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PROCEDURAL RIGHTS OF SUSPECTS AND ACCUSED WITH PSYCHOSOCIAL OR INTELLECTUAL DISABILITIES

ITALY

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Article 32 of the Constitution, which safeguards the right to health, is undoubtedly one of the most complex to examine, interpret and apply, because it guarantees a multifaceted set of rights: right to care, freedom rights and the right to make independent choices in respect of medical treatment. Such complexity is also expressed through the paradigm of the fundamental right regarding the protection of health in relation to the interest of the community whereby all its members should enjoy the best possible health assistance, with the Government offering the most appropriate health facilities and services. From this perspective health is a right for the individual and an interest for the community. The right established by the Constitution is both seen as the set of health services (also of a preventive nature) aimed at ensuring public health intended for the majority of the population, and as the "duty of the individual not to infringe or jeopardise with their behaviour other people's health, based on the principle that the limit of individual rights should consider mutual recognition and equal protection of other people's rights" (Constitutional Court núm. 258/1994).[1]

As regards mental disorder, the topic of safety has always been one of the most significant items on the agenda, and psychiatrists are often called upon by a scared society asking for protection from a violence which is seen as incomprehensible, unpredictable, senseless and the result of a black-out in the mind, which can be expected in the case of someone suffering from mental distress. These community requirements need to be tackled within the framework of prevention and care services provided at local level, in the vicinity, so as to involve patients, their family and the community where they live. The collective interest in mental health consists in effective programmes and services for prevention, diagnosis and care. In a better psychiatry which enables meeting others in need of help as well as providing treatments characterised by a higher level of appropriateness, which are set within a social context more open to the possibility of integrating persons who – at some point in their life – happen to be afflicted by a mental disorder; this also means avoiding any stigmatising approach.

[1] Legal literature in this regard is very extensive. A non-comprehensive list of the most interesting studies, includes the following: Carlassare, L. (1967), "L'articolo 32 Costituzione e il suo significato", in Alessi, R. (a cura di), L'amministrazione sanitaria italiana, Vicenza, Atti del congresso celebrativo del centenario delle leggi amministrative di unificazione, pp. 105 ss.; Vincenzi Amato, D. (1976), Articolo 32, 2° co., in Comm. Costituzione Branca, Bologna-Rome, Zanichelli-Il Foro Italiano, pp. 175 ss.; Luciani, M. (1980), "Il diritto costituzionale alla salute", Diritto e società, pp. 769 ss.; Pezzini, B. (1983), "Il diritto alla salute: profili costituzionali", cit., t. I, pp. 21 ss.; Romboli, R. (1988), Articolo 5. Delle persone fisiche. Artt. 1- 10, in Comm. Scialoja-Branca, Bologna-Roma, Zanichelli-Il Foro Italiano, pp. 225 ss.; Morana, D. (2002), La salute nella Costituzione italiana. Profili sistematici, Milano, Giuffrè.

In Italy, Law 180/1978, aka Legge Basaglia, was the result of a "turnaround",[2] whereby the dignity of the person — and no longer the disease — were placed at the centre of the mental distress universe, making this the focus of the psychiatric approach, of attention and action in service provision, and finally of discussion within the social framework. This law actually put an end to confinement facilities such as mental asylums, making the individual the centre of attention in respect of a suffering human being, rather than the abstract fear of the destructiveness and danger of the mental disorder from which the person is suffering.[3] [4] [5]

One of the main principles emerging from this important reform in the psychiatric sector includes the integration of psychiatric assistance, mostly oriented at local level, as part of the National Health Service; also, from an organisational perspective, therefore, there have been radical changes in this area.

The axis of psychiatric intervention underwent a substantial shift from the hospital facility to the community through the implementation of Article 118 of the Constitution, Article 7 paragraph 1 of Law no. 180/1978, stipulating that the administrative functions regarding psychiatric assistance, previously exercised by the provincial government, should be transferred to Regional Governments and to Special Statute regional administrations.

Law no. 833/1978 establishing the National Health Service and the regional implementing laws thus included departmental services for health protection, which were normally part of each local health unit, for purposes of prevention, diagnosis and rehabilitation, with multidisciplinary teams. The law, in regulating the treatment of mental illness, seemed to completely abandon the asylum-based and para-conviction approach which characterised the old law of 1904, and established a scale of values where human health, freedom and dignity prevailed over any other

[2] For an updated survey of the reform, see Associazione Antigone (2018), La riforma della sanità penitenziaria compie 10 anni: più ombre che luci, www.antigone.it/quattordicesimo-rapporto-sulle-condizioni-di-detenzione/wp-content/uploads/2018/06/XIVrapporto-sulle-condizioni-di-detenzione-riforma-sanità-penitenziaria.pdf.

[3] For many years in mental asylums at provincial level, all over Italy, you would find not only person suffering from mental disorders, but also totally healthy people, whose only fault was being a danger to society, a risk, merely a source of embarrassment. In those days Italian psychiatric hospitals also housed homeless persons, outcasts and mainly political opponents. The word manicomio, (from the Greek *manìa* (madness) and *komèo* (cure), became the best and most practical way of "getting out of the way" possible misfits, thus bypassing long and complex legal procedures.

[4] The situation of people suffering from mental disorders was regulated by Law no. 36 of 14 February 1904, entitled "Provisions on mental asylums and deranged persons. Custody and care of deranged persons". In 1902 there were 36,845 people in Italian mental asylums, a substantial increase compared to the 12.913 of 1875; this growth in numbers continued uninterruptedly; just think that in 1905, one year after law 36 entered into force, there were 39,500 people in mental asylums. The local public safety authority could order, on a temporary basis, admission to a psychiatric hospital for anyone based on two requirements: a medical certificate and emergency. This prerogative, which the law, at least *initially, stipulated just as an exception, soon became a common practice, a rule which was easily applicable and gave police forces a chance to act against individuals who were seen as a* "nuisance", without any need for those procedural mechanisms and guarantees required by the penal codes in force.

[5] Such a clear anomaly led those who were against this law to conclude that it had been written, rather than by doctors, by cops. The alliance between psychiatrists and police forces authorised the admission of people who were not "insane", but suffering from paralysis, pellagra, alcohol addiction, any form of perversion, all people who might cause scandal and who, instead, being locked up in psychiatric hospitals, stopped being a problem for the community and the family.

interest (see, in particular, Article 1, para. 2, and Article 2, para. 2, lett. g) of Law 833/78, and Article 1, para. 2 of Law 180/78). A different approach to mental health was postulated, changing the fundamental objectives of public intervention — from social control of patients to promoting health and prevention of mental disorders — which involved shifting the focus of institutional action from hospital treatment to establishing local services.[6]

The treatment of patients in hospital, following a choice expressly made by law, was thereby turned into an absolute "final resort", of a residual and transient nature, specifying the locations where therapeutic and rehabilitation actions should be conducted were Centres and services outside the hospital; for hospitalization, on the other hand, specific wards for diagnosis and care were to be created inside departmental facilities for mental health (Article 34, para. 5, Law 833/78 and Article 6, para. 2 and 3, Law 180/78).

Having regard to health visits and treatments, they are made subject to the general principle of voluntary acceptance by patients with disabilities, and – only as an exception – a streamlined procedure is established for a possible mandatory treatment (Involuntary psychiatric assessment – in Italian ASO and Involuntary psychiatric treatment – in Italian TSO), which is under the responsibility of the doctor and of the local authority in charge of public health (the Mayor), plus an external and guarantee function assigned to the Judge supervising guardianship.

The social and legal culture, since then, has progressed even further, having established the right to equal opportunities as all other citizens, through the approval of Law 67/06 which bans any form of direct or indirect discrimination against persons suffering from mental or physical disability. At international level the dignity of all persons with disabilities was restated and acknowledged by the Convention on the Rights of Persons with Disabilities approved by the UN in 2006 which was ratified by Italy with its national law no. 18/09, totally focused on the right to social and employment inclusion, with lifestyles which should be – as far as possible – similar to those of able-bodied persons.[7] In this way the expectation was to increasingly implement the movement from a medical/individual model, which only guarantees social protection and care, to a bio-psycho-social model of the disability condition based on respecting and enhancing human diversity, as well as attributing increasing importance to the context within which a person lives as a factor which can have a considerable impact on autonomy and social inclusion, fully in line with the *European Disability Strategy 2010-2020*, aimed at promoting the gradual and full inclusion in all areas of economic and cultural life.

[6] On an organisational level, this meant adding psychiatric services to general health services, thus eliminating — although taking into account the specificity of therapeutic measures — any form of social discrimination and segregation with regard to mental disability care sectors, and in order to encourage, at the same time, the recovery and social inclusion of persons suffering from a mental disorder (Article 2, para. 2., lett. g), law. 180/1978).

[7] Law 5 February 1992, n. 104 “Framework law for assistance, social integration and the rights of disabled persons” has been amended and integrated by Law 8 March 2000, no. 53, by Govt. Decree 26 March 2001, no. 151, and by Law 4 November 2010, no. 183.

Local system for social-welfare and health protection of those suffering from mental disorders

Within this context, the regionalisation of health assistance in the psychiatric area can be divided into two periods: a first phase following Law 180/1978, during which the implementation of the reform has been extended indefinitely over time, thus leading to crystallised "transitory situations" which could have been dealt with in a short time, and a second stage, that of Objective Projects, which represented a watershed towards full and effective implementation of the letter and spirit of the reform.

The ground-breaking choice made by Law 180, with the abolition of psychiatric hospitals marking a point of no return, involved the necessary structuring of a network of mental health facilities at local level, based on a totally alternative model to that of care in mental asylums.[8]

The adoption of Objective Projects was therefore a catalyst for approval by the Regional Governments of the relevant standards (laws and regulations), implementation plans and projects at regional level, aimed at defining the organisational-management aspect as well as clinical services.

