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THE GENOA PARADIGM:  
TRANSITIONING FROM OPGSTO REMS  
AND THE STRUGGLES OF LAW 180/78

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- The abbreviation M.A. appearing throughout the paper indicates the initials of the patient belonging to my research project at the Genoa REMS. The data used for this analysis come from internal documentation provided by the institution, which for confidentiality reasons cannot be disclosed here. (Case M.A, internal data, 2024).

**LIST OF ABBREVIATIONS**

- ANMR - National Agency for REMS Monitoring (Agenzia Nazionale per il Monitoraggio delle REMS)
- CIM - Mental Hygiene Center (Centro di Igiene Mentale)
- CEDH - European Convention on Human Rights (Convenzione Europea per la Protezione dei Diritti Umani e delle Libertà Fondamentali)
- DAP - Department of Penitentiary Administration (Dipartimento dell'Amministrazione Penitenziaria)
- ERDF - European Regional Development Fund (Fondo Europeo di Sviluppo Regionale)
- ESF - European Social Fund (Fondo Sociale Europeo)
- EU - European Union (Unione Europea)
- LGBTQ+ - Lesbian, Gay, Bisexual, Transgender, Queer, and others
- LFE - Experimental Fiscal License (Licenza Fiscale Sperimentale)
- M.A. - Initials of the patient in the case study. The pseudonym “M.A.” is used through the document to safeguard the patient's identity and respect the privacy.
- NHS - National Health Service (Servizio Sanitario Nazionale)
- NRP - National Recovery Plan (Piano Nazionale di Ripresa)
- OPG - Judicial Psychiatric Hospital (Ospedale Psichiatrico Giudiziario)
- REMS - Residences for the Execution of Security Measures (Residenze per l'Esecuzione delle Misure di Sicurezza)
- RRF - Recovery and Resilience Facility (Meccanismo di Recupero e Resilienza)
- SPDC - Psychiatric Diagnosis and Care Service (Servizio Psichiatrico di Diagnosi e Cura)
- SSN - National Health Service (Servizio Sanitario Nazionale)
- TSO - Compulsory Health Treatment (Trattamento Sanitario Obbligatorio)

## Abstract

The purpose of this dissertation is to analyze the transition sanctioned by Italian Law 180, known as the Basaglia Law; the closure of the Psychiatric Judicial Hospitals (OPGs) and the establishment of the Residences for the Execution of Security Measures (REMS), with particular attention to the lack of clear, effective and standardized operating procedures.

This work stems from my interest in the prison system, the treatment of psychiatric disorders and the rights of offenders. The in-depth study of these issues was accomplished not only through the acquisition of theoretical/regulatory knowledge, but through the internship experience in collaboration with a specialized micro-team.

The experimental research was conducted at the REMS in Genoa Prà Villa Caterina, one of the most remarkable facilities nationwide in terms of number of discharges.

Particularly was investigated the case of M.A, a patient transferred from the OPG who has been residing in the REMS for seven years.

This study seeks to understand the extent to which legislation has shaped the current system, questioning whether the reasons for the patient's delayed transfer to a community are due to the severity of the illness or an overly complex system.

This regime seems to undermine confidence in real progress toward community reintegration by stabilizing patients in a facility that, although comfortable, was not designed as a permanent residential solution but as a therapeutic step toward the community.

The legal and policy implications arising from this lack of uniformity will also be analyzed, paying particular attention to operational practices and the effectiveness of patient treatment. This research aims to highlight how, despite the reforming intent of

Law 180, significant discrepancies in the application of security measures persist, influenced by regional variability and available resources.

The thesis offers a critical reading of the current system, calling for greater standardization and uniformity in REMS practices to ensure more equitable and effective treatment of forensic psychiatric patients.

My direct experience in the REMS has provided me with in-depth insight, prompting me to examine an area that still requires much attention, both human and legal.

Through the analysis of M.A's clinical case, an attempt was made to highlight the complications arising from regional enforcement discretion and lack of operational standardization.

The goal is to propose improvements for a more consistent and efficient management of forensic psychiatric patients in Italy, reducing unnecessary and potentially harmful transfers.

## **Introduction**

Among the various intricate challenges of contemporary society related to the normative response to minority problems, a delicate and little discussed issue concerns the legal position on the treatment of the psychiatric patient criminal. This discussion gives space to a debate that cannot but have an interdisciplinary character, and embrace together philosophy, law and medical procedures. An examination combining strict regulatory supervision is therefore necessary, without forgetting the strict observance of moral precepts and human rights.

Italy has adopted an innovative approach in this area, abandoning the use of restraint in favour of a more therapeutic treatment that respects human rights. This has earned it the epithet of pioneer in the right to mental health. Nevertheless, despite notable advancements, the journey is not yet concluded, and the remaining gaps and critical issues necessitate a meticulous examination and targeted legislative intervention.

The following paper opens the door to this complex and delicate scene by trying to focus on some salient points, and trying to answer a crucial question: How can the case study of M.A., a schizophrenic criminal patient in the REMS of Genoa, reveal the structural and legislative gaps of the Italian system for the management of psychiatric patients who are perpetrators? And how can a proposal for regulatory reform, inspired by the last law 81/2014, transform Italy into an example of international excellence in the treatment of these patients? This research question aims to explore not only the shortcomings of the current system, but also to suggest concrete and feasible solutions that can elevate Italy as an international reference model.

The methodology adopted in this research was divided into several phases, each of which responded to a specific need for analysis.

First, was carried out an in-depth study of the texts of the main Italian legislation, from the Giolitti Law of 1904 to Law 81 of 2014. The choice to go back to direct sources was driven by the desire to raise criticisms that were not contaminated by the opinion of later scholars or their political positions. This chronological path has naturally led to an interpretation of the sources through the lens of Foucault's thought, where in the works *Madness and Civilization* (Foucault,1961), *Discipline and Punish* (Foucault,1977), and many others, It was recognized that the concept of biopower has infiltrated the laws and practices related to the management of madness and deviance. Foucault's critical analysis of disciplinary institutions provides a perspective that, surprisingly, is still extremely modern and applicable today, allowing us to unravel the dynamics of power underlying legislative transformations.

The second phase of the research involved an experimental on-site study at REMS in Genoa, with a particular focus on the case of patient M.A. (Case M.A., Internal Data, 2024).

This case study is a key example of how systemic shortcomings not only justify scrutiny of the remaining flaws in criminal justice system but also have the potential to negatively impact patients' lives. This can occur by delaying or preventing necessary therapy, which may eventually result in a lower quality of life. The case study highlighted substantial deficiencies in the existing system, emphasising the imperative for a multidisciplinary approach integrating forensic psychiatry, criminal law and human rights.

In response to the findings of the regulatory analysis and case study, legislation 81/2024 was proposed as a legislative reform with the objective of addressing the key issues that were identified therein. This proposal, inspired by Law 81/2014 but improved in its most critical aspects, has been divided into detailed articles and paragraphs, with the

objective of standardizing operating procedures, Improve staff training and establish a national agency for the monitoring of REMS. These elements, which have been neglected so far, are considered essential to ensure not only the effectiveness of safety measures but also the protection of patients' rights.

Finally, to highlight the cultural, legal and operational peculiarities that distinguish the different European models, the thesis concludes with a comparative analysis of the Italian legal system compared to those of three other European countries: the Netherlands, Austria and Portugal.

Three case studies are brought into analysis to understand further issues raised by the complex dynamics that revolve around the psychiatric patient. Subtle dynamics, which need attention and on which I could not go too far in this paper, but I intend to analyse them in more detail in the near future.

In conclusion, the paper stands not only as a constructive critique of the existing legal and social debate, but also as an innovative contribution on the management of psychiatric patients offenders, with the hope of promoting concrete reforms that can have a real and lasting impact.

## **1. The Legal and Historical Evolution of Italian Psychiatric Legislation**

### **1.1 Introduction: Foucault's Perspective on Madness and Social Control**

A particularly controversial and still contentious area of Italian criminal law is that of mental health, and in particular the regulations concerning offenders who are patients in psychiatric institutions. Starting with the Giolitti Law (1904) and continuing with the Basaglia Law (1978) and Law 81/2014, a period of significant legislative reform in Italy has brought about a number of notable innovations in the field of mental health law (Vella, 2016). While this has seen Italy earn the epithet of pioneer in this area of legislation, it is important not to forget how all reforms have been accompanied by numerous criticisms, instabilities and social challenges along the long road. The two World Wars for instance, witnessed significant social transformations that gradually heightened awareness of the need for mental health care, thus bringing to light a problem evidently ignored until then.

This intricate and contentious social issue has been the focus of the insights of one of the most eminent scholars of insanity, social regulation and biopower, Michel Foucault (Foucault, 1961). In his seminal manuscript, entitled *'Madness and Civilisation'*, the French philosopher Michel Foucault presents a compelling analysis of the asylum structure. To analyse Foucault's thought in a more modern and in-depth manner, scholars such as Allan Beveridge (2012) have made significant contributions. Indeed, in his article, *'Reading about the history of psychiatry'* (Beveridge, 2012), he analyses the interweaving of Foucault's ideas with the historical evolution of psychiatry, extending a social problem with ancient roots into the contemporary context. Foucault's theories, as discussed in Beveridge's research (2012), were critically important in proving that the asylum is a part of an overall framework of social control rather than merely a medical facility. As claimed by Foucault, the asylum's main goal

was more than just helping those with mental health issues. Instead, the primary goal was to control and normalise these people in line with the dominant social standards of the particular historical period in question. Based on this perspective, disciplinary authority influences social interaction through a variety of practices rather than only appearing in the form of punitive actions (Foucault, 1961; Beveridge, 2012). Although Beveridge's analysis and Foucault's may seem to suggest a degree of conspiracy when presented in this manner, it is through the concept of biopower, evident not only in the design of asylums but also in the governance of public health, sexuality and human productivity, that the relevance of Foucault's work for contemporary society can be seen. It can be posited that the governance of biopower represents a paradigmatic instance of social control that pervades all aspects of human existence. This defines the boundaries of a regulatory apparatus that monitors the population through a synthesis of medical and political means capable of giving life, from their alliance to a form of social control that seems to have more than a protective nature, the despotic one (Foucault, 1976; Campa, 2015).

This intriguing hypothesis posits that Foucault has established a correlation between the growth of psychiatric facilities and the advent of a distinctive form of social authority that transcends the conventional boundaries of traditional sovereignty (Foucault, 1977). Could this be an invisible, modern form of control? Being able to take action without using violence or making threats is dependent on the invisible hand of political choices. In modern times, this position of power is used to control and monitor day-to-day activities. The development of a science of insanity has made it possible to categorise, investigate, and treat mentally ill people as subjects for research and care (Foucault, 1961).

In the scenario of the psychiatric patient criminal, Foucault is therefore particularly

noteworthy, since we are faced with a scenario dotted with individuals often tied to a system that oscillates between care and control in this context. These examples show how institutions can, intentionally or unintentionally, perpetuate forms of power that manifest themselves in subtle and coercive ways as well as through regulatory modes (Foucault, 1977). This call for an in-depth investigation of the measures taken in the care of those classified as "deviant" or "dangerous." Examining the role that these institutional practices have in maintaining the power dynamics that are hidden under the facade of therapeutic interventions is also crucial.

The complex relationship between law, medicine and authority in the care of psychiatric patients who have committed offences (Boaron, Gerocarni, and Fontanesi, 2021), as discussed by both Foucault (1961) and Beveridge (2012), remains an important and relevant topic for discussion. Notwithstanding the advances made by contemporary psychiatric facilities, Foucault's concerns regarding the exercise of biopower and the implications of biopolitics remain pertinent. It can be challenging to ascertain the points at which the responsibilities of handling and oversight converge, as the distinction between them is often not clear-cut. This highlights the vital necessity for a critical reappraisal of the methodologies employed in the treatment of mental health concerns within societal contexts. In addition, mental health policies must be reoriented to align more closely with the values of individual rights and human dignity. It is imperative to mitigate the potential risks associated with portraying social control as an accepted form of medical care (Foucault, 1976).

By tracing the development of Italian legislation chronologically through a Foucauldian lens, it is possible to examine how, in many cases, the concept of social control was effectively obscured, and how the objective of moving towards a therapeutic logic has also encountered this necessity over time.

It is beneficial to examine the pivotal moments in the history of this revolution from a personal, critical, and philosophical perspective. This approach enables the identification of shortcomings, an analysis of their causes, and an examination of the transformation of the form of control that occurred, particularly in the transition from asylums to REMS. Nevertheless, it is crucial to acknowledge that this does not necessarily signify a transformation in the fundamental nature of the phenomenon under examination.

## **1.2 From the Giolitti Law to the Italian Constitution: The Origins of Social Control**

The Giolitti Law (1904), officially designated as Law No. 36 of Feb. 14, 1904, and entitled “*Provisions on Asylums and the Alienated,*” represents the Italian state's first organic attempt to regulate psychiatric care. The draft presented by Giolitti on December 6, 1902, was hailed by psychiatrists as the synthesis of what they had been asking for more than 30 years, and this even though it did not sanction, as had been the case in previous drafts, the fundamental principle of full authority and responsibility over all internal services of the asylum by the medical directorate. The psychiatric profession exerted considerable influence to achieve this goal and was highly successful in doing so. Indeed, the result was the passing of Law No. 36 on 12 February 1904, which was enacted on the following day.

This legislation granted psychiatrists comprehensive authority over the health service, high oversight over economic and financial management, and disciplinary power, which included responsibility for all transgressions of the law itself. It is noteworthy that during the parliamentary debate, some jurists spoke in an alarmed tone about psychiatric power, which they called “boundless and almost despotic” (Babini, 2009).

That of 1904 was a legislative measure that emerged in a historical context characterized by overcrowded asylums and extremely degrading living conditions, an environment in which the mentally ill were more likely to be relegated to the margins of society rather than the object of real therapeutic interest. In fact, Giolitti's law (1904) established social “dangerousness” and “public scandal” as the criterion for internment (Scarpa, Castelletti, and Lega 2019).

In the debate in the Chamber of Deputies on February 10, 1904, advocating the goodness and urgency of the asylum law, neurology professor Leonardo Bianchi stated without hesitation that “*the madman who clutters society symbolizes, in the social organism, what the toxins and the infections in the individual organism represent*” (Babini, 2009).

The law also provided for admission by judicial procedure, with the sole exception of urgent cases for which, on a provisional basis, the local public security authority could proceed with hospitalization; it gave the provinces responsibility for expenses related to the insane poor; and it established a special service for supervision of the alienated. With regard more specifically to discharges, it protected the category of psychiatrists by relieving their responsibility which, moreover, risked being a brake on discharges. Indeed, Article 3 stipulated that discharges requested by relatives or free citizens could be authorized only by court decree, at the request of the asylum director or subordinate. Also, the director was allowed to “order the dismissal” of the inpatient “on probation,” giving immediate notice to the public prosecutor and the public security authority. Law 36 thus sanctioned the total domination of Italian madness by psychiatry, the only one, as of that moment, through which any new method and approach to treatment would have to pass (Babini, 2009).

Under this legislation, anyone who was considered dangerous to himself or others, or who could cause public scandal, could be involuntarily interned at the request of family members, public authorities or private citizens, with the validation of a medical certification (Carta, Angermeyer, and Holzinger, 2020). Once interned, the individual lost his or her civil rights, including the right to vote, thus being isolated from society in a veritable “warehouse for human beings” (Canosa,1979).

The Giolitti Law (1904), despite its apparent intent to create a regulated system of care, proved to function primarily as a tool of social control rather than a mechanism for humane treatment of the mentally ill. The ease with which a person could be interned, based on broad and ambiguous criteria, opened the way for frequent abuse. Many people were interned not because of genuine mental illness but because they were considered socially undesirable or deviant, including the poor, homeless and women who defied social norms. The law aimed not so much to rehabilitate patients as to maintain social order, emphasizing that the risk of public scandal was the prevailing criterion for admission, underscoring a moralistic intent rather than a genuine concern for the health and welfare of the individual.

A concept that is interesting to mention here, in order to have a more comprehensive understanding of the implications of this legislation, is that of "biopower", as anticipated before. In order to be more specific, the term was coined for the first time by the philosopher Michael Foucault (1976), who, analysing what he defined as technologies of power, and applying them to human life, outlined a criticism of the dynamics of control generated by these technologies. In this analysis, power acts on bodies, defining what is normal through increasingly rationalised practices. In this context, the Giolitti Law is evident not to represent legislation aimed at curing the mentally ill, but rather a device of social control. Indeed, the law institutionalizes

deviance, transforming individuals considered “abnormal” into objects of management, to be isolated and segregated rather than rehabilitated.

The central concept of medical gaze in Foucault, which refers to the way power is exercised through clinical analysis, finds full application in the Giolitti Law (Vella, 2016). This view reduces the patient to a case to be managed rather than a person with rights and gives doctors and authorities the power to detain anyone deemed deviant, isolating such individuals from society and submitting them to medical authority. The entity of the mentally ill person thus becomes the target of the power dynamic that has been created and ends up transforming himself from a subject to an object of manipulation (Foucault, 1976).

The evolution of the penal system, which Foucault describes as a transition from visible physical punishments to an "economy of suspended rights" (Foucault, 1976), finds an obvious parallel in the treatment of mentally ill people under the Giolitti Law (Vella, 2016). Whereas in the past criminal repression was manifested through torture and public exposure of the condemned, with this law we are witnessing a less visible but equally stringent control: the body of the sick is confined, deprived of liberty and subject to a system of constraints that isolates him from the community.

However, it is important to know that the formalization of this law did not find an easy ground for enforcement. During this period, the situation was aggravated by the succession of scandals and critical reports on the management of the asylum, but these were often ignored, as public opinion showed little interest in the defence of the mentally ill, confined to asylums and thus far from the view of society. The bill, presented to the Senate of the Kingdom by the Minister of the Interior Giovanni Giolitti on 6 December 1902, met with significant resistance and was initially rejected in 1903. The provincial delegations expressed conflicting views on the text of the legislation,

particularly with reference to the management of psychiatric hospitals and the costs of psychiatric treatment, which were primarily their responsibility.

With the advent of fascism, the Giolitti Law not only remained in force, but its application became even more draconian. The manicomial institutions, once places of exclusion, were transformed into instruments of political and social repression, used to internate political dissidents, homosexuals and other individuals considered threats to the fascist social order. The number of people admitted to manicomial institutions increased dramatically, from 60,000 in 1926 to over 96,000 in 1941 (Ianni, 2019). During this period, the use of invasive therapies such as electroshock, popularised by Ugo Cerletti for conditions such as autism, depressive disorders and schizophrenia, became increasingly widespread, reflecting the regime's brutal approach to "cure" deviance (Babini, 2009).

