

The Paradox of the Waiting List to Enter REMS: A Delay in the Execution of Magistrates' Orders or a Search for a Better Way to Treat Mentally Disordered Offenders? Reflections Three Years after the Closure of Forensic Psychiatric Hospitals in Italy

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Abstract

In Italy, Public Law n. 81/2014 promotes innovative, recovery-oriented, rehabilitative treatment for people with mental disorders who have committed a criminal offense, without criminal intention, but who are, nonetheless, regarded as socially dangerous. A relevant innovation was in the transfer of responsibilities and management of care from the Ministry of Justice to the Ministry of Health. The reduction of the number of beds during the transition from Forensic Psychiatric Hospitals (OPG) to Residences for the Execution of Security Measures (REMS) led to 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.

Based on the experience in the Piedmont Region concerning the handling of mentally disordered offenders, the factors influencing the contrasts between the legal system and the health system have been examined: management of facilities by the regional health system and governance of the security measures by the Judiciary, extensive use of diminished responsibility, functions of the old OPGs not passed on to the REMS. The experience of managing the waiting list in Piedmont has revealed ways of dealing with these critical issues, but there is still a need for further organizational and, above all, legislative innovations.

Keywords: Italy; Forensic psychiatry; Residenze per l'Esecuzione delle Misure di Sicurezza (REMS); Ospedali Psichiatrici Giudiziari (OPG); Mentally disordered offenders; Mental illness; Deinstitutionalization

1. Introduction

The transition from Forensic Psychiatric Hospitals (Ospedali Psichiatrici Giudiziari - OPG) in Italy [1, 2] to secure, residential units, which we will refer to as REMS (*Residenze per l'Esecuzione delle Misure di Sicurezza* - Residences for the Execution of Security Measures) staffed only by healthcare personnel [3] was completed in January, 2017. A relevant innovation was in the transfer of responsibilities and management of care from the Ministry of Justice to the Ministry of Health. Public Law n. 81/2014 promotes innovative, recovery-oriented, rehabilitative treatment for people with mental disorders who have committed a criminal offense, without criminal intention, but who are, nonetheless, regarded as socially dangerous.

In Piedmont, a region with about 4.4 million people in the northwest of Italy, there are two REMS in operation: "San Michele" in Bra with 18 beds, all reserved for men and "Anton Martin" in San Maurizio Canavese with 20 beds, with the possibility of accommodating two women [4]. The total number of beds is lower than the average number of beds used in OPGs in their last years of operation, which were more than 50. The Piedmont Region has required a high level of cooperation from the healthcare agencies to implement community projects in favour of the mentally disordered offenders (MDOs) to prevent hospitalization in REMS or reduce its duration as much as possible. The reduction of the number of beds and the intention to carry out community projects also on patients who already had a REMS entry order (REMS assignment) led to a waiting list. The waiting list is normal practice in healthcare but not for executive orders from magistrates.

The aim of the work is to explore the critical points of the reform through one of its most controversial and unintended consequences: the creation of waiting lists for entry into REMS. The problems concerning waiting lists are a way to examine the peculiarities of the Italian system. In fact, they highlight the friction between the legal system and the health system.

We will analyze the following critical points:

- Full management of the REMS by the regional health system (they are no longer prison administration structures);
- Governance of the security measures by the Judiciary (there is not a diversion system whereby one leaves the judicial circuit);
- Extensive use of diminished responsibility;
- REMS are not substitutes for the OPGs.

2. The Full Management of the REMS by the Regional Health System

With the reform established by Italian Public Law 81/2014, the REMS began operations. While these facilities were conceived to carry out judicial orders, their principal mandate is treatment. They are a part of the organization through which the Regions manage the health system; specifically they are part of the network that takes charge of

