates and the limited capacity of REMS set by law, some regions are creating patients' waiting lists. This is generating tensions between judicial and health systems, as the Courts would like to see their sentences promptly applied. New REMS are opening to try to respond to the current demand. For example, at the beginning of 2017 new REMS have been

launched in Nogara (Veneto), Barete (Abruzzo), San Maurizio Canavese (Piedmont), Genova Pra (Liguria), Carovigno (Puglia), Santa Sofia d'Epiro (Calabria) (Corleone, 2017).

However, the process is a slow one, which is hindered by the current financial difficulties of the SSN, the reluctance of citizens to accept new REMS in their communities and the challenges of regional Departments of Mental Health to work with subjects in security measures (SIP, 2016). In addition, the REMS have higher running costs (55 Million Euro medical budget per year) (personal communication from member of staff, July 01, 2017), compared to the old OPG (22 Million Euro medical budget on last year of operation) (Casacchia et al., 2015).

Finally, another limitation of REMS paradoxically lies in their emphasis on issues related to equality, self-determination and human rights over elements of restrictiveness. Whereas these elements are praiseworthy in principle, they present some limitations when translated into daily practice. The case-study by Di Lorito et al. (2017), discussed in section 3.2.2, found that the autonomy granted to patients in managing their daily routine can translate into neglect of some of the needs of patients who need greater motivation to be active and engaged in their recovery process (Di Lorito et al., 2017). These patients have lamented that the lack of a more structured daily schedule and more intensive emotional and psychological support may trigger feelings of apathy (Di Lorito et al., 2017).

4. Discussion

This study represents the first literature review around the Italian reform which has led to the total closure of forensic psychiatric hospitals and the conversion to a fully-residential system of forensic psychiatric care. Although the reform has had revolutionary implications within national borders and might be relevant for forensic psychiatric clinical practice and policy at the international level, limited literature has been reported around it. Updated information about the status and the outcomes of the reform is non-existent.

We addressed this gap in research by gathering a diverse range of sources to support our findings, which provided the review with a holistic quality. These sources included a variety of international peer-reviewed articles; printed materials such as textbooks and works by key authors who have influenced the reform process (Lombroso, Basaglia); articles published by not-for-profit organisations which had a key role in inspiring the public opinion and driving

policy changes (StopOPG); governmental papers and documents; and personal communications with professionals working in the current system.

Although most of these sources had undergone the peer-review process, they were not substantiated by any empirical data, bearing possible author bias. This limitation may also have affected the grey literature retrieved through the Google search, which was not subject to the process of peer-review. The only empirical study we retrieved (Di Lorito et al., 2017) was extremely small with a restrictive sample from only one REMS, which may not be representative. Given the lack of systematic research in this area, we opted to include all relevant sources, but carried out attentive quality assessment to ensure the integrity of our findings.

The diverse range of our sources allowed us to build a comprehensive picture of the long and tortuous historical process that culminated in Law 81/2014, which represented a victory for civilisation and a fundamental step towards equal human rights for psychiatric patients who have committed a crime. Law 81/2014 finally put an end to unjust practices which traced their origins back to the positivistic era, such as the phenomenon of the "ergastoli bianchi" (white life sentences).

Our review highlighted that currently in this first phase of implementation of the reform, the system is already generating benefits, but it is also experiencing some key challenges, requiring further work to ensure continuation with the inspiring work of reformers. Some advocate that minor changes to the current system of mental health care, such as the introduction of adequate training curricula (Grattagliano, Scialpi, Pierri, Pastore, Ragusa & Margari, 2014) or a specialisation in forensic psychiatry, would ensure the system better address the complex needs of forensic psychiatric patients (Scarpa, Castelletti, & Lega, 2017; Casacchia et al., 2015).

The movement Democratic Psychiatry, founded by Basaglia and the special commissioner for the closing down of OPG Franco Corleone, argue instead for more substantial reform, including a revision of the current penal code, which is almost 90 years old and obsolete in relation to contemporary issues (Corleone, 2017). To this day, plans to amend the code have been advanced by different reformists such as Pagliaro, Grosso, Nordio, and Pisapia; however, these attempts have all failed, given the resistances of political and institutional leaders (Corleone, 2017). The supporters of the reform contend that the abolition of the insanity/partial insanity plea (Article 89 of the penal code) would ensure that all offenders,

regardless of their psychiatric condition, are detained and treated in the prison system (Corleone, 2017; Peloso, D'Alema & Fioritti, 2014). This reform would generate benefits at different levels.