Supporting Foucault's thinking on the biopolitics of an influential state in controlling the population, was later the scholar Ernst Rüdin. Indeed, he confirmed how during fascism, biopower manifested itself in the segregation of the mentally ill, who were seen not as individuals to be cured, but as elements to be eliminated from society (Newman, 2023).

With the fall of the fascist regime, the bureaucratic and regulatory structures inherited from the past were not immediately dismantled, and many of them were incorporated into the new republican system. The legislation originated under Giolitti, was maintained within the Italian democratic legal system without changes, perpetuating a medical culture anchored to previous models, with a significant influence of the organic tradition in academic publications, textbooks and universities.

The enactment of the Republican Constitution in 1948 marked a striking shift in the landscape of political and normative culture. The principles set up in the

Constitution, based on the rejection of the most inhumane aspects of European totalitarianisms, immediately contrasted sharply with the extensive use of incarceration and internment that had been employed in Italy up to that point.

The Italian Republican Constitution (1948) enshrines the inviolable rights of man (Article 2), the equality and equal social dignity of all citizens without distinction of personal and social conditions (Article 3) and the inviolability of personal freedom (Article 13). These principles collectively aim to establish a civil community based on pluralism, tolerance, mutual respect and solidarity.

Article 32 of the Constitution states that: *“the Republic shall protect health as a fundamental right of the individual and an interest of the community, and shall guarantee free care to those who are indigent.”*

It is stated to be unlawful to subject any individual to a specific form of medical treatment unless it is explicitly permitted by law, being this principle officialized with: *“The law may in no case violate the limits imposed by respect for the human person”* (Cuzzocrea, 2016; Article 32 Constitution of the Italian Republic, 1948).

A profound cultural shift is encapsulated in a few sentences: health is first and foremost a right of the individual and then an interest of the community. This right must be universally ensured, while respecting the individual's freedom, which can only be compelled by law in circumscribed cases to compulsory treatments.

Despite the clear intention to move away from the previously held paradigms regarding mental illness, tangible changes did not occur rapidly or easily. While the Constitution began to be applied with great precision with the establishment of the Constitutional Court in 1956, for several years doubts were raised in the field of jurisprudence and doctrine about the immediately preceptive value of constitutional provisions, even to the point of coining a classification that included merely programmatic provisions.

In the 1950s, trade unionists advanced the proposition that the Constitution should be extended beyond the factory gates with a view to safeguarding workers' rights and "demilitarising" domestic relations. A comparable argument could be made with regard to prisons and asylums.

The 1960s and 1970s were a period of significant social and political transformation in Italy, characterised by the growth of the student movement, social protests and the emergence of new progressive ideas. This climate of social ferment provided an environment conducive to the emergence of the anti-manicomialist movement, which sought to end the segregation and institutionalisation of psychiatric patients.

### **1.3 From the Gorizia Congress to the Basaglia Law: Transition to a New Psychiatry**

One of the pivotal events that facilitated the proliferation of anti-manicomialist ideologies was the 1961 Gorizia Congress, at which psychiatrist Franco Basaglia publicly denounced the inhumane conditions in psychiatric hospitals and proposed a novel approach based on community care and respect for patients' civil rights.

Basaglia achieved a degree of media visibility and public support as a result of his association with the Radical Party and the publication of his book "*The Denied Institution*" (1968), which contributed to the raising of public awareness of psychiatric issues.

The Italy of the seventies is the "Country of Basaglia". This is also why the law that closes that decade, the historical compromise and psychiatric battles, is wrongly called "Basaglia Law". But it is, the country of Basaglia, especially for those who are not Italian: in fact the world looks to Italy for its anti-institutional experience as a pioneer, an exponent of a mythical experience that has no equal anywhere in the world: a model which most countries, from the 1980s onwards, it will not be possible to avoid

reference. Basaglia has in fact indicated in that link of illicity and mystification of madness, the rules of a game, that of power, which with different modalities and intensity, is repeated in other social and institutional realities (school, health, workplaces) and to which psychiatric science has become subservient (Babini , 2009). For this reason, in the 1960s and 1970s, the battles against authoritarianism, fixity of roles, violence of stereotypes, non-neutrality of science, recognized in the psychiatric experience of Gorizia first, and then Trieste, an anti-social practice, an institutional framework with which measure oneself concretely ,and from which to identify the processes through which the criminalization of disease and deviance "is scientifically implemented" (Basaglia, 1982).

The radical turning point in the debate on psychiatry in Italy came in 1961 with the Congress of Gorizia, where a movement was soon to be launched which would profoundly transform the psychiatric system. Franco Basaglia, a young psychiatrist of Venetian origin, took over the management of the Gorizia asylum and found himself faced with a dramatic reality: more than six hundred patients lived in inhuman conditions, tied to beds, confined in cells, and deprived of all human dignity. This discovery led him to embark on a de-institutionalization process, inspired by the theories of Maxwell Jones' British therapeutic community which he visited between 1961 and 1962 (Basaglia, 1978). Maxwell Jones (1953) introduced for the first time the practice of "face-to-face" meetings between patients and staff, in which everyone (patients and non-patients) is asked to intervene immediately before the situation "closes", the "Life and learning situation" in which the habit and value of choral decision is acquired (Shittar, 2007). The basic principle of the therapeutic community is that just as the social environment is considered co-responsible for the onset of the disease, so too it may positively influence, once the mechanisms put in place by the

pathological process have been identified: The interaction of the roles of community members, if properly guided and controlled, may be sufficient to ensure the therapeutic nature of the new institution (Basaglia, 1970). So, life in the Gorizia asylum has changed radically; indeed, more properly, it has finally entered. By unsettling the power relations, in particular that dictated by the doctor-patient binomial, the therapeutic mode has produced remarkable recoveries (Babini, 2009).

Basaglia quickly understood that the institutional logic of the asylum could not be reformed from within but required a complete overthrow. The "discovery of freedom", if carried to its extreme consequences, seems to require a further and priority step: the destruction of the asylum.

From here he welcomes the idea of opening the doors of wards, abolishing physical restraint practices and promoting community meetings where patients could make collective decisions. This process, however, was not without challenges and contradictions. The system, although initially welcomed by a progressive minority, met with strong resistance from traditional medical staff and state institutions, deeply rooted in a logic of social control rather than care.

On 20 September 1965, the Socialist Minister of Health, Luigi Mariotti, at a conference held in Milan, launched an unusual and resolute act of denunciation of the state of psychiatric care in Italy that would provoke protests in the following days. He complained that:

*"There are psychiatric hospitals where the doctor in the morning goes to hear from the nun if there is something new and then disappears... We have today psychiatric hospitals that resemble real Germanic camps, real Dantesque bolge... The mentally ill, according to the old law of 1904, are considered irrecoverable men, and are also registered, according to a medieval principle, in the criminal record at the court, as if*

*they were really common... It is necessary to introduce into this world elements which establish a new relationship between the sick and the doctor and between civil society and the individual"* (Babini, 2014).

In this context, the intervention of the Minister of Health, Luigi Mariotti, was decisive for the enactment of the Law Mariotti of 1968 (Law n. 431), which introduced three key reforms in psychiatric care:

- Voluntary admission without loss of civil rights: Article 4 of Law n. 431 of 1968 allowed the patient to be admitted voluntarily at the request of the patient, with the authorisation of the doctor on duty, in a psychiatric hospital. This innovation represented a significant advance in the protection of the rights of psychiatric patients since, until then, mentally ill people were treated as irretrievable individuals, often registered in the criminal record as if they were ordinary criminals, according to a principle that Mariotti called "mediaeval" (Babini, 2009). Furthermore, the repeal of Article 604 of the Italian Criminal Procedure Code, which pertained to the incorporation of asylum decisions into the judicial register, has resulted in the removal of a significant stigma attached to mental illness. This development has the effect of facilitating a process of de-registration, whereby individuals who have been identified with a mental illness are no longer identified as such. This is distinctly important in the context of their admission to psychiatric facilities.
- Establishment of the Mental Health Centres (CIM): the law has established the Mental Health Centres as the first form of community service for psychiatric care in Italy. The inauguration of CIM marked a notable advancement as the first example of psychiatric care that can extend beyond the boundaries of the traditional asylum. In a shortened time frame, these centres have become a

reference point for the treatment and prevention of mental illnesses, aiming to promote a more humane and integrated approach to the care of the mentally ill, avoiding hospitalisation in psychiatric hospitals.

- Allocation of financial resources and expansion of the medical and psychological workforce: Legislation allocated funds to expand the budget for medical and psychological staff, introducing medical teams for each psychiatric division, funded by the state. The Italian Constitution established that the Republic should protect the fundamental right to health both from a subjective perspective, as an individual right, and as a community interest. According to this principle, the Mariotti legislation was enacted with the objective of enhancing the quality of life experienced by patients in psychiatric hospitals. To this end, he has precisely determined the capacity of the facility, providing a maximum number of beds and thus addressing the issue of overcrowding. Additionally, the legislation delineated the requisite number of medical and nursing staff for each facility, establishing a correlation between patient population and staffing levels with the objective of guaranteeing optimal care.

This law represented an important step towards psychiatric reform; however, despite the innovations introduced, the Mariotti Law remained anchored to a custodial logic, limiting the effectiveness of its transformative potential. This scenario shows that superficial reforms, if not accompanied by profound cultural change and adequate structural investments, risk perpetuating the same dynamics of exclusion and marginalisation that they should have overcome.

The real transformation would come only a decade later, with the Basaglia Law of 1978, which, putting an end to the age of mad houses, would mark a definitive turning point towards a more just and humane psychiatric system. But until then, the Mariotti Law,

although a step forward, remained trapped in the links of a system that, in fact, continued to see the mentally ill more as a problem to be managed than as an individual to be treated and reintegrated into society.

The Basaglia Law of 1978, officially designated as Law No. 180, represented the culmination of the reform process initiated in the 1960s. It identified itself as the inaugural and most significant revolution in both the legal and psychiatric fields. The three fundamental principles that defined its scope of action were: the reform of Compulsory Health Treatment (TSO), the transfer of crisis management from asylums to civil hospitals, and the gradual but definitive closure of asylums, with the reinvestment of freed resources in alternative territorial services.

Nevertheless, an examination of the original regulatory text, uninfluenced by subjective opinions and interpretations, reveals that certain significant critical issues constrained its efficacy and prompted inquiries regarding its genuine capacity to transform the Italian psychiatric system.

In relation to the initial innovative element mentioned above, namely Law 180, it is crucial to highlight the revision of the TSO. The initial reform introduces a modification to the mandatory observation period, reducing it from one month to one week with the possibility of renewal. The decision to cut time so drastically seemed to be directed towards greater protection of patients' rights, reducing a measure that inevitably entailed, by its very nature, a restriction of personal freedom.

However, although the intentions were laudable, it did not eliminate the risk of abuse inherent in the TSO. The shift in the burden of proof from patient to physician, as permitted by Law 180, has the potential to result in the TSO being employed not as a therapeutic instrument, but rather as a vehicle for social control. Consequently, in an effort to humanise the treatment of psychiatric disorders, the law permitted the potential

instrumental use of the TSO, which could result in its transformation from an exceptional health measure to a tool for the containment of deviance.

As can be deduced, it is evident that the dilemma at the core of this issue lies in the eternal difficulty of balancing the pendulum that oscillates between the protection of public welfare and the respect for individual rights. This conflict while struggling to be solved, did not succeed in making a fully satisfactory outcome. This tension is clearly reflected in the jurisdictional control provided for the TSO. The Protective Court, which was responsible for validating or cancelling the TSO within 48 hours, had to make sensitive decisions in a very short time frame, often without the time needed for a thorough assessment of the patient's clinical status and the circumstances justifying compulsory treatment.

The reform's methodology in this domain gives rise to concerns regarding the capacity of the system to forestall abuses, particularly in scenarios where expediency may supersede the necessity for contemplative deliberation.

Additionally, the option of revoking or modifying the TSO at the request of any individual is unlikely to be a viable solution in practical terms, especially in operational contexts where resources are scarce and bureaucratic procedures are extensive. In an effort to preclude the recurrence of previous oppressive practices, Law 180 has not furnished adequate instruments to guarantee the TSO remains an exceptional measure. The absence of transparent operational directives and the discretionary authority vested in administrative entities gave rise to a system wherein the reformist aspirations collided with the potentiality of the practice becoming routine, thereby undermining the protection of individual rights.

The two others fundamental pillars, marking a cardinal moment in the history of Italian psychiatry, regard the transition of crisis management to civil hospitals and,

above all, the definitive closure of mad houses. This reform was, without doubt, revolutionary in its intention to dismantle a system that for too long deprived individuals of their dignity. However, its application revealed profound flaws and contradictions which undermined its effectiveness.

The closure of the mad houses should have been accompanied by a strengthening of territorial services, but this has not happened in an adequate way. The rush to implement the reform has created a care gap, leaving patients who had to be reintegrated into society to manage their difficulties in an environment lacking the necessary support structures. The compromise with the unions, which allowed the temporary reopening of mad houses, is a tangible demonstration of a reform imposed without any real preparation, almost a symbolic gesture rather than a substantial transformation.

In addition, the non-inclusion of Judicial Psychiatric Hospitals (OPG) in the reform has perpetuated a logic of segregation that Law 180 should have abolished. The OPGs, with their overcrowded structures and lack of adequate resources, have become the emblem of a system that has not been able or wanted to overcome the custodian mentality. In these contexts, the therapeutic function has been crushed under the weight of an approach that preferred to neutralize rather than cure.

Therefore, the law 180, although born from a noble intention, has been stuck in a series of compromises and structural failures that have betrayed its original spirit. The reform has ended up leaving intact many of the oppressive dynamics that it intended to overcome, re-proposing under a new guise old institutional logic. The illusion of a revolution has clashed with the reality of an incomplete and superficial transition, which has left unresolved the deeper problems of the Italian psychiatric system.

In the light of the critical issues that have emerged, it is once again possible to interpret Law 180 through the prism of Foucault's thinking, particularly through the concepts of biopolitics and governmentality. Foucault teaches us that power is not only exercised through visible repression, but also through more subtle forms of control, which manifest themselves in the management of daily life and the regulation of bodies. In this sense, the Basaglia Law (1978), although having abolished manicomial institutions, transferred control from places of institutional detention to communities, while maintaining intact the logic of management and normalization of deviance (Foucault, 1977).

The reform has not eradicated the doctor's capacity to determine patient autonomy; rather, it has merely redefined the parameters within which this authority can be exercised. The TSO, despite being subject to judicial oversight, continues to serve as a biopolitical instrument through which the state intervenes directly in the lives of individuals, justifying the use of coercion on the grounds of protecting public health (Foucault, 1977).

On the other hand, governmentality, understood as the set of techniques and strategies by which the state regulates citizens' lives, emerges clearly in the decentralized approach that Law 180 introduces.

The apparent emancipation of patients from psychiatric institutions is accompanied by a multiplication of places of control: the psychiatric departments of civil hospitals, the CIM, the territorial structures. These new spaces, although less visible and less oppressive than the asylum, are no less pervasive in their ability to regulate patients' lives and impose forced normalization (Foucault, 2007).

Foucault's thinking needs a reflection on why institutional reforms, although they may be motivated by the best of intentions, may fail in their aim of emancipation if they do not radically tackle the power structures they intend to reform (Foucault, 1976).

#### **1. 4 REMS: A New Asylum Without Locks?**

After a long evolutionary process and numerous internal challenges, the closure of the Psychiatric Hospitals (OPG) in Italy, formalised in 2015 with the introduction of Residences for the Execution of Security Measures (REMS), represents the last and decisive moment in the history of Italian psychiatric legislation to date (De Vito, 2014). This change, enshrined in Law 81/2014, has been welcomed as a step towards a more humane and respectful system for the rights of psychiatric patients.

The REMS, conceived as a therapeutic alternative to OPGs, was intended to overcome the coercive and degrading practices of the past, focussing on the integration of patients into society and respect for their dignity. However, a critical and legally thorough reflection raises fundamental questions about the actual scope of this reform: Is it really a break with the past or simply a new look for the same logic of social control that has always characterised the management of psychiatric deviance in Italy?

From a legal point of view, this continuity with the past raises serious concerns. Law 81/2014, while introducing important innovations, has not succeeded in definitively breaking the connection between psychiatric treatment and social control. The REMS, although representing an improvement compared to the OPG, continues to operate within a logic of exclusion based on the presumed dangerousness of patients. This keeps alive the risk of perpetuating a view of psychiatric patients as "others," to be kept separate from society for the good of the community, rather than as individuals to be reintegrated and supported. This theme has remained a persistent feature over the years, accompanying numerous reforms. The various regulatory and psychiatric reforms

appeared, at least in their stated intentions, to replace the custodial logic with a more therapeutic, treatment-orientated approach. It is not our intention to present an unpublished critique. However, whereas the preceding observations were primarily concerned with the identity and intentions of the structures, the critical issues that have emerged with the implementation of Law 81/2014 have highlighted more profound technical and procedural problems.

The absence of standardised operational procedures between different REMS has resulted in disparate patient management strategies, with notable variations in treatment modalities and available resources. This has resulted in the reform's effectiveness being undermined, with the consequence that the system has become fragmented and often ineffective. The absence of a uniform protocol for a law that should operate on a national scale raises questions about the procedural neutrality of the process, particularly in view of the potential for regional dynamics to exert influence. This may lead to a weakening of the original intention, as regional policy could impede the necessary standardisation, resulting in discrepancies between regions where health and justice are more closely aligned and those where there are more resignations.

Taking the Foucauldian thought and the concept of biopower described above, in reading this situation, it is possible to observe how REMS can be seen as a continuation, albeit more humanised, of the practices of social control. In these residences, power is exercised not so much through direct physical coercion as through the management of health and the regulation of patients' lives. Does the absence of freedom of action not mean, in some way, subordination to an instrument of power? This is how deviance is once again normalised and regulated, and individual freedom continues to be subordinated to the security needs of society. As Foucault (1977) illustrates, the shift from a punitive to a more therapeutic system does not inherently entail a reduction in

control; instead, it signifies a transformation of the latter into a broader and more intricate form of governance.