patients who have committed crimes. In these structures the maximum number of people who can be hosted at the same time is established by law within specific organizational and structural requirements. The health managers are committed to respect this limit in order to guarantee the quality of the work done and the safety of patients and staff. Waiting lists are an area of controversy: healthcare must guarantee transparency and consistency and, at the same time, effectiveness and appropriateness, including the protection of the community [5]. When a system consistently operates at full capacity while demand fluctuates unpredictably, the creation of a waiting list cannot be avoided [6]. Given the impossibility of perfectly coordinating demand with the supply of beds and also given the request to limit REMS beds, also present in Public Law 81/2014, and to avoid reproducing the logic of OPG, it was immediately necessary to organize a waiting list with the intention of encouraging a pragmatic use of available resources. The waiting list in the health sector has a very old tradition that is combined with that of triage [7], to avoid the use of a FIFO model (first in-first out). As has been noted, “the FIFO model may be acceptable for many service industries but in healthcare, clinical need is usually the dominant factor” [8]. In this way, levels of needs are introduced, not limited to the needs of the patient, as normally happens in healthcare, but also to those of the Judiciary system.

3. Governance of Security Measures

The Italian Penal Code provides mediation between classical and positivistic approaches by the creation of what is called the 'dual track' (*doppio binario*) [9], according to which offenders who were judged responsible for their conduct would be directed to the penal track (i.e. trial, sentencing, imprisonment), while offenders who were mentally incapacitated and considered a danger to society would be admitted to the security measures track [10]. The application of security measures, their revocation or modification (aggravation or mitigation) are exclusively under the jurisdiction of the judicial authority. Even after the introduction of the new regulations, the transition from REMS to a community facility does not depend exclusively on a clinical judgment, but is subject to a decision by the magistrate. Judges usually do not consult a third-party forensic psychiatrist. Instead they decide on the degree of the social dangerousness based on reports of the care providers who, correctly, do not express opinions on this specific matter, but on clinical conditions and the course of treatment.

In fact, the treatment providers are not explicitly responsible for the containment of the danger (i.e. the risk of recidivism) much less to act as guards. The result is that there is a lack of technical investigation on this very issue. This is even more paradoxical since the so-called psychological expertise is rarely implemented by the judges, even though it is permitted by the Criminal Code in the execution phase, contrary to what is provided in the cognition phase. Moreover, when the dangerousness of a subject can no longer be considered an expression of psychopathology, the judge can neither prescribe entry into a prison nor apply the security measures provided for other criminal subjects, unless the medical practitioners declare the person cured.

4. Extensive Use of Diminished Responsibility

In Italy, as in other jurisdictions [11] there are three levels of criminal liability in which an offender can be placed: full responsibility, diminished responsibility, excluded responsibility (the latter comparable to the Not Guilty by

Reason of Insanity (NGRI). This tripartition is not limited to serious crimes, nor does it cover only certain types of mental disorders. The person for whom diminished liability is recognized receives a one-third reduction of the sentence and the application of a security measure at the end of the sentence, as long as the person is recognized as socially dangerous. The diminished responsibility identifies an intermediate position in a continuum between full mental capacity and lack of mental capacity. But it favors the application of the same pool of security measures (i.e. REMS and community facilities under supervised freedom) to persons with very different needs.

The beneficiaries of this type of plea, diminished responsibility, may not have a particular and rapid benefit from entering REMS, but they are nevertheless legally expected to do so. Their entry measure has the same value as that of the NGRIs and once the final sentence has been passed, they must be immediately transferred to REMS. Their stay in a correctional institution is practically illegal. Since 2005, the possibility of applying diminished responsibility in the case of serious personality disorders has further broadened the range of people who may be subject to security measures [12]. One could say that with the closure of the OPGs, an attempt has been made to take a pragmatic approach in Italy, as is the case in Britain, Ireland and the Scandinavian countries. According to this perspective, it should be relevant whether or not the offender is mentally disordered and in need of treatment [13]. However, this aspiration has not come to terms either with the resources allocated to mental health departments or with the dictates of the Penal Code, which remain based on the level of responsibility of the offender.

Contamination between the two approaches can give very bad results [14]. First, the assessment remains the responsibility of the forensic psychiatrist who will not be the person who will carry out the treatment; secondly, the assessment carried out in the forensic context, which by law refers to the time of the offence, will continue to influence the whole treatment, possibly for a long period of time, despite changes which may occur. And last, offenders with antisocial personality disorders may be referred to a healthcare pathway because a more appropriate correctional treatment is not available in prisons.