The most significant aspects of the resulting interventions can be summarised as follows:

1. establishing of the Department for Mental Health (in Italian DSM) as coordination body to ensure unified and integrated psychiatric services throughout a region;
2. selecting the type of organisational components of the DSM (local facilities, hospital services, facilities for semi-residential activities and facilities for residential activities), as well as defining the relevant standards, in relation to the population;
3. outlining the functions of the DSM and of all its organisation components;
4. enabling connections with other "related" services (general practitioners, school doctors, on-call doctors, clinic, social services, child neuropsychiatric services).

This guidance has been further strengthened by the Objective Project for "Mental Health Protection 1998-2000", which operationally included specific guidelines regarding the task of mental health departments, health objectives and interventions which had to be implemented as priorities, on measurement systems aimed at ensuring that all services were sized according to requirement and demand assessments.

[8] For more details, please refer to: La salute mentale tra libertà e dignità. Un dialogo costituzionale by Stefano Rossi in Studi di Diritto pubblico 2016 Ed. Franco Angeli.

In 2013, the unified State-Region and Local Government Conference approved the "National action plan for mental health", whose lynchpin is the need to work on projects which are specific and differentiated following an assessment of individual needs, as well as on the implementation of care pathways able to take into account actual health needs, thus contributing to upgrading the organisation of facilities, the working procedures followed by the various teams, the updated clinical programmes offered to patients.

This document outlines a model to approach emerging issues and needs in the mental health sector with a view to guaranteeing:

a) accessibility, assistance provision, continuity of care and customisation of each project;
b) pathways with different intensity of care depending on personal requirements;
c) flexible services, geared towards individual needs;
d) mandatory levels of care (in Italian LEA), offered by the local health unit as a whole, and not just by the Mental Health Department (DSM) or by facilities for neuropsychiatric disorders in children and adolescents;
e) possibility of individual pathways, even as part of group activities or community actions.

The care pathways need to be implemented by specialised mental health facilities (DSM and/or services for neuropsychiatric disorders in children and adolescents), favouring a "bottom-up" approach to enhance existing good practices at local as well as regional level, at the same time encouraging exchanges with formal and informal support networks.

Within this framework, it is worth mentioning the high relevance for the purpose of their improvement and full and comprehensive actuation of the following references:

- implementing the quality of Mental Health Centres (CSM) and their ability to respond to the demand for treatment of different mental disorders, counteracting stigmatisation and reducing waiting lists, streamlining the procedures for taking care of patients, creating differential treatment pathways, following approved guidelines and procedures, based on efficacy tests;
- implementing collaboration protocols between services for adults and for the development age, to ensure therapeutic continuity when treating mental disorders in children and adolescents;
- implementing the National Mental Health Information System according to Ministerial Decree 15 October 2010.[9]

[9] The text of the Decree can be found at www.gazzettaufficiale.it/atto/serie_generale/caricaDettaglioAtto/originario?atto.dataPubblicazioneGazzetta=2010-10-29&atto.codiceRedazionale=10A13028&elenco30giorni=false.

The national mental health information system

The national mental health information system (the acronym in Italian is SISM)[10], managed by the Ministry for Health, respecting the privacy of citizens-patients, has been designed with a view, through the implementation of an information system for monitoring and protecting mental health, to achieving the creation of a database focused on the patient, from which information could be acquired regarding the characteristics of persons undergoing treatments for pathologies related to mental health. In order to allow for the transmission of data, each regional government/public administration has to appoint a safety officer, as regional contact person in charge of managing patients who have access to the "mental health" system for the region in question. In order to provide for a unified data measurement system by regional information systems, both a document outlining Specific Functions and an operational Manual were then drafted, listing the characteristics and rules for uploading information, with a view to making sure that their content could be properly assessed according to the technical specifications appended to Ministerial Decree of 15 October 2010.

SISM is part of the wider New Health Information System (NSIS), which derived from the need to share – at both national and regional level – a wealth of data, rules and methods, in respect of measures for quality, efficiency, appropriateness and cost, in support of National Health System management, monitoring of essential levels of care (LEA)[11], and of the health budget, as well as being an important source of support for clinical-operational decision-making through an advanced analysis of levels of care.[12]

Legal capacity and safeguards for mental disability

In order to protect people with a reduced capacity (disabled) or totally unable to make decisions (debarred) due to a confirmed mental disorder, and for those with limited independence there are several legal alternatives.[13]

The protection of persons unable to make decisions, and therefore take care of their own interests is guaranteed through others with legal capability. These persons, depending on the extent of the inability, are called upon to replace or help those who are incapacitated by

[10] See the institutional website www.salute.gov.it/portale/temi/p2_5.jsp?lingua=italiano&area=sistemaInformativo&menu=mentale.
[11] For more details about levels of essential care, see www.salute.gov.it/portale/temi/p2_5.jsp?area=programmazioneSanitariaLea&menu=lea.
[12] See the institutional website www.salute.gov.it/portale/temi/p2_4.jsp?lingua=italiano&tema=Piani,%20finanziamenti%20e%20monitoraggio%20del%20SSN&area=sistemaInformativo.
[13] For a synthetic and synoptic sheet, see www.risorsasociale.it/files/pages/Amministratore_di_sostegno/Sintesi_delle_forme_di_tutela.pdf.

performing the necessary actions to manage their assets and social life. Such protection can be arranged through:

- parental responsibility over children;
- guardianship of children (who have no parents) and those judicially or legally debarred;
- trusteeship to compensate legal capacity;
- tutorship for people who are totally or partly dependent.

Parental responsibility and the protection of children without parents

"Parental responsibility" (or the authority of parents) consists in the power-duty on the part of parents to "protect, educate, teach their non-emancipated minor children and to take care of their assets". The said authority is exercised by mutual agreement between the parents, and, if there is any disagreement on matters which are particularly relevant, each parent may resort to the judge (Family Court), who will suggest the most appropriate solution in the interest of the children and of the family. In the case of children whose parents are either dead or unable to exercise authority over their children for other reasons, as well as of those who have been judicially or legally debarred, a guardian needs to be immediately appointed. With regard to the administration of property, it should be noted that:

- the guardian only engages in the routine management of the assets, and in actions necessary for maintenance and social life;
- for actions beyond routine management, authorisation by the supervisory judge is required (Article 374 Civil Code);
- the guardian is entitled to dispose of the assets with the authorisation of the court, after having consulted with the judge supervising guardianship (Article 375 Civil Code).

Trusteeship

The intent of the incapacitated person is integrated by the action of a trustee. Trusteeship is thus different from guardianship in the following respects:

- the trustee is not a representative, but rather an assistant: this means thus the function here is not to replace but to compensate the intent of the emancipated and disabled person;
- the activity of the trustee is not relevant for all official actions but only for some of them;
- the trustee (unlike the guardian) just takes care of asset-related interests. Special trusteeship involves both "caring for the assets" of the individual, and "caring for personal needs".

The authority of the special trustee (detailed by law in each case) is much wider than that of the ordinary trustee, indeed it may include a wider or more restricted set of representation powers and taking care of interests which are not related to assets.

Tutorship

This option was introduced through Law 6/2004 to protect people in difficulty, while at the same time imposing as few limitations as possible on their legal capacity. Article 404 of the Italian Civil Code, as amended by this law, stipulates that those who – as a consequence of infirmity or of physical or psychological impairment – are even partly or temporary unable to take care of their own interests, may be supported by a tutor, appointed by the Judge supervising guardianship. In order to appoint a tutor, there needs to be an infirmity or physical or mental impairment in the broad sense of these words. Therefore, it includes not only mental diseases but also a wide range of intellectual disabilities, for example mental retardation, brain damage, autism, Down syndrome, etc. The court decides which actions may be performed by the tutor in the name and on behalf of the person in difficulty, and those which the person in question may perform with the support of the tutor. The tutor, in turn, for some important choices such as the sale of assets, needs authorization from the judge. In any case the person may independently perform only actions necessary to meet daily life requirements, for example buying goods for personal use (food, clothing) or collect a monthly pension.[14]

It is also worth mentioning Law 112/2016, also known as the law about "Dopo di noi" ["After us"], which affirms that the protection of persons with disabilities is a strong social need. It is important to have suitable tools to safeguard persons with disabilities throughout their life, guaranteeing not just moral support but also being materially mindful of their dignity. With this law important tax relief measures have been introduced to support all actions geared towards safeguarding persons suffering from serious disabilities.[15]

Legal status of persons with psycho-social and intellectual disabilities in the area of criminal law

One of the pivotal elements in the Italian penal law system is that of culpability (*nullum crimen, nulla poena sine culpa*); alongside the typical and unlawful event this is indeed the third element which constitutes a criminal offence.

According to paragraph 1 in Article 27 of the Italian Constitution, "all penal responsibility is individual". This is then clarified even better later on in Article 27: "Penalties shall not involve treatments which go against the sense of humanity, and they should be aimed at re-educating the guilty party".

[14] For a more in-depth analysis, see also www.notariato.it/sites/default/files/Guida_Dopo_di_noi.pdf.
[15] See footnote no. 13.

This wording (which was approved after lively debate) confirms the educational purpose of any conviction which presupposes that the person should be blamed.

If the Government merely punished an individual for having caused an event leading to an injury, without considering its psychological connections, the said Constitutional provision would appear senseless. It would be sufficient to merely have caused a harmful event to justify a penalty, which would have deviant consequences: just think for example of the ensuing proliferation of court actions and the subsequent increase in the number of convicts, not to mention the feeling of injustice which, for obvious reason, the person convicted would feel.