The REMS can be considered an emerging form of disciplinary power, given its concentration on social risk and security-motivated incarceration. Despite their ostensibly benevolent nature, these structures serve to perpetuate the notion that the protection of society is of paramount importance, even at the expense of individual liberty. This confirms the existence of a form of surveillance that, although less overt, is equally efficacious in maintaining social order.

A further noteworthy criticism is the failure of the REMS to facilitate the genuine integration of patients into society. Structural deficiencies and a lack of resources have often relegated these structures to a kind of limbo, suspended between the old punitive model of the OPG and a therapeutic ideal that is struggling to materialize. While it is true that the asylum's logic has been partly overtaken, replaced by a more therapeutic identity, the fact remains that REMS risks becoming a luxury hospital without locks or windows. A place where patients live better than before, but which remains without a real opening to the outside world, limiting the real possibility of reintegration. This situation raises doubts about the real extent of the rupture with the past. The REMS, although presented as a definitive solution to the problems of the Italian psychiatric system, seems to perpetuate the same dynamics of exclusion and surveillance that characterised the OPGs. The promise of a rehabilitation system that allows patients to look beyond the walls of the institution and reintegrate into the social fabric appears, for now, unfulfilled.

It can thus be stated that the evolution of Italian psychiatric legislation from the Giolitti Law (1904) to the Basaglia Law (1978) and the introduction of REMS reflect a complex interaction between progressive ideals and a persistent logic of social control

(Foucault, 1977). Although the REMS represent an advancement upon the OPG, it nevertheless fails to fully transcend the exclusionary and surveillance-orientated dynamics that have historically defined the governance of mental health in Italy. Furthermore, it is confronted with considerable technical and organisational challenges, which serve to undermine the perception of reform as a genuine triumph.

The challenge for the future will be to develop a truly emancipatory approach to mental health that goes beyond the logics of control and normalisation, putting at the centre the autonomy and dignity of the individual. Only through a radical change in current structures and practices will it be possible to build a mental health system that truly respects the rights and freedoms of all patients, finally breaking with the shadows of the past. Later in my paper, I will propose an ideal model that aims to overcome these defects, building a system that really puts the person and his rehabilitation at the centre and definitely abandoning the control logics that have characterised the management of mental illness until today.

## **2. Case Study Analysis: M.A. and the Genoa REMS**

### **2.1 M.A. Case Study Presentation**

With the transition from OPG to REMS, we saw how Italian forensic psychiatry has succeeded, or almost succeeded, in overturning the custodianist paradigm that had led to the detention of mentally ill people for decades, maturing the design foreseen years earlier by the Basaglia law. The new residences have therefore endeavoured to put emphasis on a model orientated towards rehabilitation and social inclusion, and it is for this reason that despite the difficulties encountered, they are worthy of a more in-depth study. During my six-month trial at the REMS in Genoa, considered one of the most successful in Italy for the number of successful resignations, I was given the opportunity to observe closely the application of a law and how it impacts and has

directly impacted the life of the individual patient. A case study was selected for examination by a multidisciplinary team of experts, including a psychologist, psychiatrist, security staff, and social workers.

The case study concerned the patient M.A., who had undergone the institutional transition from several OPGs to REMS and who, after seven years, was not yet discharged. The choice of MA was deliberate, and the subject was selected because of the particular background. M.A., who was born in Albania on August 11, 1983, and moved to Italy in 1997, has experienced a lengthy and circuitous journey through various penitentiary and psychiatric institutions, culminating in his current stay at the Villa Caterina REMS in Genoa. His condition is characterised by paranoid psychosis, which presents with hallucinations and self-directed aggression. His case is illustrative of the difficulties inherent in the administration of psychiatric care within the Italian penal justice system. The fact that M.A., along with two other patients from former OPGs, is taking longer to leave the REMS may be indicative of more than just the severity of his illness. It may also be a consequence of institutional disillusionment. Despite the fact that the REMS proposes a solution that is more community-based in nature, the system remains anchored in terminology within the penal code that is both antiquated and imprecise, which inevitably has a knock-on effect on the treatment path followed by the patient. A review of M.A.'s legal proceedings, psychiatric assessments, and activities at the REMS from 2017 to the present reveals a confusing and inconsistent approach to Italian law, which has subjected him to a series of confusing and contradictory decisions. Responsibility for this situation lies with the institutions, which are unable to implement Law 180 in a linear and effective manner and to update procedures by promoting research. M.A.'s case thus exemplifies the institutional and regulatory deficiencies of the Italian forensic psychiatric system, while also

underscoring the imperative for a more humane and consistent approach to the management of patients with mental disorders. A more progressive interpretation of the legislation that is faithful to the spirit of Law 180 could finally offer patients like M.A. better perspectives.

## **2.2. Judicial Iter: A Case Study of Crime and Recovery**

The M.A. court case commenced in 2007, when he was involved in a serious incident of domestic violence, namely an attempt to kill his mother. This act, which may be construed as an attempted murder, is assessed in accordance with Article 56 of the Italian Penal Code, which provides that: "*Whoever performs suitable acts, unequivocally directed to commit a crime, shall be liable for attempted crime if the action does not take place or the event does not occur.*" In accordance with this rule, which is also known by the Latin quotation "cogitare, agere sed non perficere" (to plan, to act, but not to carry out), the attempted crime is punishable by imprisonment, with a reduction of the punishment from one-third to two-thirds in comparison to that established for the consummated crime. In 2008, M.A. was diagnosed with schizophrenia, a psychotic disorder characterised by auditory and visual hallucinations, magical thinking, disorganised and incoherent speech, expansive delirium, and megalomania. The diagnosis describes a psychological condition in which M.A. is convinced that he was poisoned with wine and subsequently died. Following his return to life, he began to perceive constant voices. On November 19, 2009, the Court of Genoa issued a ruling that M.A. was of unsound mind and therefore not criminally responsible under Article 88 of the Italian Penal Code. The article in question stipulates that: "*A person who, at the time of committing the crime, was, by reason of infirmity, in such a state of mind as to exclude the capacity to understand or will is not imputable*". This disposition, based on a bio-psychological conception of insanity, requires that the

mental pathology has totally nullified the subject's capacity to understand and will at the time of the commission of the act (Cuzzocrea, 2016). Indeed, the norm considers the individual to be not imputable not only in the presence of mental illness of a psychiatric nature but also of physical conditions that, by causing delirium or significant mental alterations, affect the individual's capacity for self-determination. It is thus evident that the mental alteration in question must be of a nature that results in an impairment of the cognitive and volitional faculties in concrete terms. In the case of M.A., the psychotic episode diagnosed by the psychiatric experts had a tangible and definitive effect on his capacity to comprehend and to exercise volition at the time of the act (Kelly and Donnelly, 2023).

In light of the aforementioned considerations, the court invoked Article 88 of the Italian Criminal Code and thus excluded any possibility of holding the accused accountable. The period between 2009 and 2013 was characterised by a series of incarcerations and transfers between different prisons and therapeutic facilities. Following the Genoa Court's ruling on November 19, 2009, which recognised M.A.'s state of complete insanity under Article 88 of the Penal Code, the decision was taken to initially intern him in the Turin Prison Facility. Despite the recognition of M.A.'s insanity, the choice to place him in an ordinary penitentiary could be seen as a transitional measure, awaiting the identification of a facility capable of providing appropriate psychiatric care. Thereafter, M.A. was transferred to the Judicial Psychiatric Hospital of Barcelona Pozzo di Gotto in Sicily, and in 2009, once more, to Syracuse Prison and subsequently to Marassi Prison.

It may be postulated that such repeated transfers may indicate logistical or administrative obstacles associated with an inability to identify a long-term placement that is both therapeutic and safe for the individual in question, especially where each

transfer is accompanied by a comprehensive mental health assessment and an evaluation of the prisoner's suitability for the corresponding environment. This complex process requires the input of legal authorities, psychiatric professionals, and prison management.

In the aforementioned year, M.A. was allocated to the Prà Ellera therapeutic community, which was deemed to be a more conducive facility for his schizophrenia-related treatment needs. In 2013, during a period of acute psychotic decompensation, M.A. set fire to the bed of a co-dependent and was immediately transferred from Prà Ellera to the Psychiatric Service for Diagnosis and Treatment (SPDC). As a consequence of this incident, he has been charged with total mental incapacity, as defined in Article 88 of the Italian Penal Code. The psychiatric expert report corroborates this conclusion, and the Court of Genoa issued a judgement on January 14, 2014, formalising this condition. Following the pronouncement of the sentence, M.A. was relocated, in accordance with the prevailing legislative provisions, to the Judicial Psychiatric Hospital (OPG) in Montelupo Fiorentino. He was subsequently transferred in 2015 to the OPG (Orfanotrofio Provinciale di Garanzia) in Castiglione delle Stiviere. In 2017, following the ultimate closure of the judicial psychiatric hospitals (OPGs) in accordance with Law 81/2014, M.A. was transferred to the REMS Villa Caterina. This transition represents a pivotal point in his judicial and healthcare trajectory. The 2014 law (81/2014) effectively mandated the divestment of OPGs and the establishment of REMS as replacements, with the objective of ensuring a more humane and rehabilitative treatment of patients with mental illness who are incarcerated (Kelly and Donnelly, 2023).

The Villa Caterina REMS (Residence for the Execution of Security Measures) in Genova Prà is characterised by a unique environment, already impacting at first to offer

a protected and modern scenario that corresponds to the objectives set by the Italian Law 180 of 1978, which supports a therapeutic and rehabilitative approach for individuals with psychiatric disorders. This move has greatly improved the management of M.A.'s care, fostering a more favourable environment for its treatment and rehabilitation. It is currently expected that soon, after the legal review of the case, M.A. will be released into a community environment in line with his clinical condition and the recommendations of the attending psychiatrist.

### **2.3 Patient Clinical Pathway**

M.A. (born August 11, 1983, in Albania; immigrated to Italy in 1997) is a patient with a complex medical history significantly shaped by traumatic childhood experiences, including the abandonment of his mother and siblings, immigrated to Italy, leaving him with his father in Albania. Given the evidence, it seems plausible to suggest that this traumatic episode was a significant causative factor in the onset of his severe psychiatric disorders. M.A. is presently diagnosed with paranoid schizophrenia and paranoid psychosis, which are typified by pervasive and debilitating symptoms, including auditory hallucinations, persecutory delirium, and disorganised and aggressive conduct. The patient displays a range of symptoms, including persistent auditory hallucinations that issue commands, paranoid delusions that engender a constant sense of threat and persecution, and disorganised behaviours accompanied by violent and negative thoughts towards the mother figure. These symptoms, in conjunction with magical thinking and delusions of death, resulted in the diagnosis of paranoid schizophrenia. Additionally, M.A. regularly exhibits indications of abandonment-related distress and feelings of inadequacy. These emotional states appear to be rooted in her traumatic childhood experiences. In 2007, M.A. attempted to kill her mother during an argument, which resulted in a diagnosis of insanity in 2008. Despite multiple attempts at

antipsychotic pharmacological treatment, there has been a lack of consistency in his adherence to the prescribed treatment, with variable outcomes. There have been occasions when some degree of stabilisation has been demonstrated; however, episodes of auditory hallucinations and disorganised behaviour persist, indicating that the response to pharmacological treatments has been partial. Contemporary psychiatric practice acknowledges the impact of multiple variables on the efficaciousness of antipsychotic therapies. These variables include the severity and chronicity of the underlying psychiatric condition, the patient's compliance with the prescribed treatment regimen, and environmental and psychological factors. By the time of drafting this report, M.A. is currently in treatment at the facility of Villa Caterina REMS in Genova Prà, where he persistently manifests symptoms characteristic of a psychotic disorder. Auditory hallucinations of MA are common and often command verbally, which increases the likelihood of violent conduct. It is clear that the incident of attempted murder of a roommate, which occurred during a period of hospitalisation at the SPDC, reflects a very high risk factor for himself and others and calls for the urgent need to implement robust security protocols and continuous monitoring. Following this incident and given the established condition, the placement in a double room is strongly contraindicated as a means to prevent further incidents of violence. Consequently, placement in one of the facility's three single rooms was deemed the optimal solution, as it minimises the risk of violent behaviour and facilitates more effective control of psychotic symptoms. The risk assessment demonstrates that M.A. represents a considerable risk to himself and others, largely as a consequence of auditory hallucinations that give rise to violent behaviour and persecutory delusions that engender a pervasive sense of threat. Notwithstanding the developments that have occurred in contemporary psychiatry and the utilisation of psychotropic medication, the

management of cases such as that of M.A. continues to present a challenging and complex undertaking. It is possible that his failure to respond fully to treatment is attributable to a number of factors, including the chronic nature of his condition and the potential for psychological and biological resistance to medication (Kelly and Donnelly, 2023). It is of the utmost importance that M.A. be placed in a highly controlled setting with an intensive treatment program that incorporates pharmacological and psychotherapeutic interventions. It is of the utmost relevance to implement continuous psychiatric monitoring in conjunction with prompt remedial action in the event of decompensation in order to ensure the efficient supervision of his condition and guarantee his safety within the facility.

#### **2.4 A Comparative Study of OPGs: A Multifaceted Landscape**

In the course of the judicial and therapeutic process undergone by patient M.A., it has been noted that, amidst the numerous and often disorganised transfers, M.A. was relocated across three distinct psychiatric judicial hospitals (OPGs). Barcellona Pozzo di Gotto in Sicily, Montelupo Fiorentino in Tuscany, and Castiglione delle Stiviere in Lombardy (Santambrogio, 2024).

Despite their categorisation as OPGs, a notable contrast can be observed between the operational and rehabilitative approaches of the institutions in question. The aforementioned discrepancies give rise to significant questions regarding how state-designated facilities, which are intended to uphold consistent rehabilitative norms, can deviate so significantly as a result of regional discretion (Law February 14, 2012, n.9). This leads to the coexistence of practices that may be considered as exemplary and instances that may be viewed as deplorable.

This analysis highlights the necessity for a more unified and coherent framework between the judicial and local psychiatric services. Moreover, the creation of

comprehensive guidelines would enable a more frequent and uniform application of alternative measures in lieu of institutionalisation. The implementation of these measures would contribute to the alignment with the jurisprudence of the Constitutional Court in relation to the principle of *favor libertatis*, a principle that is currently underutilised in practice (Sentenza n. 253/2003).

Improved collaboration could help to resolve the prevalent issue of the routine prolongation of security measures, which are frequently substantiated not by ongoing dangerousness but by a dearth of adequate external residential and rehabilitative facilities. It would prove beneficial to the relevant mental health departments if they were to identify and provide such facilities.

During the Italian Senate's session in January 2012, a decree known as "*svuota carceri*", which translates to "empty the jails", was under consideration. At a later stage of the discussion, Senators Ignazio Marino, Felice Casson, and Alberto Maritati proposed an amendment to the legislation, which would result in the definitive closure of all open psychiatric facilities by 31 March 2013. This proposal was based on the findings of a parliamentary commission.

The decree was enacted on February 14, 2012, thereby initiating a countdown that required regions to establish new facilities within twelve months to accommodate inmates. The deadline was deliberately set so as to convey the urgency of the situation, as highlighted by Ignazio Marino (Report of Sitting Session No. 141 Wednesday, January 25, 2012).

In order for a judge to impose a custodial security measure in place of or in addition to a penalty, two criteria must be met: the commission of a crime and the social dangerousness of the individual (Traverso, Ciappi, and Ferracuti, 2000). Individuals who commit criminal acts while exhibiting an inability to comprehend or control their

actions due to severe mental disorders, such as schizophrenia, manic-depressive psychosis, paranoia, or dementia, are exempt from incarceration (Artt. 88-89, Italian Criminal Code). Consequently, in the event that they are considered to present an imminent risk to society, they are subjected to security measures that are commensurate with the level of risk they present, with OPG detention representing the most severe such measure (Law 26 July 1975, n. 354).

An exhaustive examination of the investigations undertaken at the three OPGs reveals a plethora of factors, when applied to M.A.'s case study, which provides an in-depth account of the legal and psychiatric history.

Such an analysis offers invaluable insights into the systemic issues and individual experiences within these institutions.

#### **OPG Barcellona Pozzo di Gotto**

The Judicial Psychiatric Hospital (OPG) of Barcellona Pozzo di Gotto in Sicily provided a striking illustration of the systemic deficiencies and inhumane conditions that were pervasive in such institutions (Santambrogio, 2024). The hospital is situated within a magnificent Art Nouveau edifice, constructed in 1925 and originally designed for its current purpose. Nevertheless, despite its architectural grandeur, the internal conditions revealed a tragic dissonance between the intended function and the grim reality of the situation.

During his inspection of the Pozzo di Gotto facility on June 11, 2010, Ignazio Marino, assisted by members of the Parliamentary Commission of Inquiry for the Effectiveness and Efficiency of the National Health Service, noted a considerable degree of decay and structural and sanitary deficiencies. The cells, designed to accommodate up to nine individuals, exhibited clear indications of uncleanliness and deterioration. This suggests that the maintenance procedures employed by the responsible parties are inadequate: the

walls and ceilings were coated in a layer of grime and exhibited clear indications of disrepair. The windows were observed to be in a state of disrepair, exhibiting evidence of damage and broken glass. Moreover, there was unmistakable proof of dampness, the presence of mold and the metal beds were observed to be in a state of significant deterioration, exhibiting visible evidence of corrosion and damage. Similarly, the condition of the flooring was also observed to be significantly compromised. The internal atmosphere was defined by the pervasive presence of urine, which was accompanied by an overall atmosphere of neglect and poor hygiene (Marino and Others, 2010). There was a severe shortage of psychiatrists and psychologists. Moreover, the inmates, frequently in a state of uncleanliness and malodour, articulated feelings of complete abandonment. The lack of educational and recreational activities, overcrowding, a general sense of degradation, and the absence of security in the working environment were also highlighted, as were the presence of narcotic drug request vouchers lacking the requisite pharmacy stamp and prescriptions for narcotic drugs that were not accurately recorded in the loading and unloading register, in contravention of Articles 60 et seq. of Presidential Decree 309/1990. During the visit, a bleak picture was reported: one inmate had been found naked and tied with gauze to a rusty iron bed with a central hole for excrement, which prevented movement (Marino and Others, 2010). This incident brought to light the existence of undocumented and potentially abusive restraint practices, illustrating significant human rights violations and a lack of respect for patients' dignity.