On the one hand, it would prevent individuals with marked traits of antisocial behaviour and comorbid substance abuse from being diverted from prison to community mental health care services and reduce excessive population heterogeneity, to the benefit of service quality. On the other hand, it would grant real equality to all offenders, reduce stigma against offenders with psychiatric disorder, and decrease service running costs (Scarpa, Castelletti, & Lega, 2017).

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 (Ferracuti & Biondi, 2015).

Finally, a crucial element for service improvement is the implementation of systematic monitoring of REMS, which is lacking at the moment. Shortage of research data has been endemic in the history of Italian Psychiatry. Throughout the period of operation of the old OPG for example, official reports were seldom released from the single institutions and only a few studies systematically investigated the characteristics of patients and service provision (Andreoli, 2002; Fioritti et al., 2006; Lega et al., 2014).

We advocate that this trend be reversed and that the restricted number of forensic psychiatric patients (around 600 at the national level) should not discourage research in this area. Thus far, the REMS have been the object of investigation of only one case-study (Di Lorito et al., 2017), which we have discussed in section 3.2.2. Given the limitations of the project, which only sampled a restricted group of older male patients living in one single REMS, further monitoring initiatives, which may include the creation of a national epidemiological registry for patients, are crucial to guide policy and practice and ensure that the changes made in the Italian system are defensible.

This appears a crucial exercise, given the fact that Italy is "pioneering" a new model of care, which is grounded in the conviction of reformers that by reducing restrictive practices to a

minimum, patients' recovery can be more easily accomplished. This stance is in contrast with the policy, practices and beliefs of other countries worldwide, which, despite the adoption of recovery-based philosophies (Drennan et al., 2014), are still founded, to various degrees, on greater restrictiveness, justified in terms of preventing security incidents and ensure the safety of both staff and service users.

The revolutionary trait of the Italian reform places the country under the scrutiny of these professionals, clinicians, academics and policy makers who operate in different professional frameworks, but are similarly pressured to improve care provision in terms of cost optimisation, recovery outcomes, and ethical treatment. These issues know no boundaries and are universal priorities in contemporary times. Research reporting on the successes and failures of the Italian reform is therefore pivotal to stimulate debate on alternative ways of achieving these objectives.

At present, the paucity of empirical research around Italian forensic psychiatry does not allow comparisons against the models of care adopted elsewhere. Comparative studies may not be able to provide definitive answers as to which type of model is more effective, given the complex interplay of factors ranging from differences in patient populations, diagnoses, legal frameworks and service provision to cultural, political and public expectations across different countries. They would nonetheless allow for the identification of those elements of care and treatment which are more beneficial for service users and professionals working in the forensic psychiatric sector.

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1019 Figure 1. Selection of sources through database and Google search