The regulatory concept of culpability has been reviewed over the years and, apart from the reference to the motivation process suitable to graduate the severity of guilt, there has been the addition of a component which could be defined "strictly speaking more psycho-personal": chargeability. This legal category refers to psychological functions which necessarily have to be present in a person in order to reach a judgement of culpability.[16]

Having regard to a guilty person suffering from a mental disorder and who is not of sound mind, in the Italian penal system there is what is also known as "dual track"[17]: this is a mechanism in the legislation whereby those who have committed an offence as a consequence of mental disorders are acquitted and, if they are considered a danger to society, specific safety restriction may be imposed on them.

For those who are partly of sound mind and therefore chargeable and/or convicted, even though with a reduced sentence because of their not being totally of sound mind, this additional safety restriction may be imposed only after the penalty has been served in full or the statute of limitations has run out (Article 211 Penal Code).

Anyone whose sentence has been reduced due to their being partly of sound mind, may serve the sentence in question in institutions or divisions for people suffering from mental infirmity or impairment whenever their conditions appear incompatible with a term in an ordinary jail.

[16] For a more in-depth analysis of the issue of chargeability in case of personality disorders, see: Polichetti, G.B.I. (2018), Il problema dell'imputabilità nei disturbi di personalità, Psicologia & Giustizia, Anno XIX, Issue 1, January-June 2018, www.psicologiagiuridica.com/pub/docs/anno%20XIX,%20n_1/6_%20Polichetti%20-%20Il%20problema%20dell%27imputabilità%20nei%20disturbi%20di%20personalità.pdf.

[17] Considering the extent of the bibliography, reference is made only to the main monographic sources: Caraccioli, I. (1970), I problemi generali delle misure di sicurezza, Milano; Musco, E. (1978), La misura di sicurezza detentiva. Profili storici e costituzionali, Milano; Fioravanti, L. (1988), Le infermità psichiche nella giurisprudenza penale, Padova; Bertolino, M. (1990), L'imputabilità e il vizio di mente nel sistema penale italiano, Milano; Manna, A. (1997), L'imputabilità e i nuovi modelli di sanzione. Dalle "finzioni giuridiche" alla "terapia sociale", Torino; Collica, M.T. (2007), Vizio di mente: nozione, accertamento e prospettive, Torino; Pelissero, M. (2008), Pericolosità sociale e doppio binario. Vecchi e nuovi modelli di incapacitazione, Torino, 79 ff. For a more in-depth analysis and further bibliography, see also www.law.unc.edu/documents/faculty/adversaryconference/doppiobinario-italiano-pelissero.pdf.

These persons, as soon as their pathological conditions appear to have been resolved or significantly improved, are transferred to an ordinary jail, possibly after a trial period.

Chargeability[18]

Article 85 of the Penal Code lists the chargeability criteria for the offence and for punishability of a person.

According to this provision "*nobody can be punished for an action which the law considers an offence if, at the time the said event was committed, the person was not chargeable*". Paragraph two reads as follows: "*In order to be chargeable a person needs to be of sound mind"*.

Culpability therefore necessarily presupposes that the person, at the time the offence is committed, is either of sound mind, or – if this is not the case – not considered chargeable and thus not punishable (which means that no penalty may be levied for the crime under penal law), even if the action actually constitutes a criminal offence.

Being of sound mind refers to the ability of a person to understand the significance of their actions, as well as any moral, legal and factual consequence which such actions or failures to act may have on the outside world; this obviously also implies a cognitive capacity as well as the ability to make forecasts.

This is different from ignoring that an action is actually against the law, because Article 5 of the Penal Code clearly states that "*nobody may use as an excuse the ignorance of penal law provisions*". On the other hand, being of sound mind involves the individual ability to make free and independent decisions, thus implying an element of volition, related to achieving a purpose, which follows the correct representation and perception of reality. The Penal Code considers typical instances where chargeability is limited or excluded, taking into account situations where the person can be presumed incapable of making independent decisions. The individual ability to make choices may be limited or excluded:

- in cases of acute intoxication because of drug or alcohol abuse in occasional circumstances or due to force majeure (Articles 91-93 Penal Code);
- in the case of persons who are over 14 but under 18 years of age, who are still considered immature and therefore, at the time the offence was committed were unable to decide (Article 98 Penal Code);
- if the condition of not being of sound mind of guilty party was caused by others;

[18] Fiandaca-Musco (2015), Diritto Penale, parte generale, Zanichelli, seventh edition; Antolisei, F. (2016), Manuale di diritto penale. Parte generale, Giuffrè. For more recent in-depth surveys see also www.deiustitia.it/cms/cms_files/20180228063350_xmpl.pdf.

- in those cases where the person, at the time the offence was committed, was suffering from a type of infirmity which excluded being of sound mind (Article 88 Penal Code): "A person cannot be charged if, at the time the offence was committed, they were suffering from an infirmity which caused them not to be of sound mind";
- if the person, when the offence was committed, was suffering from an infirmity which reduced their being of sound mind (Article 89 Penal Code): "if, when an offence is committed, the person responsible was suffering from an infirmity which greatly hindered their ability, without excluding their being of sound mind, they shall be held accountable, but a reduced sentence will be levied".

Having regard to the two final bullet points, mental disorders must be so strong and serious as to rule out any unified action and intent which is the prerequisite for a crime. There are several disorders which, if there is a causal connection which is adequate and provable, may lead to an acquittal because of the accused not being of sound mind. Schizophrenia, manic-depressive psychosis, major depression, paranoia, dementia, mental retardation, are all disorders which jeopardise the functions of the Io and thus constitute prerequisites for limited or no chargeability.

On the contrary, penal responsibility is always excluded under fourteen years of age (Article 97 Penal Code) because of their being an absolute presumption of the person being unable to make independent choices: *Nobody who is under fourteen years of age when a crime is committed, is considered chargeable.* In this case only the application of possible safety restrictions may be considered.

Custodial and non-custodial measures during the criminal proceedings

Safety measures

In the case of social danger, the judge responsible for examining the legal case, can choose[19] the most suitable security measure also on a provisional (precautionary) basis, as provided for in Article 206 (Provisional application of security measures), in the awareness of the length of the process, and the impossibility of keeping in prison a subject recognised as complete mentally ill, or of being able to perform a security measure against the semi-mentally ill only when he has fully served the criminal sanction (despite the reduction due to the mitigating factor of the semi-infirmity) (Article 211 of the Penal Code).

In relation to the type of security measures applicable to children under the age of 14 or over the age of 14 and under the age of 18, if found as not chargeable and who have committed an act referred to by law as a crime and have been deemed dangerous, for forms of imprisonment in the silence of the Penal Code regarding the minimum age for application, on the basis of common experience, it is considered that before the age of 12/13 the child has neither the autonomy nor the capacity to inflict sufficient harm to escape parental supervision so the Article 224, paragraph 1, of the Italian Penal Code is indicated as the only possible form of detention: admission to a reformatory.

If the security measure cannot be executed, the minor can be assigned to the social services of a child in a correctional facility or to a pedagogical institute or in a psychiatric hospital; in any case, it is only a rehabilitative measure (probation).

Therefore, with the exception of minors, personal safety measures are generally divided into custodial and non-custodial measures.

These are detention security measures:

1. the assignment to a farming establishment or to a work-home;
2. admission to a nursing home and custody;
3. admission to a mental asylum;
4. admission to a judicial reformatory.

With regard to these custodial security measures, for the sick and semi-minded, the Law 30.5.2014 n. 81 led to the effective replacement of judicial psychiatric hospitals and nursing

[19] For an extensive study and bibliography see Argenio, M. (2018), The uncertain foundation of social danger, in Criminal law, in Law & Rights www.diritto.it/fondamento-incerto-della-pericolosita-sociale/.

homes, with REMS (Residences for the Execution of Security Measures, provided for in Decree Law 211 of 2011, converted with L. n. 9/2012) introduced – without having inserted them into the Penal Code – two important rules:

- one puts a time limit on security measures,
- the other dictates the principle – also taken for granted – that the custodial security measure may be only arranged when the other measures are inadequate. Since the admission in REMS must be considered an instrument of last resort, usable only where the non-custodial security measures are absolutely not practicable⇥

These are security measures without detention:

1. probation;
2. prohibition of residence in one or more municipalities, or in one or more provinces;
3. prohibition of going to pubs and public alcohol outlets;
4. expulsion of the foreigner from the State.

Mental Health Departments have become fully-fledged **owners of therapeutic and rehabilitation programmes** in order to implement, as a rule, custodial and non-custodial treatments in territorial and residential settings.

In 2017, the Superior Council of the Magistracy reiterated the need for "*the* **judging offices** *to maintain a relationship of constant collaboration, exchange of information and* **a widespread knowledge of the network of mental health services** *which are part of the DSM to which Law no. 833 of 1978 assigns the responsibility for prevention, treatment and rehabilitation of mental health problems*". **And this should allow the judicial authority to** *"address the non-attributable to a therapeutic programme appropriate to the individual case, to shape the security measures from the moment of pronouncement in the criminal process, to respect the fundamental link between the territorial fabric of origin and the execution of the measure"*.

The magistrate is therefore required to adopt an approach to the subject that presupposes particular knowledge, even if not strictly 'legal', and that in this perspective, **justice and health must always 'talk to one another'**: in essence, when a file is opened for a patient or alleged offender patient, at that same time the magistrate must activate the mental health service immediately must therefore build a **working group** that will develop a therapeutic project, imagining care pathways and not places where people stay.