The consequence of the 'dual track' is that those who are "not guilty by reason of insanity" cannot remain in prison. The assessment of what happened at the time of the offence takes precedence over the current needs of the patient when he/she has to be managed and treated. The NGRI patient must go to a healthcare facility even if the need is now more correctional than therapeutic. Even if, over the years, an attempt has been made to keep the old regulatory system in step with the times, the rigidity of this system is evident. For example, the system continues to be an obstacle to the creation of a psychiatric care unit in prisons since there is a tendency to move MDOs out of the correctional system regardless of the needs expressed, even in the pre-trial detention phase. It should be made clear that being outside the correctional circuit means going to facilities staffed exclusively by healthcare personnel. In this way, the National Health System is forced to guarantee assistance and care to people in pre-trial detention and to convicted people even when correctional demands take priority over therapeutic demands.

Public Law 81/2014 was intended to give special emphasis to community treatment, thus the reduced number of beds. Instead of giving precise operational guidelines, the law introduced the concept of *extrema ratio*. More than

four years after the roll-out of the REMS, it can be said that this was too vague an indication. The custodial security measures (i.e. REMS) were also applied to people who were able to undergo treatment in a community facility.

There is also a difficulty in effectively integrating dangerousness and illness. For example, when there is an overlapping of the two conditions (for which a diminished or absent criminal responsibility is recognized) this can take completely different forms. A patient may have a severe disorder, but if he commits offences whose "seriousness of the damage or danger caused to the person offended by the offence" [15] is minimal, he risks the most restrictive safety measures. Thus, he may find himself in REMS together with people with high antisocial potential and behavioral problems, with little chance of improvement through medical treatment.

5. The REMS Are Not a Substitute for OPGS

According to Public Law 81/2014, only a limited number of patients who committed crimes could be treated in a REMS; and only when it was not possible to treat them in any other local facility. The REMS are healthcare structures, built by the Regions with a number of beds proportionate to the local resident population but markedly inferior to the number of beds in the old OPGs, because they were not considered a substitute for them. Fortunately, they will not accept any patients over the number of available beds. This *proviso* is very different from OPGs, which were often overcrowded. The decision on the part of the directors, to consider the REMS as places of treatment, was the object of bitter controversy with some judges, who could not conceive of a refusal of entry.

The limited numbers of beds in the REMS, compared to initial forecasts, was in line with the principle of the 'least restrictive alternative' [16] for MDO treatments. As in many other jurisdictions [17] this concept has not been made operational in practice. Moreover, in Italy there is only one type of therapeutic security facility and it is managed exclusively by medical personnel (REMS). Due to the 'dual track', a REMS facility is not interchangeable with the psychiatric observation wards in penitentiaries, unlike what happens in other jurisdictions [18]. Therefore, although REMS are not necessarily used as a measure of *extrema ratio*, they are likely to be the end of the line for those who are deemed to be socially dangerous.

At present, REMS are not articulated in various levels of security. In order to implement such a system, it would be necessary, at least initially, to increase the number of beds to allow reorganizing to accommodate different levels of security. However, the beds could quickly become saturated because of the need of the judges to execute orders, which is based on the patient's condition at the time of the offence and not updated on the basis of current treatment needs. The Superior Council of the Judiciary [19] has surveyed the Presidents of the Supervisory Court on the consequences of the reform. Almost all of the Presidents stigmatized the reduced number of available beds and the creation of waiting lists. It is not surprising that the waiting list can become a battleground, because for the Judiciary it is a list of unexecuted measures, while for healthcare it is a very heterogeneous list of patients who can benefit in varying degrees from different treatments, not all of which are limited to REMS.

The judges do not recognize a link between level of need and therapeutic placement. This perpetuates a punitive view of the security measure strictly connected to the place and not to the therapeutic project.