A further visit was conducted on August 9, 2012, once again led by the same commission, during which the OPG was housing 268 individuals. Of the aforementioned individuals, 117 were subject to security measures, with 90 undergoing extended detention due to the absence of external accommodation facilities. The

Department of Penitentiary Administration (DAP) reported a capacity of 452, overlooking the fact that only parts of the institution were operational. Specifically, only the third, fifth, and eighth pavilions and the ground floor of the sixth pavilion were in use, resulting in an effective capacity of only 210 (Antigoneonlus, 2012).

Notable tragedies have marked the facility's history, including two instances of inmate suicide and the death of a third individual due to gas inhalation.

Notwithstanding subsequent legislative mandates and an apparent reduction in the number of inmates by June 2011, the fundamental issues of overcrowding and inadequate resources remained unresolved.

The wellbeing of the inmates at Barcellona Pozzo di Gotto was a matter of great concern. A significant number of patients who had recovered from their acute illnesses nevertheless required continuous support of a long-term nature, which the Mental Health Departments (DMS) were unable to provide. As a consequence, a significant number, while no longer representing a significant social threat, were nevertheless subjected to prolonged detention due to the combined effects of bureaucratic inertia and the absence of a coordinated reintegration plan. This scenario was exemplified by the case of a 46-year-old inmate who tragically took his own life in September 2011 after seven extensions (Marino and Others, 2010).

The case of M.A., whose 2009 hospitalisation forms the focus of the present study, raises serious questions concerning the conditions of his stay at the OPG in Barcellona Pozzo di Gotto. Given the patient's limited lucidity, objective and reliable testimony regarding the circumstances of his time at the facility is unattainable. Nevertheless, the reports from the period in question regarding the general conditions of the facility indicate that M.A. endured significant difficulties throughout his tenure. It can be assumed that the above circumstances have had a profound impact on M.A.'s well-

being, undoubtedly placing him in one of the most difficult situations he has faced since the beginning of his illness to date. In light of the results of Ignatius Marino's investigation, it can be assumed that these circumstances have had a significant impact on M.A.'s well-being, undoubtedly placing him in one of the most difficult situations he has faced since the beginning of his illness to date.

It is imperative to contextualise M.A.'s experience in the broader discourse on the impact of environmental factors on mental health, with specific emphasis on cases involving severe psychiatric disorders such as schizophrenia. One cannot omit the evidence that a further aggravation of the patient's already critical psychiatric situation was caused by the oppressive atmosphere and lack of adequate medical and psychiatric care.

Indeed, it would be no small mistake to underestimate the influence of the environment in delicate situations such as this. For a patient like M.A., the move from a prison to a psychiatric hospital might initially seem like a step towards more appropriate care and support. However, the reality of Pozzo di Gotto in Barcelona, with its deplorable conditions and paucity of therapeutic interventions, quickly belied any optimistic hopes. The discrepancy between expected and actual outcomes may have contributed to M.A.'s sense of distress.

Notwithstanding the implementation of select infrastructural enhancements, including the refurbishment of the seventh pavilion designated for female inmates originating from Calabria, Puglia, and Sicily, the fate of the institution remained undecided. The enactment of Law 9/2012, which directed the closure of OPGs by March 31, 2013, had a significant impact on the future of the institution (Law February 14, 2012, n. 9). A critical examination of the physical conditions of the institution, undertaken by the Senate Commission of Inquiry, revealed a fundamental lack of suitability for a

psychiatric residence. The facility was persistently overcrowded, with cells holding up to twelve inmates each. Furthermore, a notable deficit in the number of trained medical professionals resulted in inmates with critical conditions, such as heart problems and disabilities, being deprived of the requisite care. The provision of psychiatric and psychological therapies was inadequate, which undermined the fundamental premise of rehabilitative detention (Perrone, 2012).

In light of these unsatisfactory circumstances, the Senate committee mandated the cessation of operations at Barcelona Pozzo di Gotto within a 30-day period (Perrone, 2012). Notwithstanding certain minor enhancements in specific domains, the committee concluded that the overall milieu remained incompatible with the standards of a psychiatric facility striving to meet rehabilitative benchmarks. The findings of the commission revealed a pervasive culture of neglect that had effectively transformed these institutions into places that were akin to prison ghettos, devoid of the humane and therapeutic qualities that are expected of modern facilities that provide psychiatric care. In addition, there were some serious administrative shortcomings in the investigation, particularly as regards the failure of the Sicily region to transfer health responsibilities from the prison administration to the regional health service, as required by the existing law (Castelletti and Others, 2014; Legislative Decree June 22, 1999, n. 230).

This bureaucratic inefficiency contributed to the widespread shortcomings observed in Barcelona Pozzo di Gotto, thus preventing the effective implementation of the necessary reforms. In response to these circumstances, Senator Marino, in collaboration with fellow legislators, has proposed the appointment of a full-fledged commissioner, also to facilitate the closure of OPGs and the transition process. Two main objectives were the driving force behind this approach: first, to avoid further delays and second, to ensure that the funds allocated are used effectively. These funds,

which were specifically earmarked for the above purposes, included €120 million for 2012 and €60 million for 2013, and were to be used for the establishment of new residential facilities and for recruiting suitable staff (Perrone, 2012).

Isolating the conditions identified from the specific case study, and considering a larger analysis, The oppressive and negligent conditions at Gotto Well in Barcelona may have contributed to the worsening of mental health problems for many patients. The deficiencies observed highlight the crucial importance of ensuring that the the dignity of the patient and humanity as fundamental aspects of psychiatric care, Because only when patients are approached with dignity and respect can care be truly effective. The Sicilian OPG is a glaring example of chronic neglect and human rights violations that are deeply rooted in the system of psychiatric hospitals.

### **OPG Montelupo Fiorentino**

The OPG of Montelupo Fiorentino, located within the historic Medici Villa, is an emblematic example of the structural and institutional challenges that characterize the system of psychiatric hospitals in Italy. Although originally designed as an aristocratic residence, the building has since been adapted to house psychiatric patients, an adaptation that inevitably brought to light many critical issues arising from the inadequacy of this structure for health purposes (Marino and Others, 2010). The inspection carried out on 22 July 2010 by the Parliamentary Commission of Inquiry into the Effectiveness and Efficiency of the National Health Service revealed a series of worrying deficiencies in the structural and hygienic-sanitary conditions of the institution. The delegation, composed of distinguished senators such as President Sen. Ignazio Marino and Senator Albertina Soliani, found serious structural damage, plaster that broke off from the walls, cramped and overcrowded spaces, and sanitary facilities in deplorable conditions, with urine residue on the floor and a pungent odor. These

conditions contributed to a highly degraded physical environment, which was detrimental to the mental well-being of patients (Santambrogio, 2024).

The overcrowded conditions of the cells, designed for no more than seven inmates, resulted in a complete lack of movement for the prisoners, creating an oppressive and unhealthy atmosphere. In addition, the 2010 inspection revealed instances of restraint not properly recorded in clinical journals, as evidenced in the cases of the interned S. R. and A. H., accentuating the lack of transparency and inadequate management of restraint practices (Marino and others, 2010).

From a management and care point of view, it was found that nurses and doctors often lacked the training needed to effectively manage more complex psychiatric cases. Furthermore, the presence of cultural mediators was irregular and insufficient, thus limiting the institution's ability to provide continuous and adequate care to foreign patients, hampering communication and treatment. Evidence from nursing staff indicated the existence of a ward with up to 30 beds for internees requiring observation, emergency care and intensive treatment (Santambrogio, 2024).

Despite the structural and organisational challenges, the OPG of Montelupo Fiorentino has tried to implement a number of rehabilitation and recreational programmes over the years. These included theatre classes, weekly film forums, football matches and adapted physical activity programmes. These efforts were an attempt to improve the quality of life for patients by facilitating leisure and socialization opportunities, which could have a positive therapeutic effect. These included theatre classes, weekly film forums, football matches and adapted physical activity programmes. These efforts were an attempt to enhance the quality of life of patients by facilitating leisure and socialization opportunities, which could have a positive therapeutic effect. However, such programmes have often been constrained by a lack of funding and resources, which has

undermined their effectiveness and prevented the creation of an optimal and stimulating environment for (Santambrogio, 2024).

As highlighted by the 2015 report, the future of the facility was shrouded in uncertainty due to the deadline imposed on 31 March 2015, which required the implementation of the process of abolishing OPGs in favor of alternative ways of treating mental health. The ambiguity surrounding this procedure led to a significant reallocation of funding for internal activities and structural adjustments, creating a stalemate that has had a detrimental impact on the institution's functionality. Despite some recent renovations, the facility was still fully operational. However, the prevailing climate of uncertainty was experienced with trepidation by staff who continued to carry out their duties, ignoring de facto any future developments (Santambrogio, 2024).

In the case of M.A., whose history is discussed in the paper, although the conditions of the structure were already improving in 2014, it is likely that he lived in an environment still characterized by significant imperfections. M.A. had a distinctive cultural and personal legacy, marked by a history of maternal abandonment and repressed hatred towards his mother, which had left an indelible mark on his psyche. This intricate cultural and family dynamic requires a tailored psychological therapeutic approach that recognizes traumatic experiences in an alternative cultural context. Cultural differences, although not related to language, may have exacerbated M.A.'s feelings of loneliness, complicating the interpretation of his emotional and therapeutic needs.

The lack of properly trained cultural mediators and the lack of training in intercultural competence among medical and nursing staff is a significant shortcoming in the health system. The staff involved should have experience not only in the psychological therapy of patients with delicate clinical situations, but also have the necessary tools to approach immigrants and individuals from different cultural

backgrounds, to ensure effective treatment that is sensitive to the specific needs of each individual. Furthermore, although there have been improvements in the structural and health conditions of OPG, these may have further aggravated the situation of M.A., perpetuating a cycle of mental distress rather than facilitating its resolution.

The management of human rights within the institution was a significant and complex issue. The lack of cultural mediators is not to be seen as a practical deficit, not only, but it clearly shows a flagrant violation of the patient's right to receive treatment that respects his cultural identity. This problem was of particular importance in the context of patients such as M.A., who were likely to experience an intensification of marginalization and alienation when there was a perception that their cultural identity was not fully understood or even completely misunderstood. A lack of cultural understanding may result in misdiagnosis and inappropriate treatment, which could exacerbate patient discomfort and hinder the therapeutic process (Parliamentary Committee of Inquiry on the Effectiveness and Efficiency of the National Health Service, 2011). Although the OPG of Montelupo Fiorentino demonstrates a modicum of excellence when compared to facilities such as the one in Barcelona Pozzo di Gotto, it nevertheless presents a plethora of serious deficiencies that necessitate prompt and comprehensive intervention. The experience of M.A. at the OPG in Montelupo Fiorentino exemplifies not only the significant inherent deficiencies to the system, but also the incremental progress towards a more respectful and humane treatment. The presence of cultural mediators, an adequate health environment and sufficient and qualified personnel are essential elements to improve the quality of life and the treatment path of psychiatric patients, especially those from different cultural backgrounds (Scarpa, Castelletti, and Lega, 2019).

### **OPG Castiglione delle Stiviere**

The Judicial Psychiatric Hospital (OPG) of Castiglione delle Stiviere, last in the comparative analysis and in the chronological path of the patient, represents a significant progress in the context of Italian detention facilities for patients with mental illness, highlighting a humanitarian and therapeutic approach that departs sharply from conventional forms of restraint. Geographically located in a large green space, this facility operates on the basis of an agreement between the Carlo Poma hospital consortium of Mantua and the Ministry of Justice. The first noteworthy innovation concerns the decision of the OPG of Castiglione delle Stiviere, to avoid the constant presence of prison guards, opting instead for an approach exclusively medical and therapeutic (Vella, 2016). Since 1990, under the direction of Dr Antonino Calogero, the hospital has evolved into increasingly broad views and ideologies, gradually embracing an increasingly inclusive approach to psychiatric treatment (Parliamentary Committee of Inquiry on the Efficiency and Effectiveness of the National Health Service, 2011). An inspection conducted by the Parliamentary Commission of Inquiry on the Effectiveness and Efficiency of the National Health Service in 2010, led by President Sen. Ignazio R. Marino and Sen. Albertina Soliani, documented the operating conditions of the OPG in Castiglione delle Stiviere (Vella, 2016). In partnership with the Anti-Celebration and Health Units of Parma and Cremona, an in-depth inspection was conducted, resulting in a detailed evaluation that subsequently shaped the direction of reform (Marino et al., “Relazione dei Sopralluoghi,” 2010).

From an architectural standpoint, the structure's organizational design evinces a profound adherence to the dignity and respect of the inmates. Possessing a large, spotless room promotes both physical and mental well-being in addition to maintaining the patient's dignity. Patients' ability to customise their rooms to better fit their own

personal preferences is another example of the care and dedication to maintaining patient dignity. The fact of having adopted as architectural features the standard doors and the metal grilles only at the windows, is a purposeful strategy designed to foster the development of a community that respects personal autonomy and encourages the patient population's feeling of accountability to flourish. This is a departure from earlier ideas of solitary confinement, which were frequently associated with the usage of segregated cells.

The therapeutic regime in Castiglione delle Stiviere is holistic in nature, incorporating educational, artistic, craft and culinary programmes with the objective of facilitating the social reintegration of patients. A setting that promotes protection and recovery is facilitated by the presence of recreational amenities like a gym and swimming pool in addition to wards that adhere to the highest health standards. As per the Parliamentary Commission of Inquiry on the Efficiency and Effectiveness of the National Health Service (2011), the conclusions of the commission support the belief that the OPG is a psychiatric care model that prioritises the welfare of our patients.

The medical practices in Castiglione delle Stiviere are mainly informed by pharmacological therapies, supplemented by psychotherapeutic interventions and socio-rehabilitative treatments. More radical methods such as the use of physical restraint are rare, typically limited to the application of wrist and ankle clips in a supine position. No shock therapy is used, reflecting the facility's commitment to minimize the use of force and respect the dignity of patients.

Infectious and contagious diseases are managed in single rooms, with an additional department dedicated to patients experiencing severe psychopathological episodes.

Medication administration in this setting is solely the responsibility of licensed nurses,

who ensure strict adherence to individualised treatment plans and relevant legal and medical regulations (Marino et al., “Relazione dei Sopralluoghi,” 2010).

The OPG in Castiglione delle Stiviere has challenges despite its creative approach, and overcrowding is still a major problem. In January 2012, the facility housed 322 interns, exceeded its maximum capacity, and highlighted the need for systemic reform that went beyond temporary solutions.

In economic terms, the management model of the facility, with an annual budget of 13.7 million euros financed by the Lombardy Region and the National Health Fund, demonstrates the financial sustainability of high-quality psychiatric care. This is in stark contrast to the situation of traditional OPGs, where a substantial part of the budget is allocated to prison facilities rather than health resources. The economic sustainability of the REMS model is further evidenced by the 55 million euros allocated annually since 2013, an investment comparable to the 57 million euros provided for the OPGs by the National Health Fund and the Department of Penitentiary Administration (Canetta; Fiore, 2012).

The transformation of the OPG in Castiglione delle Stiviere into a REMS facility, following the Legislative Decree n. 81 of 2014, marks a clear and official transition from custodial assistance to rehabilitation.

In 2015, the patient M.A., the case study presented here, was transferred to the OPG of Castiglione delle Stiviere, celebrating the conclusion of his journey through the Italian psychiatric hospitals system (Vella, 2016).

The transition from the poor conditions at Pozzo di Gotto in Barcelona to the more therapeutic environment of Castiglione delle Stiviere reflects a notable enhancement in the quality of care provided, subsequently upgrading, in 2017, with the relocation to a REMS institution, a significant advancement in the therapeutic process.

The transition from prioritising the use of physical constraint to prioritising the provision of evidence-based psychiatric therapy is a significant turning point in the overall development of mental patient treatment in Italy. The fact that punitive methods are becoming less common and rehabilitative approaches to treatment are becoming more essential is evidence of the tremendous progress this sector has achieved.

## **2.5 Therapeutic Communities and Legal Synergy: Evolving Psychiatric Care**

It seems evident, from the survey results about the transition from receiving facilities to judicial mental hospitals in Italy, that a detailed investigation of another institution of paramount significance is required. This is the therapeutic community (TC). This complex configuration has witnessed a notable increase in prevalence in Italian settings since the 1960s and 1970s, initially emerging in response to the pervasive impact of the heroin epidemic (Sashidharan, Mezzina, and Puras, 2019). This type of facility represents a complex and elusive phenomenon that resists rigid categorisation. It has an extraordinary capacity to adapt to therapeutic systems that attempt to simulate a familiar environment. However, if not managed with astute discernment and precise directives that facilitate a gradual process, CTs can precipitate considerable detriment (Barbui, Papola, and Saraceno, 2018).

Subsequently, the remit of therapeutic communities has been expanded to encompass not only addiction but also a broad range of mental health disorders (Jones, 1953). The provision of therapeutic communities for adults attached to mental health services has traditionally been the responsibility of the National Health Service (NHS). Indeed, the institutional culture of the NHS has ultimately led to the stigmatisation of CTs. They have been viewed as long-term, restrictive residential health facilities for individuals with severe mental disorders (Vella, 2016). Consequently, CTs have come to occupy the same social role as asylums and psychiatric hospitals, which were closed following the

Basaglia reform of 1978 (Barbui, Papola and Saraceno, 2018).

The NHS has established a dual-level accreditation system for CTs and their management bodies. The first level is an institutional one, which applies structural and organisational standards defined at ministerial and regional levels, and the second is a commercial one, which is based on quality control systems in accordance with international ISO 9001 standards. Nevertheless, the clinical efficacy of CTs and the scientific credibility of their therapeutic modalities have never been subjected to rigorous evaluation and accreditation programmes endorsed by public institutions (Barbui, Papola, and Saraceno, 2018). Consequently, CTs were progressively marginalised to the role of "containers of suffering humanity", excluded from society, following the old asylum model, to the extent that they were labelled "mini-asylums", an epithet that reflected a derogatory perception.

The Italian anti-psychiatric movement has gradually acquired an increasingly influential critical voice in Italian society, in collaboration with emerging user and family organizations and scientific societies advocating the community mental health model (Barbui, Papola, and Saraceno, 2018).

Together, they have begun to question the institutional role assigned to CTs by the NHS. Over the past decade, there has been a growing consensus among all stakeholders in the field of community mental health (CMH) that a regulatory and scientific framework is required which respects the human rights of users and ensures the clinical effectiveness of treatments (Kelly and Donnelly, 2023). This framework would justify the significant social spending that has been allocated to this specific area of mental health (Sashidharan, Mezzina and Puras, 2019).