Most recently with the **resolution of 24 September 2018** it again intervened *"in continuity with decision of 19 April 2017"* underlining once again the absolute necessity that *"the reports of knowledge of the therapeutic and rehabilitative offer on the territory [...] are firm and constantly updated"*. With this resolution, taking note of the not yet complete, effective and satisfactory degree of realisation of the system governed by the Law n° 81 of 2014 and of the principles

therein sanctioned, the Superior Council of the Judiciary has intended to deepen the aspect relative to the **formalisation of agreements through the signature of protocols between the institutional subjects involved in the management of the security measures for the not chargeable**, *"in order to confer to the already hoped-for collaboration between the public and private organisations involved, a stable character and a structured form"*.

In fact, a consequence in relation with the aforementioned principles, in particular, that of the residual nature of the detention security measure. The importance of a "*full integration between the mental health services on the territory and the judicial order*" and, in particular, the **recognisability by the judicial bodies of the therapeutic and rehabilitative offer on the territory**: this is in order to allow the judicial body, from the first moment of contact with the mentally ill offender, a useful and conscious choice of measures to be taken in practice to address the social danger giving priority to the needs of care and social inclusion of the same, given the undesirable effects and overall imbalance for the maintenance of the system of the mere neutralising custody.

From this perspective, the Operational Protocols constitute a valuable working tool, of **integration of the judicial process in each of its phases**, also those characterised by greater criticality (from the choice of the measure in concrete application to the management of the acuity of the author of the crime and to the execution of the measure in course), which contributes to avoid the recourse to the application of a *"massive and indiscriminate access to REMS because of the absence of concrete alternatives"*.

So, on the basis of the data collected and on the basis of the experience already gained in virtuous realities, a **content of the minimum constant content of the Operating Protocols**, has been elaborated, concerning the subjects involved, the type of solutions, the timely effectiveness and the phases of the procedures to be referred to, the residual principles to which the protocols must be inspired and the aspect of joint training and monitoring of the executive phase.

Residences for the execution of safety measures (REMS) for the non-chargeable

The reform provided for under Law 81/2014 can now be said to have definitively come into effect. On February 1, 2018, the National Authority of the rights of persons in custody or deprived of their liberty, signed an agreement with the Campania Region that allows access to the information System for monitoring the overrun of psychiatric prison hospitals (OPG), called "SMOP". The System, which consists of a shared IT platform between the Rems of the Regions that have signed the agreement and the territorial social-health services, mainly allows to monitor the presence and the inflow and outflow of guests in these residences.

From the point of view of data collection, the SMOP system (Information System for Monitoring the Overrun of PCOs and Prison Health Services), implemented by the Campania Region, allows to monitor the overall 'state of health' of Rems.

As of March 15, 2018, however, we have no improvement over 2017, the numbers remain perfectly in line with the previous year. In the 30 Italian REMS, 599 people are hospitalised, 54 of whom are women (9 %, almost twice the percentage of women detained in prison). The number of participations corresponds to the places available.

Regarding the previous year, patients with an interim safety measure rose to 274, increasing by 22 % to 45.7 % of the total.

The interim security measure ex Article 206 Penal Code corresponds to the pre-trial detention pending a final sentence and should therefore constitute an exception, the last resort at the judge's disposal. In prison, 34 % of the total are not permanent inmates, ten percentage points less than temporary inmates.

Another indicator of the state of health of the REMS system is the analysis of entry and exit flows from January to December 2017. In the case of admissions, it is an index of the orientation of the judicial Authority and of the capacity of the institutions involved to make truly effective the provision of law for which the REMS should constitute the last resort, in a progressive and temporary perspective (and not become a 'white life imprisonment' as was the case in the past, before the approval of Law 81/2014). In the case of resignation, this is a symptomatic index of the institution's ability to find and build paths that involve other 'structures' of the territory (above all, the specialised psychiatric communities) and that point to freedom, and therefore to the complete rehabilitation of the person. The balance between admissions and dismissals is unbalanced towards the former. In 2017, 46 more people entered the REMS circuit than those who left.

Among the admissions, it is interesting to note that 97 (26 %) came from prison, confirming a connection between the penitentiary question and the REMS question. Obviously, as a direct result of the OPG closure, the 'safety valves' on which the prison 'offloaded' the most troubled cases, has disappeared. In terms of the dismissals, it should be noted that more than half (180, or 54 %) are actually transformations from the custodial security measure (such as admission to REMS) to the non-custodial security measure (in the form of probation). This means that most of those who leave REMS continue to be subject to an institutional (and criminal) control, but in other structures (communities, apartment groups, clinics, nursing homes). This is the well-known phenomenon of the 'transitionalisation', whereby certain subjects tend to enter into mechanisms such that some form of 'control' lasts forever.

In Italy, the Authority of people held in custody or deprived of personal liberty[20] published its Report to Parliament in 2018.[21]

Three aspects have affected the activity of the Authority:

- The first concerns the never-ending attempts to reduce the scope of the reform process that has begun, with the risk of reproducing even in better facilities, with a limited number of patients and widespread in the territory, a logic that recalls, however, the indistinct hospitalisation.
- The second aspect concerns the need to contain the use of hospitalisation in REMS within the numerical margins of the actual need.
- Thirdly, it concerns the results of the visits carried out and the difficulty of retraining staff that have worked for years in structures that made reference to this logic.

As for the first aspect, the National Authority has had the opportunity to express its dissatisfaction with the prospects of regulatory reform (wording of Article 1, paragraph 16, letter d) of the authorisation law of delegation no 103 of 23 June 2017 No 103).

Such perspectives foresee, in fact, that REMS can be assigned not only to those who serve a security measure as they are not imputable, but also to those who, being detained – and, therefore, chargeable – have developed problems of mental discomfort during the course of the execution of the sentence. The National Authority does not agree with this approach and considers that the distinction between incarcerated and detained subjects (for whom, however, a psychic link with the crime committed was ascertained) must be maintained, while assuring both types of subjects of plans for taking charge of a therapeutic-rehabilitative type in full respect of the right of each to what is guaranteed by Article 32 of the Constitution.

The provision of 'mixed' territorial structures runs the risk of reproducing the all-encompassing logic typical of past judicial psychiatric structures. He therefore asked that current and future Governments do not exercise the delegation with respect to this point.

As for the second aspect, it is stressed by the frequent "cries of alarm" about the measurements not carried out due to unavailability of places in the current Rems. By April 2018, 625 people had been admitted to the Rems, of whom 236 had been interned with provisional safety measures and 387 with definitive safety measures. Of these, 61 are women and 564 are men. From the data drawn from the measures issued by the Judicial Authority of application of the measure of

[20] In Italy, a process that began in 1997, led to the establishment of the National Authority regarding the rights of persons detained or deprived of their personal freedom at the end of 2013, but the appointment of the College and the establishment of the Office, which allowed the effective operation, took place only in the first months of 2016. See institutional site www.garantenazionaleprivatiliberta.it/gnpl/.

[21] The report is available at www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/29e40afbf6be5b608916cad716836dfe.pdf.

security – definitively or provisionally – it turns out that 441 persons were, as of March 31, 2018, waiting for hospitalisation in the structures territorially competent for unavailability of beds.

The third aspect, which emerged from the visits, concerned the unripe forms of application of the law, even in a context of many positive experiences started: some regions have no Rems, others have adopted reconversions of psychiatric hospitals that are not adequate and with aspects that recall the past.

Changes in the Italian Prison Administration for the prevention of distress in prison[22]

Since 2012, the Prison Administration, taking into account the rulings of the Court of Strasbourg and the enquiry of the Senate Commission that intervened on the OPG, has started a discussion on a new detention model based on the empowerment of staff and detainees and on the collaboration of the territorial support network.

With regard to the effects of detention on the psychological balance of prisoners, the content of the 'Guidelines for the reduction of self-inflicted harm and suicide risk in prisons' approved by the Unified Conference of 19 January 2012, and a study has also been carried out on the effectiveness of the Protocols signed by the regional Authorities of the Prison Administration to ensure an integrated system of prevention and to promote plans of intervention on distress and the prevention of suicide in every penitentiary institution. From this study it emerged that the effectiveness of such interventions in all Italian regions is hampered not only by a general framework of scarce resources, but also by organizational fragmentation, with a rigid division of responsibilities and the consequent uncertain assessment of responsibilities.

A constant monitoring of the behaviours, which revealed especially high levels of discomfort, was also started by increasing the collection in real time at the Situation Room of the DAP of data relating to the so-called critical events. These data concerning the most serious and repeated incidents, after the necessary in-depth analysis, are transmitted to the Surveillance Offices.

Finally, the Unit for Monitoring Suicide Events (UMES) was re-established, with the task of verifying the trend of statistical data and investigating individual suicide events through the knowledge of the biographical data of the person who took his life and of his detention conditions.

[22] See Palmisano, R., Report under the project ME.D.I.C.S: Mentally Disturbed Inmates Care and Support, www.giustizia.it/resources/cms/documents/I_Relazione_Resp.Progetto.pdf.

The role of volunteers has also been enhanced to reduce the distress in prison, especially at the time of admission.

More recently, on November 25, 2015, the GDAP circular letter 0425948 was issued concerning 'knowledge of the person through organizational processes: indications to better prevent critical situations'[23] and on February 4, 2016, the circular GDAP 042087 'Measures for the prevention of suicides of persons detained'[24] was adopted which, among other things, in line with the opinion drawn up by the Director of the Studies Office on the use of cells without furnishings, urge coordination between the various professional figures and not to allocate the detainee in a single cell.

The Administration has above all undertaken a deep reflection on the models of custody and on the necessary interventions in the organisation of detention, to improve the quality of time people spend in prison, thus initiating a process of profound change.

The fundamental core of the new detention model is the differentiation of prison institutions with allocation of prisoners in separate institutions and sections by homogeneous groups in order to identify precise objectives for each of them and direct treatment in relation to the specificity of each structure, including through training of staff oriented to the various purposes pursued. The goal was to create the conditions for each prisoner to spend most of their time outside the cell, in canteens and spaces dedicated to common activities where their accountability is encouraged, and made more effective observation of the workers of various professions.