The legislation of 1930 did not create the security measures to provide the treatment of patients but to ensure public safety and to neutralize criminals. The rulings of the Constitutional Court and the reform determined by Public Law 81/2014 make them more up-to-date and more humane, but do not change their structure. However, healthcare must operate in terms of levels of need and also in terms of different courses of care to be carried out, of necessity in the same facilities. This is a major contradiction between healthcare and justice.

As a list of non-executed measures, there is no way to obtain an indication from the court on a differentiation of the levels of urgency for REMS entries. For magistrates, the enforcement of the final judgment and the avoidance of unfair imprisonment of an MDO waiting to be placed in REMS are relevant. Extending a custodial sentence to be carried out in prison for a person awaiting trial is also inappropriate. In 2018, the Piedmont Region deliberated a series of criteria designed to define the priorities for entry into REMS and to make the assignment to REMS appropriate from a clinical point of view. Experience has brought to light further dimensional criteria that take into consideration where the patient is at the time of evaluation and the persistence of the appropriate clinical requirements when waiting for admittance into REMS. Based on these additional criteria, a possible alternative project to REMS admission is proposed to the ruling magistrate. The possibility of an alternative project to REMS summarizes the patient's psychopathological condition and level of functioning, as well as his willingness to follow the therapeutic-rehabilitative path. Further needs can be reported for patients waiting to be included in REMS, such as a period of observation for people unknown to psychiatric services or with previous failures of territorial therapeutic projects.

Currently the priority criteria used in the Piedmont Region for the order of entry into REMS are:

- Inappropriateness of the current location, which is maximum when a patient with diminished responsibility has ended the prison period and the detention security measure must begin;
- The presence of a final judgment applying the security measure in REMS;
- The presence of patients in prison with a total mental defect and provisional application of the REMS security measure;
- The impossibility of an alternative therapy project to REMS.

The paradox is apparent when territorially untreatable people are admitted to REMs without a follow-up territorial treatment project in place. The services of the territory will find it very difficult to accommodate them. Therefore, they are destined to remain in REMS for a long period of time, especially if they show a lack of cooperation in the treatment.

6. The Piedmont Experience

In a previous article, we have described the organization of the Piedmont region concerning MDOs (4). In monthly meetings between psychiatric forensic units (UPF) of each of the 12 regional healthcare agencies, the directors of

the REMS and the regional coordinator, we redefine and update the waiting list. In these meetings, we responsibly attempt to take into consideration all the various perspectives. We evaluate the level of need of the patients and the planning necessary to use the beds in the REMS in the most effective manner. At the same time, we are mindful of the patients' legal standing 1) to insure they are not kept in prison beyond their legal sentence; 2) to insure against insufficient legal measures that would risk invalidating the Judiciary system; 3) to safeguard the victims of the offenders and society in general.

An unusual case is that of inmates who must be admitted in a REMS as soon as they are released from prison. Each day spent in prison over and above the end of a sentence is obviously illegal, even if these people are not being released into free society but rather into REMS. This is another consequence of the 'dual track'. Therefore, the pre-planning for the assignment of beds in REMS is essential. It is evident that it is not opportune to delay until the precise moment an inmate is released to place him on the waiting list. Therefore, it can happen that the waiting list of the healthcare officials may contain names of people who formally have not been handed their executive orders, unlike that of the Judiciary for whom the waiting list contains ordinances not yet executed, barring any other criteria. The lack of differentiating criteria that characterizes the Judiciary's point of view demonstrates another interesting aspect of the problem. The substantial number of people who follow a different path alternative to admission to a REMS, other than that prescribed by law, shows that the enforcement actions, for security measures regarding mental health treatments, cover very different clinical situations.

The outcome of the applied security measures in the Piedmont region is shown in (Table 1).

	N	%
Provisional finally disposed REMS security measures	145	100
Not executed orders (of which)	43	30
Diversión	35	24
Waiting to enter REMS	8	6

Table 1: Application of REMS (custodial) security measures from 10.01.2015 to 12.31.2019.