Analysing the term's historical origins is required to give a basic knowledge of what a "therapeutic community" is. It was in England in the 1940s when the concept of

a "therapeutic community" first appeared as a social phenomena, philosophy, and care system. The first major experiment took place at Hollymoor Hospital in the town of Northfield where Colonel Rickman and Major Wilfred Bion led the operation. Although there were opposing views, the project was a remarkable therapeutic success in treating war-related acute neurosis (Jones, 1953).

Psychoanalyst Tom F. Main carried out a second experiment at Northfield with the goal of improving upon the first findings and reproducing them via the use of a novel holistic viewpoint. In defining the Therapeutic Community, Main proposed that the hospital should be regarded not merely as a technical organisation, but as a community with the objective of resocialising neurotic individuals, thereby facilitating their reintegration into society (Main, 1989).

Simultaneously, Maxwell Jones, a psychiatrist with conventional training and an interest in psychosomatics, was developing an alternative community experience. Jones observed that patients with emotional disorders exhibited notable improvements when engaged in reciprocal interactions and discussions with staff. From 1946 to 1959, Jones was at the helm of Henderson Hospital, where he developed a theoretical and methodological model based on an egalitarian and democratic community arrangement. He placed great emphasis on the significance of shared responsibility in the therapeutic process, including that of the patients themselves. To this end, he employed techniques such as role-play in order to facilitate a therapeutic transformation (Jones, 1953).

When viewed from the Italian perspective, the history of Italy's therapeutic communities, with its numerous references to foreign and international experiences, is inevitably linked to and shaped by the historical context. This context encompasses the evolution of psychiatry in the 1960s, which led to the implementation of Law 180 in 1978 and the gradual closure of psychiatric hospitals. Additionally, it includes the

establishment of public services for drug addiction in the same year. Indeed, the initial noteworthy instances of novel approaches to mental health care emerged in Italy during the 1960s. These endeavours sought to transcend the traditional custodialist paradigms prevalent in psychiatric asylums. Furthermore, the emergence of a market for illicit drug sales was not until the latter half of the 1960s, which was followed by a significant and widespread increase in their use (Basaglia, 1968).

The first private therapeutic community in Italy was established in Rome in 1962 by Fabrizio Napolitani (Corulli, 2016). Napolitani had gained considerable experience in education and professional practice abroad, initially in Brazil and subsequently in Switzerland. During this period, he had the opportunity to interact with the pioneers of the Therapeutic Community, Maxwell Jones and Tom Main. This interaction led to the transformation of the "Villa Landeg" ward in Switzerland into a Therapeutic Community under self-government (Corulli, 2016). As a consequence of this efficacious experience, he established the "Therapeutic Community of Rome," which subsequently served as a venue for meetings and clinical seminars and remained a point of reference for developments in analytic and groupthink. The innovation of this therapeutic approach lies in the emphasis on patient relationship and participation as the cornerstone of therapy. The basic principles on which rehabilitation begins include patient autonomy, commitment to daily activities, moderation in medication consumption and a mix of individual and group treatment. Unfortunately, the Ministry of Health's inability to supply the funds as planned led to serious financial difficulties and the early termination of this innovative project in Rome in 1966 (Corulli, 2016).

Within the Italian context, Franco Basaglia, a pivotal figure in the field of psychiatric reform, merits once again particular mention. He acknowledged the merits of British therapeutic communities while adopting a relatively critical stance. Basaglia

visited Maxwell Jones in 1962, yet devoted minimal attention to him and therapeutic communities in his writings. Instead, he focused on the destruction of asylums and the liberation of patients from subservience to psychiatrists. Rather of copying the English model, Basaglia contended that the phrase "therapeutic community" signified an assembly-based and transparent administration approach for institutions. According to him, this was only a stopgap measure and wasn't the ultimate aim of mental health reform (Basaglia, 1982).

In contemporary Italian practice, therapeutic communities are defined as residential facilities offering care and hospitality to individuals diagnosed with mental disorders. Such facilities provide a range of rehabilitation services, delivered by trained professionals, with varying degrees of intensity (Barbui, Papola, and Saraceno, 2018). The clientele of Italian facilities are frequently individuals afflicted with persistent and complex mental disorders, who have experienced traumatic, deprived, and abusive circumstances. In certain situations, medication management of uncomfortable symptoms may be necessary but the main goal should be rehabilitation—which is the process of restoring an individual's capacity to carry out particular tasks and activities (Boschiero and Others, 2013). The key objective of the recovery paradigm is to support joint efforts between therapists and users to pinpoint common goals and turn the experience of the disease into a driving force for individual growth (Jones, 1953).

In relation to individuals with no history of criminality, the objective of rehabilitation and the facilitation of recovery for those with a criminal disposition represents an even more challenging goal. This work can also be conducted in psychiatric residential facilities, where, in certain cases, the primary objective is the rehabilitation or even the evocation of motivation. This is especially noticeable when the need for therapy is forced by social institutions, usually in the form of a magistrate's order, rather than

being requested by the person in issue. The challenge lies in figuring out the most effective way to interact with these patients and what it means to "take care of them," especially when their main concern is being deprived of their freedom from the outside, which makes them ignore their lack of freedom within (Cavalleri, 2017). It can be argued that the act of caring for the patient in these circumstances extends beyond the mere treatment of their ailment, and instead encompasses a distinction between care and treatment. The provision of care is contingent upon the existence of a sufficiently stable demand from the patient. In the event that there is no such desire, the patient must nonetheless get treatment, even if it is mandated by law (Cavalleri, 2017). This entails talking about a subject that is both confined by their own incoherence and by the penalty-imposing legal obligation. Instead of promoting transformation, this can focus the patient's whole emphasis on pathogenic strategies (Santambrogio et al., 2021). Seeing care as a nonlinear process that consists of a sequence of steps leading to a mutually trusting and secure condition, together with a decrease in suffering and a change in viewpoints, is crucial.

It is essential to recognize that a person found guilty may experience a duality of emotions: on the one hand, the external imposition of restrictions arising from legal judgment and on the other, an intrinsic sense of autonomy and self-determination.

Investigating the offender's inner experience becomes essential to fully comprehending and treating their behaviour. In the words of Santambrogio et al. (2021), this dichotomy might show itself as a diminished dedication to external regulations, trouble reining in urges, and trouble expressing and comprehending feelings.

In this situation, the provision of clinical care, which is focused on the internal experience of the patient, must be integrated with an assessment of behaviour and facts with social impact, which is a legal dimension in itself. A common objective is the

resocialisation and rehabilitation of the offender, with the aim of reducing recidivism in relation to violent behaviour. This necessitates the implementation of targeted therapeutic interventions with the objective of enhancing the individual's relational and social competencies.

It is essential that interventions are tailored to the individual patient, taking into account their unique perspectives on treatment, punishment, justice, and life in general. It is essential that the initial approach avoids any sense of invasion or threat, and instead promotes a non-judgemental, welcoming and understanding environment in which patients feel able to express their views. This enables the creation of collective narratives and new interpretations of suffering and trauma, facilitating shared meaning-making and the development of hope.

Rehabilitation is a multifaceted process that seeks to facilitate the patient's journey towards authenticity, adaptation and autonomy. It entails establishing contact with one's fundamental self, conducting a comprehensive assessment of reality, and cultivating the capacity to form covenant relationships. This necessitates the acknowledgement of the patient's intrinsic value and a collaborative approach with the legal system, which should facilitate the patient's perception of the legal system as a potential avenue for personal growth and the liberation of desire (Cavalleri, 2017). In order to facilitate an individual's autonomy, it is essential that a multidisciplinary approach is adopted which includes the contribution of a range of services, including those provided by international criminal enforcement agencies, mental health centres and communities. However, the current system is beset by a number of problems, including the separation of social and medical services, a shortage of funding and human resources, and inflexible cultural paradigms. Castelletti and Others (2023) posit that the high occupancy rates in the REMS for the purpose of incarceration underscore

the necessity for alternative and innovative pathways to the treatment of patients who are offenders.

The Genoa REMS, part of the Redancia Group, is an example of how Italian legislation conceptualises and oversees semi-private psychiatric facilities dedicated to the rehabilitation of offenders with mental disorders. The Redancia Group's model is built upon an integrated methodology that encompasses patients, regional care providers, and families. The intention of this approach is to establish an interactive and evolving therapeutic pathway with the objective of enhancing the patient's quality of life. The model is based on three fundamental morals: respect for the patient, welcoming of the family, and the significance of care, along with the assessment of therapy outcomes in quantifiable terms (Gruppo Redancia, 2024).

The heterogeneity of the group allows for the exact tailoring of treatment regimens, thereby aiding in the discovery of the optimal therapeutic modalities for each individual case. The Genoa REMS plays an integral role within the rehabilitative pathway for individuals convicted of criminal offences with diagnosed mental health disorders. Upon discharge, patients who have undergone rehabilitation through the REMS program are frequently referred to the therapeutic communities of the Redancia Group due to the former's familiarity with the latter's ethical standards and operational procedures (Gruppo Redancia, 2024).

The integration of technological innovations, such as the Oida system, facilitates an enhanced collaborative relationship between the Genoa REMS and the Redancia Group therapeutic communities. This computerised system enables the precise and transparent administration of treatment data, thereby preventing self-referral and enhancing the efficacy of the treatment process. The provision of semi-private facilities offers a potential solution to the challenge of delivering more flexible and tailored care, which

can be difficult to achieve within the constraints of public settings. From a legal standpoint, the relationship between semi-private facilities, such as those of the Redancia Group, and Italian law gives rise to significant questions concerning the regulation, supervision, and financing of such entities. In accordance with Italian legislation, psychiatric residential facilities are required to adhere to exacting standards of quality and safety. Moreover, these facilities are obliged to uphold patients' rights and to engage in close collaboration with the national health service. It is of paramount importance to ensure that the operations of these facilities are subject to continuous monitoring and regulation in order to guarantee the respect of patients' rights, foster transparency, confirm the efficacy of therapeutic measures, and, finally, preserve human dignity. These measures must be taken in line with the principles laid down by the Basaglia Law and subsequent regulations.

As previously indicated, Legislative Decree 81/2014 mandated the closure of judicial psychiatric hospitals (OPGs) and the establishment of regional centres for the rehabilitation and reintegration of psychiatric offenders (REMS), signifying a transition towards a more humane and therapeutic approach to the management of psychiatric offenders. REMS should operate in strict accordance with established guidelines, with the overarching objective of ensuring that treatment is orientated towards rehabilitation and social reintegration rather than merely custodial. The monitoring and supervision of these facilities is the responsibility of the Ministry of Health, which works in collaboration with regional authorities to guarantee that the requisite standards are met. The Genoa REMS and other Redancia Group facilities are situated within the aforementioned contextual framework, offering therapeutic solutions that integrate the public and private sectors with the overarching objective of providing effective care that respects human dignity (Gruppo Redancia, 2024).

One might posit that the Villa Caterina REMS and the Redancia Group therapeutic communities exemplify an efficacious model of integration between sophisticated therapeutic methodologies and legal regulation. This model contributes substantially to the rehabilitation and social reintegration of patients with psychiatric disorders and is designed to meet both the individual therapeutic needs of patients and the ethical and legal standards set out in Italian legislation for the management of mental health.

Considering the M.A. case study taken into account in this research, his relocation from the REMS Villa Caterina in Genoa to a therapeutic community within the Redancia Group represents a paradigmatic case study of the intricate interplay between therapeutic necessities, public safety, and legal considerations.

M.A., who commenced treatment at the REMS in 2017 and is now undergoing de-escalation therapy, is considered ready to progress to the next stage of his treatment in a therapeutic community setting. Nevertheless, the transition is beset with considerable implications and challenges. The decision was made to place the patient in a therapeutic community within the Redancia Group due to the availability of an experienced clinician with a detailed knowledge of the patient's case history since his arrival at the REMS. This ensured the necessary continuity of care, which is crucial for the effective management of this particularly complex situation. Such continuity is vital to ensure consistency in the treatment and clinical and emotional management of the patient, thereby reducing the risk of regression and guaranteeing constant monitoring.

Italian legislation provides a system of security measures, centred on probation as a fundamental aspect, that allows for the customisation of treatment pathways to align with the specific requirements of patients. The judge who presided over the initial proceedings may impose probation or, as is frequently the case, may modify the original probationary period upon admission to the REMS. This measure permits the imposition

of a therapeutic and rehabilitative pathway, which may extend from an initial intake at a mental health centre to a longer-term placement in either public or accredited residential facilities.

The scheduled review in the autumn will be a pivotal juncture in the case of M.A. It will be a time when both clinical and judicial authorities will have to evaluate the patient's progress in demonstrating an absence of dangerousness and assess his suitability for transfer to a less restrictive environment. Conversely, the judicial evaluation will examine the granting of the LFE (Experimental Fiscal License), which constitutes a fundamental aspect of guaranteeing that the transition occurs in a secure and regulated manner.

Nevertheless, the decision to place M.A. in a Redancia Group community, the sole facility to accept the patient, gives rise to questions regarding the capacity and preparedness of other facilities to accommodate patients with complex clinical profiles. This situation reflects a structural deficiency in the system designed to accommodate patients who have completed a REMS program.

The sustained rise in the number of individuals on probation, particularly in the post-OPG era, illustrates the growing significance of non-custodial security measures within the Italian legal system (Vella, 2016). The lack of precise details regarding the precise types of probation, along with the degree of restrictions handed down by the courts, makes it difficult to conduct a thorough assessment of their efficacy and suitability. It is crucial to differentiate between community- or residential-based probation and home-based probation. This is to prevent the community pathway from being erroneously equated with a custodial security measure, for which a comparable duration limit must be applied. The application of probation as a security measure is a fundamental aspect of the system (Ferracuti and Others, 2019); however, its implementation in the case of

M.A. necessitates a heightened level of caution and scrutiny. It is essential to subject the therapeutic continuity provided by the Redancia Group physician to rigorous scrutiny in order to prevent the emergence of dependency dynamics and facilitate the introduction of innovative therapeutic strategies. Moreover, the extensive implications of non-custodial personal security measures have prompted considerations regarding the long-term viability of community-based models and the necessity for the development of specialised community resources to accommodate individuals with criminal histories. M.A.'s case serves to exemplify, among other things, the intricate operational dynamics of the REMS and post-REMS systems, prompting a crucial examination of Italian healthcare and justice policies.

It is imperative that clinical and judicial evaluations are conducted in collaboration to ensure effective treatment that respects human dignity. However, this must be accompanied by a system that is capable of continual adaptation and innovation.

### **3. Forensic Liminality and Mental Health: Navigating Judicial Gaps and Systemic Neglect in Europe through Case Law**

In light of the Italian experience, which has served as a model for the significant advances made in the field of mental health rights for those with a history of mental illness and involvement in criminal proceedings, it is instructive to adopt a broader European perspective and examine the contrasting approaches taken by three case study countries (Kelly and Donnelly, 2023).

This concluding section is divided into three parts and analyses three legal cases on the issue of rights in the context of mental illness. The initial case under examination is *Murray v. Netherlands* (Netherlands, 2016, 10511/10), which is analysed from an illuminating perspective by Teresa Pizarro Beleza and Helena Pereira de Melo.

The second case to be considered is that of *Fernandes de Oliveira v. Portugal* (Portugal, 2017, 7810/14), which addresses the specific issue of the responsibility of authorities in the case of the suicide of a mentally ill person in a public hospital (Boschiero and Others, 2013). Finally, the ruling in *Kuttner v. Austria* (Austria, 2020, 7997/08) offers an in-depth analysis on the notion of criminal responsibility of the accused and the corresponding responsibility of the state to fulfil its human rights duties and ensure adequate medico-legal support, especially in cases where mental pathology is a crucial variable. The issue under discussion is of a particularly sensitive nature and requires a synergy between the disciplines of law and psychology to achieve an appropriate balance between the protection of the rights of the accused and the safeguarding of public safety (Boschiero and Others, 2013). In this context, it is emphasised that those who have committed crimes should never be placed in a situation where their fundamental rights are compromised.

The analysis presented in this paper emphasises the significance of appropriate action, which is initially demonstrated through an examination and evaluation of specific cases, and subsequently through a concluding observation that, on a comparative and more critical level, aims to highlight the most pertinent points. The objective of this analysis is to facilitate an informed debate and a deeper understanding of the cardinal role that law and psychology play in human rights and mental health issues within the context of criminal law (Kelly and Donnelly, 2023).

### **3.1 The Paradox of Judicial Suspension: *Murray v. Netherlands* and the Inaccessibility of Psychiatric Care**

This text addresses a crucially important issue: the extent to which states, which are responsible for the judicial and penitentiary systems, are obliged to ensure the physical and mental well-being of convicted persons, on the one hand, and, on the other

hand, to offer prisoners under their authority the opportunity to obtain conditional or final release, possibly subject to certain conditions, even in situations of life imprisonment.

A key aspect of this legal debate is the question of balancing the duty to punish those who have committed crimes with the obligation to respect the fundamental rights and human dignity of individuals within the penal system.

The debate concerns the obligation of the state to guarantee humane treatment and the right to physical and mental integrity of prisoners, as well as the pivotal role of legislation in establishing the criteria and conditions for early release.

The objective of this clarification is to elucidate these complex challenges, emphasising the importance of achieving a careful balance between the necessity to administer justice and the requirement to protect human rights, particularly in the context of life imprisonment. The analysis presented in this article will facilitate a more informed discussion and understanding of justice and prison system issues as they relate to the mental health and fundamental rights of offenders.

The case of James Clifton Murray, a Dutch citizen born on the island of Aruba in 1953, presents a complex challenge that gives rise to fundamental questions concerning the legal system and the mental health needs of individuals involved in criminal proceedings (Kelly and Donnelly, 2023; Ruggeri, 2015). Murray was charged with murder and sentenced to life imprisonment, but his case gave rise to a vigorous debate concerning the manner in which the law should address the complex mental health issues of defendants.

Initially convicted in March 1980 by the Court of Appeals of the Netherlands Antilles for intentional and premeditated murder, Murray was later pardoned by the governor of Curaçao and transferred to a health center on the island. There he spent the next few

years before dying in November 2014. His story raises important issues about the fairness of his sentence and the conditions of detention to which he was subjected.