Rehabilitation, treatment and evaluation of the prisoner's journey to prison depend first and foremost on the detention conditions and on the respect given to each person's specific identity. Not only work, education, cultural or sporting activities have a purpose of resocialisation but concretely everything in the organisation of prison life, from the use of spaces, to the rules of being together, to the ways in which relationships with family members are made possible (restructuring of the spaces dedicated to talks, especially with children, communications via Skype, etc.) and with the 'outside society', must be designed and implemented in order to develop a perspective of life and conduct in harmony with the rights of others.

The interaction of prisoners in common living spaces with group dynamics entails significant changes in interpersonal and hierarchical relations within the penitentiary institute, but above all it reproduces, on a small scale, the relational context that most resembles the condition of life in freedom. In the group-community there are tasks, intervals, responsibilities to be shared and shared, there is also the possibility to think and discuss about programmes and activities to be

[23] Available at www.ristretti.it/commenti/2015/dicembre/pdf8/circolare_dap.pdf.
[24] Available at www.ristretti.it/commenti/2016/novembre/pdf6/circolare_suicidi.pdf.

carried out, in short, in the community group there is life. In this way, the prisoner does not have a foreign organisation as his sole interlocutor and does not close in on himself.

The group is capable of playing a supporting role or to report alarming facts by acting as a filter and mediator between the needs of the individual and the complex and tiring reality of life in detention conditions.

The implementation of the new model, with emphasis placed on common areas and treatment activities, aims to make the imprisonment experience more liveable and will predictably reduce the discomfort of prisoners, which often leads to self-harm or suicide. The Health Administration is also committed on the psychological distress front, and a technical working group has been set up at the Ministry of Health for the prevention and management of suicide problems, which has initiated a permanent monitoring of the situation and in particular of the level of application of the principles expressed in the Unified Conference of 2012.

A study was also carried out involving six Italian regions on the health needs of 16,000 prisoners (1/3 of the prison population), which showed that the mental health problem is highly relevant and affects more than 40 % of prisoners.

Psychiatric pathology in prison

One of the most extensive and detailed researches carried out in Europe on the existence of mental disorders in prisons, was carried out in Italy in Sollicciano and Montelupo, between 2001 and 2002, in collaboration with the University of Florence.[25] The data of the research reveal the making of the psychopathological clinic, announcing a very high self-injury inclination, which today has become the most conspicuous problem of the penal institutions.

This research, as early as 2002, has shown, in the meantime, the worrying rise of the disorders of Axis I of the DSM within the prisons (with a prevalence of 46.7 % on new-joint subjects), then the very high incidence, among the disorders of Axis I, of Major Depressive Episodes (new-joined subjects 24.8 %), finally the very strong incidence of the serious Personality Disorders (not only of the Antisocial Personality Disorder, but also of the other Disorders, of the Borderline and of the Paranoid in particular). The data released by the Regional Health Agency of Tuscany in 2013, regarding the health state of prisoners in the Region for the year 2012, confirm those of the *Large-scale Research* on Sollicciano and all international literature: '71.8 % of prisoners in Tuscan prisons are affected by at least one disease. The most common is mental disorder, which affects 41 % [of prisoners]'. The data released by the Regional Health Agency of Tuscany in 2015,

[25] It has been published in Il reo e il folle n° 30/31 of 2008, monographic issue on La Grande Ricerca and reported in the studio 'Il reo folle e le modifiche dell'ordinamento penitenziario' by Mario Iannucci and Gemma Brandi 2018, available at www.penalecontemporaneo.it/upload/7529-iannuccibrandi218.pdf.

regarding the health state of 16,000 prisoners held in 57 Italian prisons, confirm those of the *Large-scale Research* on Sollicciano and the entire international literature: 'More than 70 % of prisoners are affected by at least one disease [...] The first pathology, which involves 24 % of the inmates of the survey, is substance dependence [...] More than 40 % of the prisoners enrolled are affected by at least one psychiatric condition [...]'.

These epidemiological data, obviously, do not only concern the population detained in Italy. The international data coming from many other western countries are comparable to the Italian data. One of the latest articles published in *The Lancet*, highlights the "*crisis of mental health in prisons of the United Kingdom*"[26]: *"It is estimated that two thirds of prisoners suffer from personality disorders, about half suffer from depression and anxiety and one in twelve suffer from psychosis. The situation is deteriorating*: *120 suicides in England and Wales in 2016, almost twice compared to 2012*". Seena Fazel and others, in a review[27] appeared a year earlier always on *The Lancet*, had provided slightly lower data on the prevalence of mental illness in prisons, basing their results on a systematic review of a whole series of studies on the mental health of prisoners carried out between 2003 and 2015.[28] According to epidemiological studies carried out a few years earlier in some Italian OPG[29] dated but significant, something had been specified regarding psychiatric diagnoses: 70.1 % of the inmates had a diagnosis of schizophrenia or delusional disorder or 42.4 % were institutionalised for murder or 32.2 % for other serious crimes against the person. A point remains established in ordinary penal institutions is crowded an impressive number of people suffering from serious psychiatric conditions. If only we were to stick to the estimates made in the United Kingdom by Talha Burki on *The Lancet*, among the 60,029 prisoners in Italian prisons at 31/12/2017, as many as 5,000 would suffer from psychosis and about 30,000 would suffer from depression and anxiety. Not to mention drug addiction (psychiatric diseases for all intents and purposes, according to the DSM and the ICD) and personality disorders.

The closure of OPGs, in addition to the progress that it has made, has nevertheless left an unresolved point regarding the mental illness that has occurred during detention: the possibility

[26] Burki T. (2017), Crisis in the UK Prison Mental Health, in The Lancet, Vol. 4, No. 12, p. 904, Dec. 2017, v. abstract.
[27] Fazel S. et al (2016), Mental health of prisoners: prevalence, adverse outcomes, and interventions, in Lancet Psychiatry 2016, July 14, 2016.
[28] Table 1: Prevalence of different psychiatric diagnoses in adult prisoners based on systematic reviews

	Men		Women	
Disorder	Prevalence	95 % CI	Prevalence	95 % CI
Psychotic Illness	4 %	3-4	4 %	3-5
Major depression	10 %	9-12	14 %	10-18
Alcohol misuse	18-30 %		10-24 %	
Drug misuse	10-48 %		30-60 %	

[29] Fioritti, A., Melega, V. et al (1999), Violence and mental illness: a study on the population of three Judicial Psychiatric Hospitals, Il reo e il folle 1999; 9-10: 137-48.

of interruption of execution of the sentence for a person with serious mental illness, in analogy with what happens in the case of serious physical infirmity that has occurred to the convict. The current Article 148 of the Penal Code, in fact, reserves for such cases the admission to the judicial psychiatric hospital now dismissed and replaced with the REMS but exclusively for those who are not chargeable.

It occurs that is the impossible to allocate the subjects attributable to REMS, on the one hand, while there is the **legislative barrier** that excludes mental illness from the scope of application of Article 146 (mandatory deferral of the penalty), provided only for physical illness.

The call of the CSM in the last Resolution of September 2018 appears to be significant[30] a **need for a systematic offer of mental health protection in prison by departmental services**, especially in a system that has remained unchanged since the legislative process has not been completed that should have resulted in the reformulation of Article 147 of the Penal Code and in the repeal of the Article 148 of the Penal Code.

It is essential – **while awaiting the desired intervention of the Constitutional Court**, to which the documents were sent by the Criminal Section I of the Supreme Court of Cassation with the very important ordinance 13382/2018[31] – that the psychiatric services of prisons and mental health. Departments pay the utmost attention to **people, with psychiatric problems that have arisen, which are not guaranteed, in the absence of codified and logistical solutions, any escape of treatment from the prison**. This is in clear contrast with the provisions for prisoners suffering from physical infirmity.

Such lack of alternatives to imprisonment of a person with a mental illness raises doubts as to the constitutional legitimacy of Article 47-ter of the Italian Civil Code. 1-ter, **with reference to the requirements of Articles 2, 3, 27, 32 and 117 co. 1 Cost.** and of total unreasonableness **of a legislative system** based on the strict conceptual distinction **between physical infirmity and mental infirmity**, seen as an overall assessment of the impact of the pathological condition on the inviolable of the human rights to the appropriateness of both medical treatment and medical assistance.

[30] Operational protocols on psychiatric safety measures (Resolution of 24 September 2018), available at www.penalecontemporaneo.it/upload/2746-csm---risoluzione-opg-2018.pdf.

[31] For a review of the aforementioned provision see Cass., Sec. I, ord. 23 November 2017 (dept. 22 March 2018), No 13382, Pres. Bonito, East. Magi, ric. Montenero, with editorial note (www.penalecontemporaneo.it/d/5954-la-detenzione-domiciliare-come-modalita-di-esecuzione-della-pena-nei-confronti-di-soggetti-imputabi) in this *Magazine*, 4 April 2018. With the above-mentioned order, the Supreme Court raised a question of constitutionality with reference to Article 47-*ter* co.+1-*ter* ord. Pen. So far as this rule does not stipulate, as possible, the application of home detention (as an exception to the ordinary limits of punishment and type of crime) in the event of recurrence of psychological disorder occurred at the time of conviction.

For years, mental disorder has certainly been the most frequently detected pathology within prison facilities, and having a reliable map of the distribution of mental health conditions in prison institutions is still difficult today.