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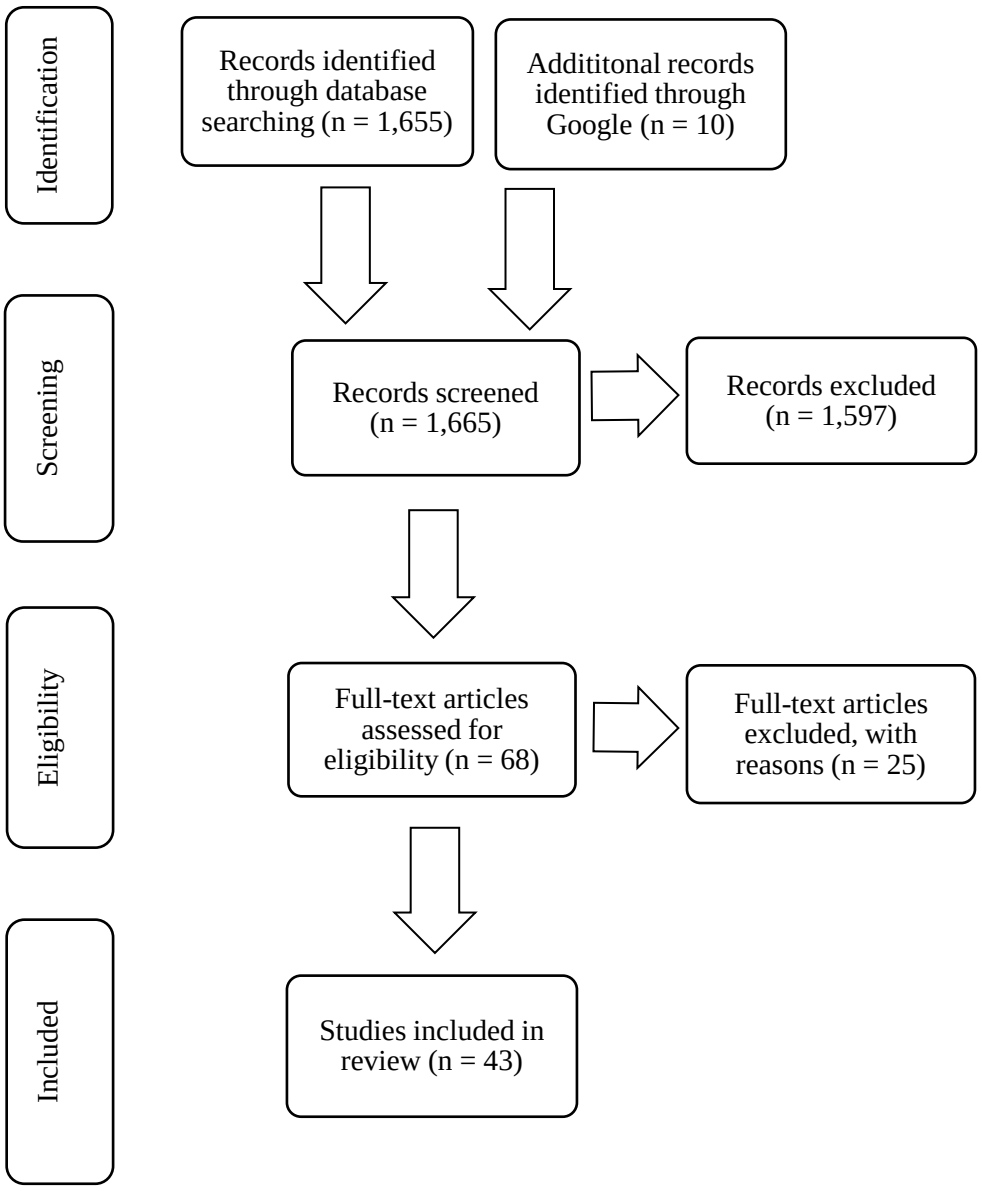

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1027 Table 1. Regional REMS by beds capacity and number of patients

Region	Location (Province)	Capacity (n)	Patients (n)
Abruzzo-Molise	Barete (AQ)	20	13
Basilicata	Pisticci (MT)	10	9
Calabria	Santa Sofia d'Epiro (CS)	20	16
Campania	Mondragone (CE)	16	15
	Calvi Risorta (CE)	20	19
	San Nicola Baronia (AV)	20	20
	Vairano Patenora (CE)	12	12
	TOTAL	68	66
Emilia Romagna	Bologna (BO)	14	14
	Parma (PR)	10	9
	TOTAL	24	23
Friuli Venezia Giulia	Aurisina (TS)	2	1
	Maniago (PN)	2	2
	Udine (UD)	2	0
	TOTAL	6	3
Lazio	Ceccano (FR)	20	17
	Palombara Sabina (Merope e Minerva) (RM)	20+20	39
	Pontecorvo (FR)	11	9
	Subiaco (RM)	20	19
	TOTAL	91	84
Liguria	Genova Pra' (GE)	20	9
Lombardia	Castiglione delle Stiviere	120	121
Marche	Montegrimano (PU)	15	20
Piemonte-Valle d'Aosta	Bra – Cuneo (CN)	18	18
	San Maurizio Canavese – Torino (TO)	20	20
	TOTAL	38	38
Puglia	Caroviglio (BR)	18	17
	Spinazzola (BT)	20	20
	TOTAL	38	37
Sardegna	Capoterra (CA)	16	16
Sicilia	Caltagirone (CT)	20	20
	Naso (ME)	20	20
	TOTAL	40	40
Toscana-Umbria	Volterra (PI)	30	30
Trentino Alto Adige	Perigine valsugana (TN)	10	10
Veneto	Nogara (VR)	40	34

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