This article aims to take an in-depth look at the case of James Clifton Murray, analyzing how the European Court of Human Rights has addressed the issues of prison conditions, assessment of risk of recidivism, and access to psychiatric care.

He will also seek to shed light on how this case may influence future debates and judicial decisions regarding human rights and mental health in the criminal justice system (Netherlands, 2016, 10511/10).

At a time when human rights and fair justice are the focus of global attention, the case of James Clifton Murray presents a significant challenge to understanding how the law should address the intricate challenges of mental health in the context of high-level criminal law.

### **Inequality in access to mental health services**

In the case of Murray, the issue of unequal access to mental health services is clearly evident, which is undoubtedly a crucial aspect of social and constitutional justice. In order to gain a full understanding of this inequality, it is necessary to consider a number of details and implications from a variety of perspectives.

The lack of financial resources available to Mr. Murray resulted in considerable restrictions on the availability of support for his mental disorder, which consequently resulted in a lack of access to quality mental health services. A consequence of the paucity of public funds allocated to this sector is a lack of consistency in state action with constitutional norms, which has prompted significant concerns. The Constitution indeed enshrines the fundamental principle of equality, according to which all citizens should have equal access to public services, including mental health services (Ruggeri, 2015).

This discriminatory practice, which was a direct consequence of a lack of financial resources, prompted an investigation into the efficacy of the state's measures to guarantee accessible and equitable mental health services for the entire population. Murray's case study serves not only to elucidate the phenomenon of discriminatory practices with regard to the provision of services, but also to highlight the possibility of socioeconomic discrimination in this context. The dearth of affordable mental health services highlighted the glaring disparities in accessibility based on socioeconomic status and personal resources. Such a response, contingent on the economic circumstances of the individual in question, would constitute a clear contravention of the principles of equality and non-discrimination enshrined in the Constitution. Put another way, an individual's capability to obtain suitable mental health care must not be contingent upon their economic circumstances. The circumstances of Murray's case thus prompt the question of the quality and scope of measures taken by the state to guarantee accessible and equitable mental health services. In summary, the unequal access to mental health services in Murray's case is a reflection of several broader issues, including limited financial resources, socio-economic discrimination, and the question of the adequacy of state measures. The dearth of suitable infrastructure and adequate funding suggests a potential dereliction of duty on the part of state authorities in providing optimal mental health services. This may contravene the state's constitutional and international obligations to safeguard the right to mental health and prohibit discrimination.

A comprehensive examination is imperative to address these issues and advance towards a more equitable and just society.

### **International Law Compliance and Its Failures**

By analysing the status of the Murray case in relation to state responsibilities, it could be argued that this case is also pertinent to matters pertaining to the international obligations of the state in question (Smith, 2019).

Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) explicitly states that: “*No individual shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.*”

The aforementioned principle constitutes a mandatory commitment for all member states, including the state involved in the Murray case. In examining the circumstances of Murray's case, the absence of sufficient treatment for his mental illness may give rise to significant concerns regarding compliance with Article 3 of the ECHR. A deficiency in access to appropriate mental healthcare may be regarded as an instance of neglect in a context requiring meticulous care. Such circumstances could be perceived as a form of inhumane or degrading treatment, given that they would subject Murray to unwarranted psychological and physical distress. It is thus incumbent upon the ECHR to safeguard individuals from such situations of disadvantage and violation. Consequently, it is imperative to assess whether or not the state has fulfilled its obligations in this particular case. In order to ascertain whether the stance adopted by the state was consistent with the tenets set forth in Article 3 of the ECHR (Smith, 2019), it is essential to undertake a thorough examination of the particulars of Murray's case. An analysis is required that evaluates the decision in a broader framework. This should assess what alternatives the state had to ensure Murray's mental well-being, whether it took adequate measures to avoid inhuman and degrading treatment at all costs, and finally, whether the principles of human dignity and respect for the individual were violated.

Murray's case thus gives rise to questions of considerable relevance with regard to the

fulfilment of the state's international obligations, with particular attention to Article 3 of the ECHR. In this case, the failure to provide adequate treatment for Murray's mental disorder could constitute a potential violation of this fundamental provision, which requires a comprehensive assessment of the state's circumstances and actions. This emphasises the necessity for unwavering commitment to international standards for the safeguarding of human rights, particularly in the domain of mental health and individual well-being (Boschiero and others, 2013).

### **Systematic negligence of mental health**

In light of the aforementioned considerations and following a comprehensive examination of the case and associated matters, a pivotal question arises concerning the manner in which individuals with mental disorders should be treated within the justice and prison system. The Murray case gives rise to concerns not only regarding discrimination in access to mental health services, but also with regard to the approach of the legal system at the national and European levels towards these individuals.

Addressing this complex challenge, therefore, requires reformulating a new approach that involves different aspects and people, not only from a legal perspective, but also from a medical and policy perspective.

First, an active role on the part of the state is required to ensure that people with mental disorders receive appropriate treatment, including mental health services (Kelly and Donnelly, 2023). This treatment must be ensured in both investigation and detention.

Undoubtedly, this entails a number of necessary investments in order to ensure

However, it is necessary for the state to be the main agent in ensuring that people with psychiatric problems have access to adequate treatment, regardless of their economic situation. In fact, lack of public resources should never be a barrier to access to mental health services.

Secondly, the issue of training must be addressed. Prison staff, including psychiatrists and psychologists, must receive adequate training to enable them to recognise, assess and treat mental disorders, regardless of their severity. Consequently, this training encompasses the capacity to discern and identify preliminary indications of mental health concerns and to furnish the requisite assistance.

It is also imperative to establish clear guidelines for the management of inmates with mental illness. This is to ensure that they receive appropriate care and that their needs are met. However, most importantly, this must be done in a humane manner.

Third, a factor that should not be underestimated is the consideration of defendants' mental conditions during trial. This requires an interdisciplinary approach, a collaboration between the legal and medical sectors, to ensure that the rights of prisoners with mental illnesses are adequately protected (Kelly and Donnelly, 2023).

Finally, it is critical to ensure constant oversight and accountability within the justice and prison system to prevent individuals like Murray from being neglected for years. It is necessary to have transparent oversight bodies that allow laws and policies to function properly.

The case of James Clifton Murray demonstrates the necessity for a comprehensive approach, involving the functions of the state, the judiciary, the prison, and medical personnel, to ensure the ethical treatment, proper care, and fundamental rights protection of those with mental disorders. Such a systematic approach to collaboration and reform is therefore essential if future instances of neglect and discrimination against individuals experiencing mental health disorders in legal and penal contexts are to be avoided.

### **Concluding Reflections on Murray's Legacy**

I have endeavoured to provide a comprehensive and timely examination of the significance and urgency of the issue of mental illness in the context of incarceration. The objective of this brief analysis is to provide the reader with a foundation for further research and reflection on how such situations are addressed in national policies. The legislative system of the Netherlands represents a useful case study for examination of the topic. However, the topic allows for examination of the diverse approaches taken in other global scenarios.

It is my intent that this study will enhance awareness of the legal position on the necessity to gain a deeper theoretical understanding of the role of mental illness.

Psychological discourse must be complemented by the implementation of a comprehensive system of protection, the objective of which should be the safeguarding of fundamental rights and of the legal integrity of all human beings.

### **3.2 Phenomenology of Institutional Vulnerability: The Case of Fernandes de Oliveira v. Portugal**

In *Fernandes de Oliveira v. Portugal* (Portugal, 2017, 7810/14), the question of the responsibility of the authorities was challenged in the case of the suicide of a mentally ill patient in a public psychiatric hospital. The ruling of the Court establishes the obligation of the authorities to implement adequate preventive measures to safeguard the lives of patients in circumstances where the risk of self-harm or suicide is identified.

This decision places particular emphasis on the specific circumstances of the patient in question, taking into consideration their capacity to adapt to potential risks, their right to privacy and autonomy, as well as the efficacy of the legal system in addressing instances of negligence or omission. The case thus provides illustrative evidence of a

number of significant issues. These include matters pertaining to human rights, the safeguarding of the lives of patients with mental illnesses within the hospital context and the legal protection measures that may be applicable.

In accordance with the ruling handed down by the Court, the fundamental tenet of human rights that was upheld is the "right to life," which is enshrined in numerous international treaties and conventions, including the European Convention on Human Rights (ECHR) (Scarpa, Castelletti, and Lega 2019). This principle is set forth in Article 2 of the ECHR, which states, "*The right to life of every human being is protected by law.*"

It is prohibited to intentionally deprive another person of their life, except in the context of performing one's professional duties.

A sentence of death is a sentence handed down by a Court upon conviction for a crime for which the law provides for such a punishment.

It is in the context of psychiatric patients that the responsibility of the authorities becomes particularly critical. These patients, who are particularly vulnerable individuals due to the nature of their disorders, are at an elevated risk of self-harm or suicide (Vella, 2016). It is, therefore, the duty of those responsible for the management of public psychiatric institutions to implement suitable preventative measures with a view to safeguarding the lives of those individuals who are particularly vulnerable.

### **Risk Assessment within Vulnerable Populations**

In order to illustrate the utility of certain preventative measures in such circumstances, one might cite the case of *Fernandes de Oliveira v. Portugal*.

This case emphasises the importance of assessing individual circumstances in relation to the drama of the patient affected by mental disorder.

The Court's ruling accurately underscores the fact that each patient diagnosed with a mental disorder is inherently distinct, possessing distinctive needs and a personal history that is unique to them. Consequently, an approach that is tailored to each individual and sensitive to the complexities of psychological distress should be adopted. It is therefore imperative to undertake a comprehensive evaluation of the circumstances surrounding the Fernandes de Oliveira case in order to prevent an unfavourable outcome.

The patient's personal history includes a previous suicide attempt, which serves as an indicator of considerable vulnerability. It would have been prudent for the appropriate health authorities to have initiated an in-depth assessment of the extent of his mental illness, the presence of suicidal ideation and his overall mental state at an earlier juncture (Echr, "Oliveira v. Portugal, 2017).

Nevertheless, it would seem that the assessment of individual circumstances was not sufficiently thorough in this instance. Despite the presence of evident risk factors, the patient was not subjected to adequate supervision or protection. This prompts the need to examine the quality of patient assessment and the efficacy of preventive measures adopted by the psychiatric hospital.

In light of the significant ramifications of this incident, it is imperative to underscore the necessity for comprehensive evaluations of individual circumstances within the psychiatric context.

It is of the utmost importance that such assessments are conducted with the utmost care and sensitivity, taking into account the potential risks, the patient's past and their particular needs.

It is imperative that mental health professionals receive comprehensive training to develop the competencies required to identify critical signals and take action in a manner that ensures patient safety and well-being.

The case of Fernandes de Oliveira versus Portugal serves to illustrate the vital importance of adopting a personalised and meticulous approach to the treatment of patients with mental disorders. Moreover, this case highlights the imperative for healthcare professionals and authorities to ensure that such assessments are conducted with the utmost care and protection for vulnerable patients.

The assessment of circumstances constitutes an essential element of the risk assessment process (Carpiniello, Vita, and Mencacci, 2020). Both emphasise the importance of a case-by-case approach to patient care, although they do so by focusing on different aspects of the care management process. The assessment of individual circumstances represents a fundamental initial step in the process of understanding the patient, whereas the ability to adapt to risk necessitates the capacity to respond flexibly to changing circumstances. It is widely accepted that these concepts represent fundamental tenets in the management of patients with mental disorders. However, it is notable that they do indeed emphasise slightly disparate elements of the process of care and protection.

The concept of risk evaluation has become a crucial element in the therapeutic process for individuals with mental disorders, extending beyond the mere understanding of the patient's personal circumstances. This concept requires a comprehensive and dynamic examination of potential threats to the patient's well-being. It encompasses self-harm and suicidal tendencies and an evaluation of the probability and ramifications associated with these risks.

A comprehensive risk assessment requires the collection of relevant information, including the patient's behaviour, any statements made, the patient's symptom

progression, their medical history and other pertinent data. This assessment is not solely an exercise in data collection; the capacity to analyse the information gathered is also essential for the identification of specific risk factors and their subsequent assessment of severity (Vella, 2016).

Moreover, risk assessment is an ongoing process that incorporates changes in the patient's circumstances. Therefore, it can be posited that mental health practitioners are required to demonstrate the capacity to continually modify their assessment in response to alterations in their patients' behaviour or condition (Kelly and Donnelly, 2023). This capacity for adaptation is a fundamental element of the implementation of suitable preventative measures, which must be responsive to the evolving nature of the risk in question.

#### **Adaptation to institutional risk**

A further crucial element that emerges from the analysis of the decision in the case of *Fernandes de Oliveira v. Portugal* is that of adaptation to risk.

In particular, the decision reveals that the hospital involved has demonstrated a considerable sensitivity to the variable risk associated with the patient's unstable mental state. This indicates that health authorities have acknowledged the possibility of fluctuations in the level of risk associated with suicidal behaviour, necessitating a responsive and adaptive approach to patient management.

An ability to adapt surveillance regimes and preventive measures in accordance with the specific needs of the patient can be regarded as an evidence-based approach that is sensitive to the individual circumstances of each case. In contrast to the adoption of a standardised solution, the authorities have demonstrated their capacity to adapt preventive measures in order to meet the evolving needs of the patient.

This flexibility is of paramount importance in the treatment of patients with mental disorders, as it allows for a more effective approach to protecting their lives and well-being.

### **Patient protection: a comprehensive approach**

Moreover, the decision reinforces the imperative of attaining a equilibrium between the safeguarding of patients and the reverence owed to their dignity and privacy.

While it is of the utmost importance to guarantee the security of patients from self-harm, it is equally vital to refrain from imposing undue and restrictive measures that could potentially compromise their dignity or infringe upon their rights. In this context, preventive measures should be designed to be as least restrictive as possible while ensuring patient safety. This recognises the need to treat patients with mental disorders in a humane and respectful manner, while preserving their dignity and autonomy.

Finally, the decision refers to the length of the legal proceedings brought by the complainant but stresses that, despite the length, it was effective in determining responsibility for the patient's death.

This underlines the importance of an efficient and functional legal system, capable of being accountable for the actions of authorities and ensuring that they are held liable in cases of negligence or omission. This system provides a form of protection for patients' rights and ensures that authorities are held accountable for their actions, helping to ensure transparency, fairness and justice in the treatment of patients with mental disorders.

In short, these points underline the Court's comprehensive and balanced approach to considering the responsibility of authorities in the case of mentally ill patients admitted to psychiatric facilities.

This judgement evinces the necessity for a case-by-case examination of patients' unique

circumstances, the tailoring of care plans to align with patients' individual requirements, respect for their inherent dignity, and the integration of patients' perspectives into the formulation of care decisions (Echr, "Oliveira v. Portugal, 2017).

It is of the utmost importance to adhere to this approach, as it ensures defense for human rights and the safeguarding of vulnerable patients. This approach is pivotal to ensuring the respect of human rights and the security of vulnerable patients.

### **Concluding Insights on Systemic Reforms**

The case of *Fernandes de Oliveira v. Portugal* highlights several significant and pioneering considerations pertaining to the safeguarding of patients with mental disorders.

Firstly, it is imperative that a personalised approach be adopted with regard to the management of psychiatric patients. It is of the utmost importance that an assessment of individual circumstances is conducted, including an evaluation of the severity of mental disorders and the presence of risk signals. Such an individualised approach not only considers the specific needs of patients, but can also inform the implementation of targeted preventive measures.

The concept of risk adaptation is of paramount importance. It is imperative that psychiatric hospitals demonstrate flexibility in adapting their surveillance regime and preventive measures to the changing needs of patients. This necessitates effective communication between the medical and care teams to enable the constant assessment of risk and the formulation of informed decisions. It is of the utmost importance to respect the privacy and dignity of patients. While it is necessary to implement protective measures, it is imperative that they are not unduly intrusive or overly restrictive. The equilibrium between the safeguarding of patients and the upholding of their dignity necessitates particular scrutiny when formulating protocols and procedures.

The outcome of this case highlights the vital necessity for a legal system that is both effective and efficient in recognising and establishing liability. It is of the utmost importance that the lengthy nature of legal processes does not act as an impediment to their implementation. It is imperative that these processes facilitate the clear and unambiguous establishment of responsibilities, as well as accountability for those in authority.

In conclusion, the case of *Fernandes de Oliveira v. Portugal* provides a detailed and multifaceted examination of the challenges associated with the care and defence of patients with mental disorders within the psychiatric system. It emphasises the necessity for a personalised approach, adaptation to risk, respect for the dignity and efficiency of the legal system, thus contributing to the promotion of human rights and the protection of the lives of vulnerable patients.

### **3.3 Judicial Temporality and Psychiatric Fragmentation: *Kuttner v. Austria* and the Erosion of the Right to Review**

In the case of the *Kuttner v. Austria*, the complainant, subsequent to the lodging of a petition for discharge from the psychiatric hospital, was subject to an infringement of Article 5 of the European Convention on Human Rights (Austria, 2020, 7997/08). In alignment with Article 5 of the European Convention on Human Rights (Villiger, 2022), paragraph 4 pertains to the individual's rights with respect to liberty and security, as well as the imperative for a prompt examination of the legality of detention. The violation of this article is confirmed by the fact that the applicant has argued that the long period of time during which his request for release was examined violated his right to an immediate review of his detention. Article 5 of the Convention lays down, in its entirety, the provisions relating to the right to liberty and security of the person and regulates the conditions under which a person may be deprived of his or her liberty

(ECHR – Art.5). It also stresses the need for immediate judicial control over the lawfulness of detention and sets out the grounds on which a person may be deprived of liberty (Frankowski and Shelton, 1992).

It also sets out the rights of detained persons, such as the right to be informed about the reasons for detention and the right to appeal to a court against detention.

In addition to this invocation of Article 5, the appellant raised a question concerning Article 6 § 1 of the Convention (ECHR- Art. 6), which concerns the right to a fair trial. He argued that the excessive length of the proceedings constituted a violation of this right, since the restrictions imposed by his detention in a mental health institution affected on his civil rights.

The Court, after careful analysis, concluded that Article 5 § 4 of the Convention was applicable to the proceedings in question, but that the proceedings had not taken too long (Dute, 2015). In any event, a breach was established against the claimant because of failure to comply with the requirement of expediency, but this damage was not pecuniary, mental or emotional.