In order to guarantee the right of persons detained to mental health, in the best possible way, as also supported by the Authority,[32] the approach to 'mental health' protection should as soon as possible be based on the following guidelines:

a) Equal treatment of physical and mental illnesses in access to suspended sentence. Thus, the difference in treatment between persons suffering from serious mental illness during the period of detention and those suffering from serious physical illness is exceeded. The line identified determines the equality of the two diseases and puts an end to this discrimination.

(b) The provision of sections specifically referring to mental infirmity that occurred during detention, to be added to the existing intensive assistance units (SAI) for physical illnesses; in this way, prison health management is strengthened with a decisive role for the Local Health Authority. With the overcoming of the judicial psychiatric Hospitals, in addition to the Rems, the law provided, in fact, for the establishment of Wards, called 'Articulation for the protection of mental health', carried out in different institutions with different outcomes, from the positive level in full connection with the local health authorities and that of mere change of labels to sections actually intended only for psychiatric observation. The guideline instead provides real departments within the Institutes, but with exclusive health management, for the care of people with mental distress. This is also in order to overcome the tendency to constitute external multifunctional structures distorting the meaning of REMS.

c) The continuity of health treatments in progress outside or inside the Institutes in case of transfer, possibly with the implementation of digital documentation. The construction of a digital medical file, which can be managed on a platform capable of connecting the health services of the various regions, is an objective to be pursued, also in order to ensure the therapeutic continuity of the people detained, in the event of inter-regional transfers. A clear objective, but not easy to pursue, given the different digital modes adopted over the years by the different regional services.

For psychological and psychiatric disorders, the general regulatory framework in force so far provides that the Institute is present 'at least one specialist in psychiatry' (Article 11 o.p.), psychologists, social workers and clinical criminologists ex Article 80 o.p. It also provides that the 'newcomers' must have a psychological interview at the same time, at the first medical examination, and that, in the event of particular distresses, prisoners receive support, in

[32] Authority of persons detained or deprived of their personal liberty, Report to Parliament in 2018, page 210 et seq. See note 21.

accordance with the general regulatory framework currently in force. This is a weak support, as the National Authority has been able to verify on several occasions during the visits. It focuses mainly on the work of the official in the legal-pedagogical area, of the staff contracted under Article 80, frequently for a few hours a week and low pay, and, often, of volunteers.

Procedural rules and practices applicable to offenders with psycho-social or intellectual disabilities

Assessment of the state of non-compos mentis[33]

The expert assessment of the cognitive and volitional capacities of the accused at the time of conduct is one of the fundamental junctures in which a ruling on criminal responsibility is articulated. Emblematic of the necessary cooperation between subjects, competences and different cognitive tools involved in the procedural verification phases, this moment is inevitably conditioned by specific methodologies and new acquisitions progressively accepted in the scientific field, which make the specialisation of competences more and more accentuated and the distance between the various protagonists of the trial increasingly prominent. In this scenario the role of the expert is crucial. He/she is requested to introduce in the cognitive patrimony of the trial subjects' "certainties" relating to human behaviour and the limits within which this, under particular critical conditions, may be subject to rational control.

The psychiatric examination is conditioned by the manner and circumstance of a committed crime: the more it appears "absurd" and "monstrous", the more likely it is for the judge, the Public Prosecutor or the lawyer to request it. Precisely, the subjects legitimised to the request are:

- the judge,
- the Public Prosecutor, or
- the lawyer (a private one or appointed by the court).

The expert or consultant appointed by the court will generally be asked to rule on three questions: 1. "Please inform us, having examined the documents of the case, having visited (name and surname), having performed all the clinical and laboratory tests that you consider necessary and appropriate, what were the conditions of mind at the time of the event for which it is proceeded; especially if the full possession of the subject's faculties was excluded or diminished due to illness". 2. "In case of confirmed mental defect also inform us if it is socially dangerous". 3. "Inform us, having examined the records, having performed all the clinical and laboratory tests that you consider appropriate and necessary, on the subject's current conditions of mind and, in particular, whether or not he/she is able to participate consciously in the process".

If the expert considers this capacity impaired, he formulates the judgment on the mental defect and highlights the mental disorder of the appraisee. The judge who will support the psychiatric

[33] For further information, see Saronni, C. (2014), The psychiatric expertise in the criminal trial and the problem of the client, in the magazine Crimen et Delictum, VIII (November 2014) International Journal of Criminological and Investigative Sciences.

expertise and therefore the non-chargeability of the offender, as he was not at the time of the event able to understand and want according to the normative parameter indicated in Article 85 of the Penal Code, will issue a sentence of acquittal from the crime.

By the law it is as if that crime had never been committed. After answering the first question, the non-chargeability of the subject will lead the expert to rule on the second question concerning his/her presumed dangerousness.

The social dangerousness foreseen by Article 203 of the Penal Code does not concern the probability that the offender may endanger other people's or his/her life and health, but it concerns the probability that the offender may again commit a crime: “For the purposes of criminal law, a socially dangerous person, even if not imputable or not punishable, is one that has committed some of the acts indicated in the previous article, whilst it is probable that he/she commits new acts foreseen as crimes by the law. The quality of socially dangerous person is presumed by the circumstances indicated in Article 133”.

The socially dangerous person will be subject to *a security measure* proportionate to the degree of social hazard detected. Article 202 of the Penal Code. Thus, it states: “Security measures can only be applied to socially dangerous people who have committed an act foreseen as crime by law. The criminal law determines the cases in which security measures can be applied to socially dangerous people for an act not foreseen by the law as a crime”.

With regard to the non-imputable subjects, who therefore committed the crime in conditions of total disability, the psychiatric prison hospitals (OPG) (a category of institutes counted among the ones which, in the mid-seventies, replaced the old criminal asylums) , the agricultural colony or the houses of work, as well as the shelter in a nursing and custody home, in Italy, have been abolished in 2013, but definitively closed on March 31, 2015, and have been replaced by Residences for the implementation of safety measures (REMS).

It is worth mentioning a particularly important aspect of the assessment of dangerousness as a moment following the declaration of non-chargeability due to mental illness: there existed in the Italian Penal Code a series of presumptions concerning the danger that led, albeit in the cases foreseen by law, to the automaticity of the security measure.

Until the 80s for the non-chargeable offender, the safety measure was foreseen under a presumption of social danger deriving from (declared) infirmity, but the Constitutional Court, in the 80s, declared the partial constitutional illegitimacy in the part in which the rules (Article 222 and 219 of the Penal Code) did not subordinate the provision of admission to prior concrete assessment of the persistent danger at the time of the application of the measure.

In the event that there is only a semi-infirmity of mind, the reduced ordinary sentence of imprisonment will be expiated at the ordinary institutions, bearing in mind that, for the execution of the sentence, the subjects sentenced under penalty reduced by partial defect can be assigned to institutes or sections for subjects suffering from infirmities or mental impairment when their conditions are incompatible with the permanence in ordinary institutions. When their pathological situations are exceeded or significantly improved, the subjects are assigned back to the ordinary institutions, potentially after a trial period in the same (Article 111 paragraph 5 and 7, Presidential Decree 230/2000).

Appointment of an expert

The expert can be appointed ex officio by: 1) judge of the preliminary hearing; 2) judge of the trial; 3) during the probationary incident (in the pre-trial phase of preliminary investigations).

The expertise can be entrusted to a psychologist, a psychiatrist or a criminologist. The psychological expertise evaluates aspects of the evolutionary process. The psychiatric one evaluates the existence of a pathology underway or in the process of structuring with the aim of being able to initiate appropriate treatment and to issue a judgment of chargeability. The criminologist works by using his epidemiological knowledge of crimes and profiles. The recipients of the psychiatric examination are all the subjects about whom doubts arise during a criminal and/or civil procedure, regarding the presence or absence of a psychopathology of the accused; in these cases, the judge can avail himself of the expertise of a psychiatrist who will professionally assess the capacity of the accused.

Statistical studies have made it possible to ascertain that mentally disturbed patients do not commit crimes significantly more often compared to the general population and it is not possible to make a direct equivalence between mental pathology and social danger.

The psychiatric examination is an assessment that can also be requested by a subject who needs advice in the psychiatric and psychopathological field or even in the medical legal field. The psychiatrist can be called to evaluate the clinical condition of a given subject by the subject himself, by the family members, by a lawyer or by a judge.

Moreover, during the assignment to the expert, the latter is invited to inform the judge about conditions of incompatibility that may make it impossible to carry out the appraisal. The psychiatric expertise in the strict sense concerns the concept of criminal responsibility that is connected with conscience and intent.

Protection of the guilty with mental illness

In Italy, the organisation and management of health care for people with mental problems of a criminal nature and affected by a restriction measure (precautionary measure, custodial and non-custodial security measure) have profoundly changed in recent years.

With the Decree of the President of the Council of Ministers (DPCM) of 1/4/2008, which sanctioned the passage of health care to persons detained from the Ministry of Justice to the Ministry of Health, that is to say to the National Health System (SSN). From October 2010, the health staff who had a contractual relationship with the Ministry of Justice has transferred this relationship to the Local Health Authorities (ASL) of competence.

The organisational and managerial responsibility of the health activities towards the persons responsible for the crime with a custodial and non-custodial security measure is attributed to the NHS. A special National Fund called "Penitentiary Health Fund" is established.

The Prime Ministerial Decree of 1/4/2008, with the subsequent agreements in the Unified State Regions Conference, has provided that, in assisting persons with custodial or non-custodial security measures, we move from a single entity, the Ministry of Justice, to a set of systems interacting with each other; the judicial system (courts, penitentiary administration) and the NHS. These have precise, distinct and collaborative functions, which respond to the constitutional provisions of the right to health, the right to personal safety of individuals, the overall security of citizens' rights and their underlying legal assets, in a complex social context rich in contradictions.