From the point of view of healthcare professionals, patients on the REMS waiting list have different levels of need. As of 12.31.2019 there were 14 patients on the waiting list. For the Judiciary there were 11 people with unexecuted measures and 3 people still detained in prison. However, from the point of view of health, we differentiate them through the criteria explained in four different categories:

- a) Patients awaiting entry (with relative evaluation of the level of priority of entry);
- b) REMS sentenced patient who is experimenting an alternative territorial project;
- c) REMS sentenced patient with an alternative territorial project under construction;

d) Patients currently detained in prison but with subsequent detention security measures in REMS. These are not yet unexecuted measures for the Judiciary.

As can be seen from (Table 2), REMS entries can be expected from both the prison and the community. In the latter case, depending on clinical conditions, the patient can be at home, in a facility or in an acute psychiatric ward.

	Prison	Community
Waiting for REMS entry	3	3
An alternative project is ongoing (pending measure conversion)	-	3
An alternative project is being realized (pending measure conversion)	2	-
The patient will be subject to the security measure at the end of the prison sentence	3	-

Table 2: Distribution of patients on the waiting list at 12.31.2019 in the four categories by type of placement.

7. Discussion

This work is, to our knowledge, the first to provide a contribution to the examination of the overall critical points of the reform through a concrete examination of the consequences of the reform itself. Previous works have dealt with organizational aspects and collaboration between the Judiciary and Healthcare systems, the definition and application of therapeutic rehabilitation paths in this patient population, and the description of the characteristics of REMS patients [9, 12, 20-22]. Examination of the function of the waiting list made it possible to highlight the different perspectives, not always easily reconcilable, between Judiciary and Healthcare. A solution that quickly overcomes all these criticalities is not to be expected, but much could be done through a path that leads to the changes. For persons with provisional application of security measures, the detention process could start in prison, perhaps in the specialized sections called "Mental Health Care Unit" (*Articolazione per la Tutela della Salute Mentale - ATSM*) maintaining, or starting with, the involvement of the relevant Mental Health Department.

Depending on the degree of patient insight and the level of compensation for mental disorders, it will be possible to define a rehabilitation therapy project (*Progetto Terapeutico Riabilitativo Individuale - PTRI*) in the medium term. If this is feasible in the territory, the person could benefit from the non-custodial security measures. The REMS admission should take place with a definitive measure or at least with a court expert's activity carried out. In any case, it should take place after the preparation of the PTRI by the authorized service. Public Law 81/2014 requires Mental Health Departments to write the PTRI within the first 45 days of the patient's stay in REMS. This time limit is often disregarded due to the difficulty of the territorial services to identify the appropriate treatment path. The delay in writing the PTRI is one of the critical issues mainly caused by the operators of the Mental Health Department.

Patients with severe and persistent behavioral disorders and poor response to psychiatric treatment [23, 24], should not compete with either territorial patients or those who benefit from REMS treatment. These patients should be observed in psychiatric sections within penal institutions like ATSM. Their presence in the security measures circuit leads to the revolving door phenomenon [25] because they often disregard the prescriptions applied by the judge at the time of release from REMS. These violations force the magistrate to order re-entry into REMS because they cannot return to prison unless they commit new crimes, obviously not conditioned by their mental pathology.

The abolition of diminished responsibility as a reason for applying security measures would reduce the number of cases that are difficult to deal with under security measure orders. On the other hand, alternative measures to imprisonment could be favored for those detainees who prove to be cooperative. It is essential that access to REMS becomes the responsibility of the health professionals who are in charge of managing the projects. The Court expert should remain the competent authority for responsibility and dangerousness, while the level of need (REMS or community facility) should remain the responsibility of the treating physicians. Consequently, mental health services in prison will need to be further strengthened.

Strengthening psychiatric care in prison makes it possible to investigate the situation of prisoners from a diagnostic and therapeutic point of view and possibly treat them. This would also help the territorial services to prepare PTRI and the REMS operators to select those patients best suited to residential treatment. For the proper clinical management of these patients it is essential that healthcare governs the course of treatment. The Judiciary is responsible for governing the path of social defense, which has criteria that are independent of the psychopathological ones. People's behavior is determined by a set of educational, environmental, personality and even psychopathological factors that must be considered as a whole.

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Conflicts of Interest

The authors declare that they have no conflict of interest.

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