In the case of *Kuttner v. Austria*, the issue concerned the violation of the applicant's right to a prompt review of his detention in a mental hospital and the undue length of the procedures associated with this request. Following an examination of the violations by the European Court of Human Rights, the Court granted the claimant compensation for the damages incurred (Villiger, 2022).

### **Protection of the rights of persons with mental disorders in the criminal justice system**

The *Kuttner* case highlights the need to ensure that such a review is indeed timely and complete. The European Court of Human Rights has recognised that the right to review must be effective and not merely formal. However, the case highlighted a discrepancy

between the ideal of a timely review and the reality of Austrian legal procedures.

This raises a crucial question for international jurisprudence: how to ensure effective and timely rights for people with mental disorders within the criminal justice system?

One of the original crucial considerations is the intersection between human rights and mental health. Article 5 § 1 of the European Convention on Human Rights clearly sets out the circumstances in which a person may be deprived of liberty, but how should cases where detention is lawful but the person concerned suffers from mental disorders be treated?

The Court has previously determined that the detention of individuals with mental disorders should only be permitted in exceptional circumstances and when it is strictly necessary. However, the Kuttner case underscores the necessity for a prompt and comprehensive review of such cases (Boschiero and Others, 2013).

The European Court of Human Rights has established that the right to review must be effective and not merely formal, but once again, the Kuttner case revealed a discrepancy between the ideal of a prompt review and the reality of Austrian legal procedures.

This gives rise to a pivotal question for international jurisprudence: how can the effective and timely realisation of rights for individuals with mental disorders within the criminal justice system be guaranteed?

One of the original and crucial considerations is the intersection between human rights and mental health. The circumstances under which a person may be deprived of their liberty are clearly defined in Article 5 § 1 of the European Convention on Human Rights. This article does not address the specific issue of dealing with detention when it is legal but the person involved suffers from mental disorders.

The Court has previously determined that the incarceration of subjects diagnosed with mental disorders should only be pursued in extraordinary circumstances and when it is

unquestionably essential. Nevertheless, the Kuttner case suggests that these guidelines may lack sufficient clarity or uniformity in their implementation. Therefore, case law must carefully examine the boundary between protecting human rights and managing mental health in a criminal context, ensuring that people with mental disorders are not detained excessively or arbitrarily. In addition, greater attention should be paid to procedural safeguards to ensure that reviews are effective and timely, avoiding unjustified delays such as the Kuttner case.

To conclude, the Kuttner v. Austria case elucidates a multitude of challenges and prospects pertaining to the protection of the rights of individuals with mental disorders within the criminal justice system. This decision serves to illustrate the necessity of ensuring rigorous adherence to international human rights standards in such contexts. The insights provided can be used to inform future developments in case law for protecting this vulnerable population within the criminal justice system. Case-law must guarantee the protection of all individuals in order to balance the protection of society and human rights.

A reasonable time limit and fair trial for all parties are key factors in the influence of international human rights law. Article 6 of the European Convention on Human Rights has been interpreted and developed by the European Court of Human Rights' case law throughout its history. This Court has acknowledged the necessity of expediency in the administration of justice and has determined that the duration of legal proceedings must be reasonable.

The Kuttner case gives rise to the fundamental question of what constitutes a reasonable duration for a judicial procedure, particularly in the context of individuals detained in mental health institutions (Kelly and Donnelly, 2023). The European Court has emphasised the necessity of considering the complexity of the case and the specific

circumstances in question. This indicates that there is no universally applicable answer, and that each situation must be evaluated on its own merits.

A crucial point that arises from this case is the necessity to guarantee the full respect of the rights of individuals with mental disorders throughout the legal process, including the right to a timely trial. It is similarly important to ensure that the timeliness of legal proceedings does not result in a compromise to the quality of justice. The Kuttner case represents a significant turning point in the ongoing discourse surrounding the optimal equilibrium between these two imperatives.

This case presents a valuable opportunity for reflection for the Austrian judicial system and international courts. Furthermore, an examination of analogous cases in different contexts may prove beneficial in identifying shared best practices and challenges associated with the protection of the rights of individuals with mental disorders within the criminal justice system. In conclusion, the Kuttner v. Austria case demonstrates the complex equilibrium between opportunity and fairness in legal proceedings, underscoring the necessity for innovative strategies to guarantee access to just and prompt trials for all.

### **3.4 Geometries of Uncertainty: Towards a Convergence of Justice, Psychiatry, and Human Rights**

In the light of the comparative analysis of the cases *Murray v. Netherlands* (Netherlands, 2016, 10511/10), *Fernandes de Oliveira v. Portugal* (Portugal, 2017, 7810/14) and *Kuttner v. Austria* (Austria, 2020, 7997/08), relevant legal issues emerge which not only highlight the complexity of mental health issues in the legal context, the urgency of a more integrated regulatory approach, respectful of human dignity in dealing with such situations.

One of the recurring elements in these legal events is the tension between the protection of individual rights and the responsibility of the state to ensure protection for vulnerable people, especially those suffering from serious psychiatric disorders (Smith, 2019). It is important to understand that mental disorders can severely impair an individual's ability to make decisions, leading to delicate questions about their ability to make informed and informed decisions. This problem poses a central dilemma in criminal law and psychiatry: to what extent can mental illness affect the criminal responsibility of an individual? The regulatory framework in case law must be more precise in covering this boundary, with a preference for generic approaches that fail to comprehend the nuances of the accused's psychiatric condition.

Another key issue is the persistence of social and institutional stigma related to mental health, which still constitutes a major obstacle to equal access to support services and justice. The quality of care is not only compromised but also prevented by discrimination, both socially and within institutions. It is thus imperative to foster heightened awareness and a systematic understanding of these issues through legislative reforms that promote the implementation of inclusive and non-discriminatory policies. It is only through a cultural shift, supported by robust regulatory measures, that it will be possible to guarantee that all individuals with mental disorders receive fair and dignified treatment.

The management of patients with psychiatric disorders within a legal context requires a multidisciplinary methodology founded upon empirical evidence and distinguished by efficacious collaboration between legal experts, medical specialists, and mental health practitioners. It is of the utmost importance to ensure that this approach is followed to guarantee fair treatment and effective care for defendants with mental illness who are involved in legal proceedings.

The case of *Fernandes de Oliveira v. Portugal* (Portugal, 2017, 7810/14) serves to illustrate the importance of a continuous and personalised risk assessment, which should consider the patient's medical history in order to allow for the adaptation of protective measures to specific needs. This case illustrates the obligation of the state to take all necessary measures to prevent foreseeable damage and emphasises the responsibility of health institutions in ensuring the safety and well-being of patients.

The *Kuttner v. Austria* (Austria, 2020, 7997/08) case offers a valuable opportunity for analysis regarding the efficacy and promptness of detention reviews for individuals with mental disorders. It is crucial that individuals subjected to involuntary detention undergo regular, comprehensive reviews to assess the legitimacy of their confinement. These reviews must extend beyond mere procedural formalities to guarantee meaningful and periodic assessments of the continued necessity of their detention. Such a solution necessitates a reform of the extant legal procedures, in addition to a tangible pledge by the Member States to guarantee that the laws are enforced in a consistent and uniform manner, and that no vulnerable individual is left without sufficient safeguards. It is therefore essential that the jurisprudence of the European Court of Human Rights continues to evolve in order to provide clear and enforceable guidelines which will strengthen respect for the human rights of persons with mental disorders held in institutions.

In consideration of the issues identified in the analysis of these cases, there is an evident necessity for systematic reform of laws and practices pertaining to the management of individuals with mental disorders within the legal framework. In particular, legislation should be developed to ensure greater integration between the health and judicial systems with a view to providing adequate medical and psychiatric support for all defendants, regardless of their economic or social conditions.

Italy offers a case study in the potential efficacy of a radical reform in the treatment of mental disorders. While the 1978 Basaglia law represented a landmark advance, its continued efficacy is contingent upon addressing current challenges, including a shortage of appropriate facilities and the problem of regional discretion.

A potential solution to the issue of regional inequalities is the greater centralisation of resources and guidelines, while maintaining the flexibility required to respond to specific local needs. Furthermore, it is imperative that the professionals involved in this field, from medical professionals to legal practitioners, undergo ongoing training in order to equip them with the knowledge and skills required to handle complex cases in a competent and sensitive manner.

This methodology has the capability of not only enhancing the efficacy of care provision but also of mitigating the stigma that is frequently affixed to mental illness. It would be feasible to achieve such an outcome by fostering a cultural change that is reflected across all levels of society.

It is of the utmost importance that any future reform considers the significance of prevention and early intervention. Investment in accessible and high-quality mental health services that can intervene before patients' conditions worsen has the potential to significantly reduce the necessity for coercive measures and markedly enhance treatment outcomes.

In conclusion, the examined cases not only reveal existing deficiencies but also offer an opportunity to contemplate how to construct a superior future for mental health management within the legal framework. The objective must be to establish a system that not only upholds human rights but is also capable of providing genuine and efficacious assistance to those who require it most. This reflection must be translated into a concrete commitment by all relevant actors to construct a system that can

reconcile the protection of the community with respect for human dignity and fundamental rights.

#### **4. Pioneering a new Reform: the draft Law 81/2024**

##### **4.1 Reimagining Forensic Psychiatry: Pioneering Reforms Under Law 81/2024**

Despite all the regulatory progress that led to Law 81/2014 and the establishment of the Residences for the Execution of Security Measures (REMS), a decade later, there are still questions about what went wrong and how the remaining challenges could be addressed.

After analysing and bringing to the surface all the critical issues of the contemporary system, it seems appropriate to move from the critical to the active level by having an innovative regulatory proposal that could systematically address the issues that have emerged to date. Such an approach would provide tangible and long-lasting solutions to enhance the REMS management system in Italy.

The new legislative proposal, which may ultimately become Law 81/2024, would seek to construct an integrated, humane, and effective regulatory framework, enabling enhanced support for individuals convicted of psychiatric offences and guaranteeing greater consistency and quality in the implementation of safety procedures.

The objective of this proposal is to address the shortcomings identified in previous legislative measures, including the Basaglia Law (1978) and the current legislation.

As previously discussed, the primary issues pertain to the existence of significant regional disparities in the management of REMS. Despite their inception with the objective of superseding OPGs, these inconsistencies have given rise to a notable degree of diversity in the manner in which patients are treated and the quality of

care they receive. The situation is further exacerbated by the lack of appropriate substitute facilities in numerous areas, leading to overcrowding of REMS and difficulties in developing effective rehabilitation pathways. Moreover, shortcomings in the training of personnel within REMS have frequently resulted in suboptimal treatment and emergency management. Finally, it can be observed that there are difficulties in the coordination of the Italian health and justice systems. There is often an insufficient interdisciplinary basis for case management, and the regulatory framework in Italy's Penal Code is not as advanced as it might be.

The introduction of new legislation, specifically Law 81/2024, would represent a significant evolutionary step in Italian regulatory practice and a means of addressing the deficiencies identified in existing legislative structures. The objective was to devise a novel model that would not only address the issues that have emerged but also be viable and sustainable within the Italian context.

In order for this legislation to become a tangible and enforceable legal reality, it is essential to gain a comprehensive understanding of the Italian legislative process and to devise a strategy that will facilitate its swift approval and implementation. The bill, given the complexity and the need for strong integration between the health care system and the justice system, could be submitted to Parliament as a government bill. This procedure envisages that the legislative initiative starts with the government, more specifically the Ministry of Health, in close collaboration with the Ministry of Justice, given the need to synergise health and legal expertise in the management of REMS. Following its drafting by the executive branch, a government bill is submitted to the legislative body, namely the Houses of Parliament, for formal approval. This is done subsequent to the proposal having been subjected to deliberation and having been

endorsed by the Council of Ministers, which constitutes the executive branch's principal body for the formulation of policy.

The decision to pursue this legislative avenue indicates the significance that is attributed to the proposal and the intention to confer significant institutional authority upon the resulting legislation. This approach facilitates coordination between the various actors involved and thereby ensures greater uniformity and consistency in the application of the aforementioned legislation at the national level.

Should an alternative approach be deemed preferable or necessary, the option exists for the aforementioned bill to be introduced as a parliamentary initiative. It is notable that in this specific context, a coalition of politicians representing a diverse range of political perspectives could present the proposal within either legislative chamber, despite differing views on other matters of public interest. From an analytical standpoint, it would appear beneficial for a unified parliamentary coalition to be constituted, comprising representatives from a diverse array of political affiliations.

By establishing an inclusive and comprehensive consensus at the earliest stage of the legislative process, the likelihood of eventual bill passage is enhanced. Moreover, this approach is aligned with the democratic and pluralistic traditions of the Italian Parliament, facilitating an inclusive and comprehensive discourse and a more intricate engagement with diverse political and social viewpoints.

The objective of this methodology is to facilitate an iterative refinement of the legislative text during the parliamentary process. In both scenarios, irrespective of whether the proposal is introduced as a government bill or a parliamentary initiative, the success thereof will be contingent upon two pivotal factors. Primarily, there is a necessity to construct a comprehensive and resilient consensus. Secondly, the ability to

surmount any resistance through a transparent and compelling demonstration of the necessity and urgency of the proposed reforms must be demonstrated.

In order to prevent approval times from becoming unduly extended, as is often the case in the context of the Italian legislative process, it will be essential to adopt an expedited process. This could be achieved through the declaration of urgency of the bill, an option expressly provided for in Article 72 of the Italian Constitution (Vella, 2016). Such a declaration makes it possible to compress the time for consideration in both parliamentary committees and plenary assemblies, thus speeding up the legislative process and bringing the law to approval more quickly. The request for urgency could find solid justification in the need to promptly address the significant critical issues that have emerged from the implementation of the previous legislation, including regional disparities in the management of REMS and the lack of integration between the health and justice systems, issues that directly affect the protection of the health and safety of citizens. In order to facilitate the bill's passage, it would be prudent for the government to prioritise it within the political agenda, potentially aligning it with a comprehensive public health or justice reform initiative. This approach would guarantee stronger political support and facilitate the attainment of the requisite consensus within Parliament. One factor that would undoubtedly be able to facilitate the development of a broader understanding would be the involvement from the earliest stage, of local authorities, regions, and professional bodies, including the psychiatrists' and lawyers' associations.

From an analytical point of view, it would also be of utmost importance for Law 81/2024 to include specific and targeted legislative additions in order to ensure its practical applicability and effective implementation in practice. In particular, nationwide standardisation of REMS should be linked to a revision and integration of

the articles of Legislative Decree No. 502 of December 30, 1992, which governs the organisation of the National Health Service. This decree, being the regulatory framework for the operation of public health facilities and their regional organisations, provides the appropriate legal framework for introducing changes to make national guidelines for the operation of REMS mandatory. For example, provision could be made for the adoption of implementing decrees, issued by the Ministry of Health in agreement with the State-Regions Conference, to set uniform operational and structural standards in detail, thus ensuring uniform application throughout the country (Vella, 2016).

At the same time, the establishment of a National Agency for the Supervision of REMS could be effectively implemented through an extension of the powers and functions of the National Agency for Regional Health Services (AGENAS), which is already operational and has a mandate to support and monitor regional health performance. The proposed solution would be an optimal choice in terms of cost-effectiveness and the optimisation of institutional resources. It would do so by leveraging an existing infrastructure with a proven track record in health oversight. This option is aligned with the principles of cost-effectiveness and optimisation of institutional resources. AGENAS therefore chooses to establish a solid foundation on which to develop and implement new solutions, opting for an already established infrastructure in the field of health surveillance. However, it might be thought that in order to give AGENAS broader powers, the issuance of a special decree-law could have very positive feedback. This would confer upon AGENAS the authority to approve applications, with the specific objective of ensuring compliance with the standards set forth in the Risk Evaluation and Mitigation Strategy. It is similarly advisable to provide

for parliamentary oversight of the agency's operations, to be achieved through the submission of periodic reports to the relevant committees of the House and Senate.

In terms of the integration of the health and justice systems, the new law could make reference to Article 71 of the Italian Code of Criminal Procedure, which governs security measures against individuals who, due to insanity, are unable to be charged.

In light of the above, it may be beneficial to suggest the inclusion of an amendment that would require the establishment of interdisciplinary teams, comprising psychiatrists, jurists, and social workers. The objective of such teams would be to facilitate a multidisciplinary assessment of cases and a periodic review of the security measures applied. This type of integrated approach could be further strengthened through structured coordination between the justice system and the National Health Service, providing for amendments to Law No. 833 of December 23, 1978, establishing the National Health Service, to create specialised units within REMS dedicated to the management of the most complex cases.

The aforementioned units could be furnished with particular resources and advanced expertise, thus guaranteeing a more appropriate and specialised approach to patient care.

A further crucial aspect is that of the sustainability and enforceability of the law. It is therefore vital to prepare a robust financial plan, which could be incorporated into the state's annual budget law, to guarantee the appropriate allocation of resources to the regions for the construction, maintenance of community facilities and ongoing training of REMS staff. In this context, the inclusion of specific funds for research and development of new therapeutic practices within REMS could be considered in order to promote innovation and the effectiveness of rehabilitation pathways. The law should, in addition, provide a mechanism for periodic evaluation of its effectiveness through the

production of annual reports to Parliament prepared by the National Supervisory Agency.

Such reports should include not only a determination of the efficacy of the legislation under consideration but should also present recommendations for potential regulatory or operational adjustments. These recommendations must be grounded in empirical data gathered in the field.

The objective is to ensure that the reports are objective and accurate. Therefore, they should be reviewed by an independent scientific committee composed of experts in psychiatry, criminal law, and health policy.

To facilitate the rapid implementation of the law, the active involvement of the regions will be crucial in the early stages of implementation. In this context, it is possible to envisage the conclusion of program agreements between the state and the regions in accordance with the provisions set out in Legislative Decree No. 281 of August 28, 1997, which regulates relations between the state and local autonomies. It is possible that such accords could impose obligations on the regions to comply with pre-established implementation timeframes and provide for forms of commissioning for regions that fail to satisfactorily fulfil their obligations.

Moreover, the constitution of a monitoring committee, comprising representatives from the Ministry of Health, the Ministry of Justice, and the regions, may be a viable proposition. This committee would be responsible for overseeing the implementation of the law and intervening promptly in the event of critical issues. Such a committee could be vested with exceptional powers to guarantee adherence to national deadlines and guidelines, and it could serve as an interface between central and local institutions, facilitating continuous dialogue and the expeditious resolution of emerging issues.