Restraining of a person with mental disease[34]

The mechanical restraint of people suffering from mental illnesses represented and in part still today represents a very widespread and often tragic side in the practices of the Psychiatric Diagnosis and Care Services (SPDC) in Italy, even those departments are not the only places in which this practice is used: the services of child neuropsychiatry, nursing homes (RSA), medical and geriatric wards, emergency rooms, REMS, private nursing homes and therapeutic communities are all facilities in which patients can be contained by various means.

Particularly painful is the case of excesses of restraint in case of intervention by law enforcement and health personnel during involuntary treatment and urgent interventions during the act of committing an offence or beyond it.

[34] For a deeper understanding see Menegatto, M., Zamperini, A. (2018), Coercion and psychic disease: restraint between dignity and security, Il Pensiero Scientifico Editore, October 2018.

According to our Constitution, appeals to practices restricting personal freedom in the context of health care should represent rare exceptions that are strictly regulated, controlled, subject to a jurisdictional system of guarantees to patients. While we continue to act in a way that is sometimes in contradiction with the best legal and health culture established in Italy and, in particular, with that "Basaglia Law" that has fully recognised the dignity and ownership of the rights of people suffering from mental illness. In many centres for diagnosis and treatment patients do not have the opportunity to be in contact with their families, to move freely (let alone go out). Such structures are often impermeable to any possibility of monitoring and control from the outside and the practice of mechanical restraining measures is a recurrent component, albeit hidden in the dark.

Dramatic and harrowing cases of which we have come to know from the news, down to the most crude and unimaginable details are, among the least recent ones, the death of Giuseppe Casu on June 22, 2006, after being tied to a bed in the hospital of Cagliari for seven days, as well as that of Francesco Mastrogiovanni, who passed away on August 4, 2009, after being contained for eighty-seven hours (his agony was fully documented through the recording of cameras inside the psychiatric ward in which he had been imprisoned). One of the most recent ones is the case of Andrea Soldi, the 45-year-old man suffering from mental issues – schizophrenia – who died in August 2015 after an involuntary treatment carried out by the municipal police and health personnel and that of Mauro Guerra, 32, who was killed by a marshal of the Carabinieri in July 2015, also during an involuntary treatment. These tragic episodes represented emblematic situations of the possible consequences of the abuse of these practices.[35]

The motivations of this inattention are multiple and profound, deriving from a thought never surpassed, according to which the human being in the moment of mental suffering no longer holds integrity and dignity and, consequently, rights, as if the mental illness made incapable of understanding, of wanting and even of perceiving the additional suffering caused by the containment practices.

What happened with traditional psychiatric hospitals and, more recently, with judicial psychiatric hospitals, superseded by REMS thanks primarily to the pressure of civil society, to the commitment of the most advanced currents of professional communities and institutions, is a

[35] For more information see the following articles: TSO: qual è il ruolo delle Forze dell'Ordine e che rischi corre il medico?, available at www.emergency-live.com/it/news/tso-quale-il-ruolo-delle-forze-dellordine-e-che-rischi-corre-il-medico/, Torino, per la morte durante il TSO di Andrea Soldi ci sono 4 indagati, available at www.emergency-live.com/it/news/torino-per-la-morte-durante-il-tso-di-andrea-soldi-ci-sono-4-indagati/, La psichiatria uccide: 4 morti in Tso dalla scorsa estate. Fermiamoli!, available at www.autistici.org/archive/20180729154134/https://www.inventati.org/cortocircuito/2016/05/22/4-morti-in-tso/, Stroncato da un tso, quattro condanne per la morte di Andrea Soldi, available at www.lastampa.it/2018/05/30/cronaca/mor-in-seguito-ad-un-tso-quattro-condannati-20ck6dAHCjq5jaBLNNNZJM/pagina.html, Processo Andrea Soldi, available at https://almm.it/sentenza-del-processo-andrea-soldi/, Mauro Guerra: a 'Chi l'ha visto?' il caso dell'uomo ucciso dal maresciallo Marco Pegoraro, available at https://it.blastingnews.com/cronaca/2018/06/mauro-guerra-a-chi-lha-visto-il-caso-delluomo-ucciso-dal-maresciallo-marco-pegoraro-002643105.html.

necessary step to reach the progressive abandonment of the practices of restraint of patients, an objective also recognised by the institutional documents for the direction and planning of social and health services.

The mechanical restraint of the patient with mental illness has been the subject of an Investigation Commission of the Senate of the Republic[36] in 2016 that stated: "The consequences, even more serious for the life of people, are those of a psychological nature. All patients undergoing this treatment live out the experience with a profound loss of self-esteem, with a painful sense of humiliation, with fear. The emergence of a feeling of rancour, of gloom, of anger often follows as a consequence. Sometimes, restraint is accompanied by a deep depression, a sort of loss of hope, the awareness of having reached the bottom and that it will never be possible to climb up. It is significant that the people who undergo these treatments lend themselves very reluctantly to re-evoke those experiences. They prefer to forget. The memory of those moments evokes feelings of shame and loss of one's identity, which become unbearable". Many have compared the difficulty of remembering and reporting the restraint to the experience of survivors of the extermination camps. Like the fatigue and the unspeakable anxiety that had to be experienced by the survivors of the *concentration camps*, those few, who wanted to face the pain of memory.[37] We come to compare the mechanical restraint and the psychic suffering that it causes directly to the torments inflicted on the deportees during the Holocaust: these statements must lead to reflection, given that "in Italy today, in 7 out of 10 of the psychiatric diagnosis services and care, restraint is common practice".[38]

Mechanical restraint as well as the involuntary treatment should never assume a curative nature and exist only as an emergency security measure for the acute phase of the disorder in order to preserve the safety of the patient and the parties involved. Many doubts of constitutionality have been evoked even in cases of so-called intervention *praeter delictum* that is, a TSO as an expression of a provision restricting personal freedom in the absence of a crime or quasi-offense in relation to which to adopt such measures, being based only on the prognostic evaluation inherent to the social danger of the subject, i.e. his ability to threaten public order.

A more punctual legislation would be necessary, confidently admitting that a treatment imposed by force on the mentally ill has by its nature a principal function of containing violent manifestations of psychosis. However, precisely fixing the limits in which such treatment can be carried out, having regard to that "respect for the human person" to be considered absolutely pre-eminent to the demands of social defence and to fully implement uniform guidelines and

[36] Senato della Republica, Commissione Straordinaria per la Tutela e la Promozione dei Diritti Umani (2013), La contenzione meccanica, available at www.senato.it/application/xmanager/projects/leg17/file/repository/commissioni/dirittiumaniXVII/RAPPORTO_CONTENZIONE_COMMISSIONE_DIRITTI_UMANI_SENATO.pdf.
[37] Dell'Acqua, G., Isidoro, Luca, Marco and the nonsense of restraint, in S. Rossi, S. (ed.), The knot of restraint., cit., pp. 34-35.
[38] Ibidem, p. 16.

protocols on the national territory between health centres and law enforcement agencies, which have already been adopted and are present at numerous regional and local realities.[39]

[39] See for example the protocols in the Province of Treviso (www.aitsam.it/public/tso/prefettura_TV_protocollo_intesa_TSO.pdf), Sardinia Region (www.socialesalute.it/res/download/1_74_20110405101827.pdf), Foggia (www.sanita.puglia.it/documents/36044/121844/Protocollo.pdf/d8255b8e-d3ff-4a8e-89c4-0f206fb0c90f), Low Reggiana (www.poliziamunicipale.bassareggiana.it/upload/bassa_reggiana_PM/gestionedocumentale/protocolloASO-TSO2018BassaReggiana_784_2041.pdf), Turin (www.aslto2.piemonte.it/_front/ssv/visualizza_docs_home.php?3436) and others.

Promising practices

Networking between justice and psychiatry is of fundamental importance for the optimal management of pathways, defining new scenarios, producing innovative ideas and practices. Only through this work of clarification and comparison of the different perspective, indeed, is it possible to make sure that citizens have real justice and appropriate care.

The shift from rigid categories and dichotomies (healthy/ill, chargeable/non-chargeable) to processes based on dimensions interacting in a complex manner (bio-psychosocial model) is expected to lead to increasingly articulated questions. This means no longer having a dual track which leads to alternative and mutually exclusive pathways, but an understanding focused on the person within the community, taking into account not only individual psychiatric or judiciary perspectives but also the various needs, starting from the most basic, to develop a care programme and a life project.

The MEDICS European project

The European project called MEDICS (*Mentally Disturbed Inmates Care and Support, JUST/22013/JJPEN/AG Action grants*), has highlighted that, in order to intercept any form of mental disorder in a convict it is necessary to connect the jail sentence with services at local level.[40] The project partnership involved institutions and civil society organisation, with a view to promoting international cooperation in favour of mental health in prisons: the Dipartimento per l'Amministrazione Penitenziaria (Italy), lead partner in the project, has been supported by the organisation National Offender Management Service (UK), by the Direcció General de Serveis Penitenciaris in Catalunya, by the civil society organisations SIMSPE (Italy) and "Healthy City" (Croatia).

The guarantee of the right to health without discrimination is the guiding thread behind the project which included two different types of action: (1) research and exchange of best practices on inmates' mental disorders, (2) training of prison staff and mentally disturbed inmates in three Italian regions.

National and cross-border research was focused on the topic of inmates' mental disturbance through the experience of several professionals (security staff, health professionals, educators, volunteers) working in prisons; on the other hand, the exchange of best practices with European partners has made it possible to select the most appropriate models for taking charge and

[40] Italian Ministry of Justice (2016), Atti del progetto MEDICS, available at www.giustizia.it/giustizia/it/mg_1_12_1.page;jsessionid=8ND+mFZXZQ1nDOmEyLz2E1iT?contentId=SPS1278389&previsiousPage=mg_1_12_1.

treatment. The operational phase of the project involved the training of prison staff and health professionals at the staff from jails in Bologna, Turin and Palermo, as well as enabling pathways for employment for inmates suffering from mental disorders serving time in these facilities.

One of the goals achieved by the project has been to enhance the training of health professionals and custody and treatment staff, a fundamental pillar for prevention. Joint training modules were organised for prison staff and employees of Local Health Units (also involving the European Network of Penitentiary Training Schools); this has made it possible to upgrade through a more systematic approach several practices which had been already implemented for partnership between prison staff and health professionals. In this regard a discussion between these two administrations has proved essential.

The project has provided a suitable answer to the request by the Prison Police to be more involved in therapeutic-treatment programmes. Priority was given to the sharing of good practices and joint reflection with professionals from different areas on the various critical elements emerging. Concrete proposals were collected, more specifically as regards procedures based on enhanced relations and integration between the various professionals involved, through the sharing of previously agreed specific techniques.

Mention was made of the importance of the concept of network, dialogue and joint reflection about the topics in hand, both at national and at regional or local level, with a view to organising homogeneous mental health services in prison throughout the country.

The research perspective, as already mentioned, highlighted the need for the management policy of prison spaces – following modern criteria mindful of individual dignity – and the organisation of staff training should be closely connected; this also means encouraging interaction with outside professionals working in the facility, thus perfectly matching the directives recently sent by Minister Orlando to DAP (the Italian Department for Penitentiary Administration), which include implementing a national action Plan to prevent suicides in jail. The Minister expressly made specific reference to treating psychological and mental disturbance, as well as to developing methods aimed at an in-depth knowledge of inmates.

Mention was also made of the need to set up a more effective system to monitor inmates' needs and to have a digital medical record to be shared between penitentiary administration and local health facilities, offering as many alternatives as possible to detention for convicts suffering from psychiatric pathologies.

The experience of civil society organisations

The Community Pope John XXIII

The experience of the Community Pope John XXIII in assisting people who suffer from some form of psychiatric pathology/disturbance serving a jail term has always been characterised by an attempt at *recovery* by developing and experimenting with new procedures aimed at an actual rehabilitation of the convict.

The suggested pathways meet the need of the persons who are being supported, both in practical and affection/relational terms, through an experimentation with activities aimed at recovering residual autonomy or acquiring new skills as regards self-management and relations with others. The assessment is made directly in the prison where the person is detained and the timing for reintroduction, depend on the availability of beds, as well as on the decision by the magistrates regarding the type of alternative sentence applied and the measures implemented as a consequence thereof, which the patient will have to follow while living with the Community.

The Social Emergency Room Sant'Aquilina

The Social Emergency Room Sant'Aquilina is a residential and semi-residential facility of a pedagogical-rehabilitation nature, which has been approved for 36 residential and 32 semi-residential places; it is the follow-up of an accommodation project which started in 1980, then took on its current characteristics in 1984, thanks to the initiative and willingness of Father Nevio Faitanini, prison chaplain in Rimini and still in charge of the operating offices.

The facility welcomes both men and women, sent by local Social Services or who independently contact the coordinator, who are going through a period of crisis and thus need some form of support. Its clients are suffering from serious disorders, mainly associated with pathological addictions, dual diagnosis, but also psycho-physical unbalances and social difficulties. Some of them are offenders who are serving an alternative sentence to detention in prison.

The challenge of this project is to enhance individual diversities, which will hopefully result in living together as a source of enrichment, through the expression of individual qualities.

The Social Emergency Room has domestic and family characteristics both as regards the design of accommodation spaces and the organisation of the day which includes opportunities for spending time together, as well as individual or group care, a schedule of activities and leisure time. Community life is developed through structured activities and with an extremely demanding organisation, which includes assigning responsibilities, tasks, as well as training and education sessions. The goals of the PSS are geared towards several areas:

- *therapeutic area:* individual interviews, group meetings, specialist sessions with psychiatrist and therapist;

- *occupational ergo-therapeutic area:* management and maintenance of the home, workshops and assembly work;
- *cultural and recreational area:* expressive activity workshops, school support, leisure time management, sports, summer and winter holidays, Sunday recreational outings.

The effectiveness of this pathway is first of all a result of community life: the person is welcomed by the group and experiences and opportunities are offered to them for a stepwise approach to other residents, with the staff and with the outside world. Moreover, special importance is attached to the integration between internal and external reality, and the human relation is the main instrument for achieving the set rehabilitation goals.

The CEC Educational Community with Prisoners

The Community Pope John XXIII has prepared an innovative project, aimed at accused and convicted offenders, whose aim is to re-educate the inmate, which can also be applied to psychiatric patients who have committed an offence.

This project has been perfected after meeting a Brazilian organisation called APAC (Association for Protection and Assistance to Convicts). The role of volunteers trained to work with the staff is a pillar of the programme: volunteers are actually specifically trained and work with the staff towards promoting and implementing the rehabilitation of convicts (who are known as "recuperandi"). The CEC[41] consists of buildings without specific restraining structures, and involves a stepwise pathway of variable length, tailor-made and based on the individual for each inmate, depending on personal characteristics and type of offence, structured in three gradual stages.

Stage one: those admitted to the CEC programme are asked to sign an agreement where they accept to take part, to have understood the project purposes and taken their own responsibilities in that regard. Participants attend group and individual meetings, as well as sessions dedicated to an in-depth reflection on values mindful of rights and legality. Participants thus focus and reflect on their own experiences and, with the help of volunteers, start to progress towards a new beginning, processing their anger and frustration. Contacts with the outside world, including visits with family members, are limited to the bare minimum in order to encourage thinking about past experiences, strengthening the commitment to change.

Stage two: This phase involves the promotion of work, not only as creative and therapeutic intervention, but also in order to promote employability, through suitable training and job opportunities. The recuperandi are encouraged to complete internships with cooperatives and

[41] For more information see also www.apg23.org/it/carcere_comunita_educante/.

outside companies; more visits from family members are allowed. During this phase, each person is assisted on an on-going basis by a dedicated volunteer or key staff member. This is when it becomes possible to start approaching the victims of the offence and possible compensation is planned.

Stage three: This final phase involves facilitating access to the job market; contacts with the family become more independent and training or educational sessions fewer. Support from the volunteer at this stage is essential. If the court so chooses, the final part of the sentence may be served in a family home or in other welcome facilities run by the Association.

The pathway which has been specifically designed for offenders with mental disorders is essentially the same as those for other inmates, namely with a view to allowing for change, first of all by making sure that the individual acquires a greater critical sense and better rooted awareness as regards the offence committed and its significance, regain control of their emotions, reconnect them to events in their past, then find a different way to express them, which will hopefully lead to a gradual process of empowerment and accountability.

Family homes[42] and the families of the Community Pope John XXIII

In order to receive and welcome all the requests for help from public institutions or directly from persons suffering from specific disorders or difficulties, in 1990 the Adult Welcome Service of the of the Community Pope John XXIII was established, whose aim is to support people affected by stabilized psycho-physical-social difficulties, both self-sufficient and with the capability to become independent again. Getting to know each person allows for an assessment the most appropriate response to a specific need which involves *welcoming them in a family home or in a family*.

Over the past few years this service has been especially active in responding to emergency situations in people with psychiatric problems. Their requests for help are multi-faceted and complex, and for each of them the Adult Welcome Service, with accommodation facilities including many local branches, tries to provide a precise and effective response.

As soon as the project to be implemented has been defined, the service makes use of all available resources, thanks to the collaboration with public and private institutions at local, provincial or regional level, i.e. social and health services, Police and Questura offices, mental health services, pregnancy counselling, anti-violence and family support centres, etc. in this way the expectation is to gather all possible resources to provide the most appropriate response to those in need.

[42] For more information see also www.apg23.org/it/casa_famiglia/.

Welcoming a person in a family home or in a family is an important response also in order to help young people who have served a penal sentence or who have the possibility of serving a sentence alternative to detention, as well as extremely vulnerable persons suffering from a serious psychiatric disorder and at risk of committing offences (e.g. situation of great instability as regards interpersonal relations, self-esteem, affections in general, with the inability to control impulses), or not legally chargeable and not dangerous.

The Cooperative L'Ovile

One of the areas of intervention for the Cooperative L'Ovile,[43] which was established in 1993 and covers the Reggio-Emilia province, are services to people sentenced for criminal offences, as part of specific and articulated projects from both an operational and cultural perspective. As a matter of fact, L'Ovile is part of the penal system, alongside all those entities and operators committed to constructing pathways and spaces for justice, where the response to an offence is not merely punitive, but rather offer the convict, victims and community some chances for redemption, recognition, respect and, if possible, reconciliation.

The Cooperative manages high, medium and low-protection facilities, focused on the therapeutic use of residential care from an educational and rehabilitation perspective. these facilities are aimed at gradually developing independence and social reintroduction of persons who have left psychiatric prison hospital (in Italian OPG) and are being taken care of by mental health services. The educational pathways are based on the concept that response to an offence should be not merely punitive, but rather offer some chances for redemption, recognition, respect and reconciliation.

The rehabilitation services provided by L'Ovile are structure to offer therapeutic accommodation: a therapeutic use of residential care geared towards education and rehabilitation.

The method on which the Cooperative is based consists in an everyday life pedagogical approach: its framework is not directive in nature, but controlled and aimed at reshaping the experience of reality. This domestic dimension allows for a recovery of familiar functions and communication codes which may be used in a future setting after this experience. In other words, housing as a starting point towards reaching the greatest possible level of independence, also by means of employment possibilities, management of cash, medications, one's own interests and the relationships with the health care system.

[43] For more information see also www.ovile.coop.