In reaching a conclusion, it can be reasonably asserted that the proposed Law 81/2024 represents a necessary development that is aligned with the imperative to enhance the REMS management system in Italy. Through the enactment of a strategic legislative process, the establishment of a transparent regulatory structure, the securing of a robust financial foundation, and the implementation of well-defined monitoring and evaluation mechanisms, it is possible to guarantee the expeditious passage and implementation of this legislation. This methodology would yield the establishment of a fairer and more efficacious system for the treatment of psychiatric patients within the Italian judicial context, while ensuring respect for human rights, administrative efficiency, and economic sustainability.

Law 81/2024, however, is not only intended to be the paradigm of Italian regulations, but also to represent, perhaps too ambitiously, a possible solution to the very wide scenario of psychiatric offenders. A problem that, as we have seen, has its roots already with Foucauldian thought, and perhaps much earlier, and spreads universally without encountering guidelines. This law should therefore not be seen as an exclusively national project, certainly, going into detail we can see how some changes may specifically concern the Italian penal code, but its real purpose is to create a model that can be applied, with due modulations, to various cultural and regulatory contexts. We can say that the great skeleton of this law is composed of flexibility, precision, and respect for human rights, and these are excellent prerequisites for it to be adapted to countries that are at different stages of development in their health and penal policies. To do this, it is crucial not to deny the evidence and to see clearly the fact that the European Union, despite its declarations of intent and founding principles of respect for human rights, has often neglected the specific needs of the most vulnerable minorities. The historical period in which we find ourselves sees society engaged in major struggles

of minorities, but the minorities on the big screen are always the same. The issue of LGBTQ+ rights and racism occupy a great deal of energy within modern activism, but where do disabled people and the mentally ill fit into this? Lack of research and information sees the EU, although it has set high standards in many areas of public health, devoting little coordinated and systematic attention to the treatment of psychiatric patients especially when within the penal system. This regulatory and operational vacuum leaves room for national initiatives such as law 81/2024, which could fill these gaps, not only in Italy, but also in other European countries.

The current context, in 2024, sees the European Union engaged in several initiatives to harmonise health policies among the member states, but these initiatives often lack specificity when it comes to psychiatric offenders who are approached with the urgency of finding a placement, not understanding which treatment approach is best for the individual.

The European mental health programme focuses mainly on prevention and mental health promotion in the general population, but offers few resources and guidelines for the treatment of individuals in the justice system.

However, in order to firmly support the universal applicability of Act 81/2024, one is aware that one may encounter numerous criticisms, which is why we have tried to find possible answers to some of the arguments that could be raised against the bill. Here are some of them.

One of the main criticisms could be the economic and practical sustainability of implementing such an ambitious law in countries with limited resources and inadequate health structures, but this is where the European Union plays a crucial role.

Within the framework of its cohesion policy, the EU already makes available structural and investment funds that can be specifically directed to the improvement of health

infrastructure and the training of personnel in the psychiatric field. Among these initiatives there are: the European Regional Development Fund (ERDF) and the European Social Fund (ESF). The ERDF stimulates the funding of infrastructure such as hospitals and health centres, and could therefore be used to advance the improvement of psychiatric healthcare facilities across Europe, with a specific focus on the offender patient. With a targeted increase in funding, the ERDF could support the construction of new REMS-type facilities and other facilities dedicated to the treatment of psychiatric offenders, bringing these facilities up to the highest standards of care.

The ESF, on the other hand, focuses on the social and economic side, and is an incentive to improve workforce skills and social inclusion. By also enhancing this fund, the EU could finance continuous training programmes for psychiatric and judicial professionals, ensuring that they have the necessary skills to effectively and humanely apply the provisions of Law 81/2024, which would also be a possible opening to more jobs for qualified people in such a specific area.

These programmes could include cultural awareness-raising, psychiatric emergency management techniques, and the teaching of advanced therapeutic methodologies; they would only need to be further strengthened to support the transition of countries with less developed health systems towards higher standards of psychiatric patient management.

Of course, this is nothing new, and in the current European agenda, the Union has already launched several initiatives to improve mental health, but what is important to recognise is that these are often not sufficiently targeted to include the population of psychiatric offenders. Act 81/2024 could not only fill this gap, but also serve as a central pillar of a European-supported reform programme.

Another opportunity to finance this transition would be to refer to the Recovery and

Resilience Facility (RRF) is the main financial instrument within the Next Generation EU programme, created by the European Union in response to the economic crisis caused by the COVID-19 pandemic. The RRF has a budget of EUR 723.8 billion (in current prices), divided between grants and loans, and is designed to help Member States recover economically and to stimulate structural reforms that strengthen long-term economic and social resilience.

The main objective of this European project is to support EU Member States in their green and digital transition and to promote social and economic cohesion. When submitting the application, Member States will be required to submit National Recovery and Resilience Plans (NRPs), which will need to set out their objectives, investments and improvements they intend to achieve with the funds provided by the RRF. Key areas such as innovation, social inclusion, environmental transition and public health should be at the heart of these plans.

Furthermore, in order to be able to control how these financial resources are managed, it could be useful to implement a monitoring mechanism managed by the European Commission, which would ensure the proper use of funds. Such a scheme would not only contribute to improving the health infrastructure in less advanced countries, but would also strengthen European integration, promoting a model of mental health management that could become a global benchmark.

A further criticism that could be raised to Law 81/2024 concerns the cultural challenge, especially in countries with a strong custodial tradition and where mental illness is still highly stigmatised. To address this complex cultural challenge, it is necessary to act with strategy and prevention, and to accompany Law 81/2024 by a European awareness and training programme that operates on several levels. First, an intensive specialised training plan for health and justice professionals is essential, so that they are prepared

not only to apply the new regulations, but also to understand and support the paradigm shift that the law represents.

This would mean opening the door to interdisciplinary training that would no longer allow health and justice to travel on two parallel tracks but collaborate in training a highly qualified staff on the latest findings in psychiatry, advanced rehabilitation practices, and have a thorough understanding of human rights as applied to the psychiatric-legal context. Training should be continuous and include periodic refresher courses to adapt practices to legislative and scientific developments. Training, however, should not only concern the staff, but since the psychiatric patient offender fits with difficulty into the social scene, a public education plan involving local communities and promoting broader social change is essential.

This programme, fundamental in the places where these facilities would be erected, should aim to deconstruct existing prejudices against mental illness, creating awareness about the causes, treatment options, and the importance of a therapeutic versus a custodial approach, which cannot be achieved without the cooperation of the community. The campaign could include media campaigns, public seminars, collaborations with non-governmental organisations, patient associations, as well as the introduction of educational modules in school curricula with the aim of transforming the social perception of mental illness from a shameful and dangerous condition to a public health issue to be treated with empathy, professionalism and respect.

It is crucial to emphasise that law 81/2024 is not intended to be a protocol of rigid rules, but to promote an integrated approach that takes into account the specific needs of each patient and each health system. This flexibility, combined with a strong ethical and legal framework, allows the law to adapt to different cultural and regulatory contexts, transforming it into a powerfully versatile and internationally applicable tool.

To sum up, apart from being a significant step forward for Italy, Act 81/2024 could be a catalyst for wider reform at European level. If implemented, it could mark a decisive step towards a more united and inclusive Europe, in which the rights of the mentally ill, in all their complexity, are respected and guaranteed. The European Union has the opportunity and the responsibility to support this transition, demonstrating that respect for human rights and administrative efficiency are not at odds, but can and must coexist in a modern and just legal and healthcare system.

#### **4.2 The legal text of Law 81/2024**

In order to provide a legally sound and practical legislative proposal, it is considered appropriate to outline a draft law that does not limit itself to critically amending the existing legislation, in particular Law 81/2014. The proposed model is realistic and applicable, with the necessary corrections expressed in the form of articles of law. The objective of this draft legislation is to introduce organic and timely amendments to the management of Residences for the Execution of Security Measures (REMS), in response to the critical issues that have emerged during the implementation of the existing legislative framework.

The following is proposed as the text of the proposed legislation:

##### **LAW 81/2024**

The legal document contains urgent provisions for the improvement of the management of the Residencies for the Execution of Security Measures (REMS) and other provisions relating to mental health.

##### **Art. 1 - Purpose of the law**

(1) The above law aims to reform and strengthen the system of Residences for the

Execution of Security Measures (REMS), in order to improve the management of these facilities and ensure a better and comprehensive protection of the human rights of the psychiatric patient who is an in-patient offender, and promote integration and more functional collaboration between health and judicial systems.

(2) The law sets out the following objectives: a) Establishment of operational guidelines and standardisation of operating and organisational practices of REMS throughout the national territory, to ensure uniformity and consistency in the care and treatment provided to patients; b) Strengthening of training programmes for health and judicial personnel working in the REMS, through refresher and continuing training programmes; c) Introduction of regular monitoring and evaluation mechanisms to ensure compliance with established standards and to ensure continuous correction and improvement; d) Adoption of economically and socially sustainable policies, respect the fundamental rights of persons interned.

(3) The objective of the proposed legislation is to address the deficiencies of the previous legislation, 81/2014, by establishing a more robust system to manage the circumstances of criminal psychiatric patients, while ensuring the protection of their rights and dignity.

#### Art. 2 - Standardization of the operational and organizational procedures of REMS

(1) Within six months of the entry into force of this Law, the Ministry of Health, in agreement with the Ministry of Justice and after consulting the Regions, shall adopt a national plan for the standardization of operational and organizational procedures of the REMS.

(2) The legislation seeks to comply with globally standardised therapy and rehabilitation procedures by establishing a national plan comprising all REMS. This will ensure that patient treatment is consistent and free from local preferences. The following points are included in the guidelines: a) A clear and detailed definition of the minimal requirements for REMS infrastructure and supplies, such as cell dimensions, hygienic conditions, suitability of health and social areas reserved for activities and rehabilitation; b) Creation of therapeutic protocols standardized for all the REMS structures to guarantee uniformity and the same level of efficiency in the rehabilitative paths; c) Periodic monitoring of the safety measures implemented, with special attention to the principle of proportionality and the defence of patients' fundamental rights; and d) Specific indications according to uniform criteria for the management of emergencies, such as the use of psychotropic drugs and restraint techniques. Emergency situations are defined as situations of high-level crisis that puts at risk the patient's and the other's safety.

(3) The Ministry of Health, in collaboration with the Regions, ensures the implementation of the national plan through the adoption of implementing decrees, aimed at ensuring the concrete application of the standards established in all REMS.

#### Article 3 - National Agency for the Monitoring of REMS (ANMR)

(1) The National Agency for REMS Monitoring (ANMR) is constituted as a public institution with managerial and administrative autonomy with the objective of monitoring the implementation of ministerial directives, and of evaluating the suitability of organisational structures and operational procedures pertaining to the REMS.

(2) The entity responsible for monitoring (ANMR) shall, in order to comply with the defined national rules, fulfil the following duties: a) Annual inspections and visits to each REMS facility. They may be agreed in advance with the structure or take place without prior notice, in order to ensure a true control of the daily dynamics in the structure; b) Regular six-month reports on the conditions of each REMS. The findings will be conveyed to the Ministry of Health and the Chambers, with a detailed account of any significant concerns and recommendations for improvement; c) The ANMR will undertake the supervision of an anonymous reporting system for REMS personnel, patients, and their families, with the objective of promptly identifying instances of abuse, neglect, or human rights violations.

(3) ANMR works with regional and local authorities, as well as international organisations and bodies to promote the exchange of good practices and the continuous improvement of the REMS system.

#### Art. 4 - Review of Safety Measures and Training of Personnel

(1) Articles 71 and 72 of the Italiana Code of Criminal Procedure are amended to provide for the mandatory establishment of interdisciplinary teams in the REMS, composed of psychiatrists, lawyers, social workers and other specialists, Responsible for carrying out multidisciplinary case assessments and proposing any changes to the security measures applied.

(2) The REMS shall ensure that the interdisciplinary team assessments are carried out at

least every six months and that the results are reported to the competent authorities for the review of security measures.

(3) REMS staff participate in continuing education programmes, specifically designed to improve the management of psychiatric patients in the forensic field. The programmes include the following modules: (a) De-escalation strategies and the management of psychiatric medical emergencies; (b) An examination of human rights and existing regulations governing the treatment of psychiatric patients; (c) An introduction to an intercultural approach to the management of patients from diverse cultural backgrounds.

(4) The REMS programme guarantees the continuous involvement of culturally competent mediators, thus providing staff with the necessary support to effectively manage the treatment of foreign patients and to prevent the occurrence of social isolation and cultural misunderstanding.

#### Art. 5 - Research and Development Fund in the REMS

(1) A national fund with an initial 20 million euro allocation for 2024 will be established for the study and creation of innovative therapeutic and rehabilitation techniques within the REMS.

(2) The fund aims to finance research initiatives approved by the Ministry of Health in partnership with academic institutions, research centres, and non-governmental organisations. The aims are: a) Facilitate the advancement of new pharmacological and non-pharmacological therapies for the treatment of mental disorders; b) Implementation of innovative programmes for the psychosocial rehabilitation and reintegration into

work of patients; c) Testing of advanced technologies for the remote monitoring and support of psychiatric patients.

#### Art. 6 - Integration between the health and judicial systems

(1) Establishment of close cooperation between the health and judicial systems in order to protect patients, healthcare professionals and speed up court decisions. This close collaboration involves the creation of specialist units prepared for the treatment of more complex patients.

(2) These units mentioned in paragraph 1, are composed of personnel carefully selected after ad hoc training to ensure the qualification of the team, equipped with the necessary skills to handle cases of greater complexity, ensuring a personalised therapeutic approach and respect for human rights.

(3) Creation of protocols formalising cooperation between the Ministry of Health and the Ministry of Justice, aimed at ensuring coordinated and interdisciplinary management of the most complex cases.

#### Art. 7 - Monitoring and Evaluation Mechanisms

(1) A Monitoring Committee is established, composed of representatives of the Ministry of Health, the Ministry of Justice and the Regions, with the task of supervising the implementation of this law and intervening in case of critical situations.

(2) The Monitoring Committee is obliged to comply with the following points: (a) Ensure that the law is implemented within the deadline; (b) Monitor compliance and

report on shortcomings of the REMS with operational and structural standards outlined in the national guidelines; and (c) Strengthen and encourage continuous communication between central and local institutions in order to be able to speed up contemporary challenges.

(3) The Monitoring Committee is obliged to draw up annual reports which are to be sent to Parliament, in order to inform it of recommendations for possible changes in operating procedures or the regulatory framework and provide an impartial and thorough assessment of the effectiveness of relevant legislation.

#### Article 8: Provisions for Transitional and Final Measures

(1) The Government will adopt the implementing decrees required for the successful execution of the provisions included in this Law within three months of its enactment, upon recommendation from the Ministries of Health and Justice.

(2) These decrees should define in detail the operational procedures, evaluation and monitoring criteria as well as the time frame for the implementation of the measures envisaged, with particular reference to the standardisation of operating procedures, continuing training of REMS staff and the creation of specialised units for the management of complex patients.

(3) The financial components of the Research and Development Fund linked to the REMS must be managed in accordance with the guidelines provided in the implementing decrees. It is suggested that the decrees described above cover the creation of guidelines for the distribution of financial resources, the criteria for selecting

projects to be supported, and the deployment of supervision systems to assess the projects' effectiveness.

(4) Within a six-month timeframe following the enactment of the aforementioned legislation, the Government, in collaboration with the relevant regional authorities, shall ensure the effective functioning of the National Agency for the Monitoring of REMS (ANMR).

(5) In order to ensure that the REMSs are fully compliant with national requirements within a year of operation, the ANMR will be fully responsible for promptly initiating the scheduled monitoring and inspection activities within one year.

(7) The stipulations set forth in this Act shall likewise be applicable to proceedings that were initiated and ongoing as of the date of its enactment, unless such application is incompatible with the specific characteristics of the proceedings in question or would result in an increased level of treatment for patients, in which case the previous provisions shall continue to govern the proceedings until their conclusion.

#### **4.3 Can Law 81/2024 Avoid the Pitfalls of Biopolitical Power?**

As previously mentioned, Michel Foucault analyses, in the course of the argumentation of his philosophical thought, how modern power is not limited to direct, violent and immediate repression as it was much more frequently the case in antiquity, but expands into more subtle, insidious and pervasive forms of control and surveillance. This biopower, as he defines it, manifests itself today in the way institutions—from psychiatric hospitals to prisons—manage and discipline bodies, standardising what is ‘normal’ and what is ‘deviant’, making the human body a puppet in the hands of the state. In his

critique of psychiatric hospitals, Foucault thus shows how the treatment of mental illness has always been intertwined with a logic of social control, rather than with a genuine desire to heal, and how the strings that command the patient's actions are actually in the hands of the state machine (Foucault, 1961).

The concept of biopolitics, consequently, refers to those precise techniques through which power exerts itself over life, disciplining and regulating populations.

In this context, after having seen how this was evident first with asylums, and then with psychiatric judicial hospitals, the question arises whether the REMS could also be perceived as a continuation, albeit more humanised, of these control practices, where the objective in some way still concerns the management of social risk.

The closure of the OPGs and the introduction of the REMS certainly represents progress, but it raises the question of whether the system has really overcome the logic of segregation and normalisation or whether it has simply masked under a therapeutic guise, the same power dynamic that characterised the previous institutions.

Foucault warns us that biopolitical power is not always visible or explicitly repressive, that the loophole in the system must be found, and thus the more progress is made towards a therapeutic philosophy, the better the state becomes at making its threads invisible. It often acts through institutional practices that appear benevolent or rational, but in reality perpetuate a form of control that embodies the same logic of exclusion and domination as in the past. How, then, can REMS be immune from this criticism, if despite the intention to create a more therapeutic environment, they continue to implement a separatist logic where patients are treated as dangerous subjects to be kept under surveillance rather than as individuals to be reintegrated into society? The containment and the closed doors of such an institution would seem to hide the Foucauldian thought, but the big challenge of the new draft law is to avoid that

ideology, ensuring that REMS do not simply become a new form of biopolitical control. To do so, specific measures must be implemented to ensure a real change in the treatment of psychiatric offenders.

Perhaps among the various criticisms that could be levelled at the text of Law 81/2024, this could be the fiercest, capable of questioning the ideal behind the intention behind such an initiative.

An initial response to this attack could, however, lie in the modular structure of Law 81/2024, which makes it possible to adapt operational and organisational practices to the specific needs of each patient, going beyond the uniform and standardised approach that often characterises control institutions. Establishing a national standardisation in the operation of REMS does not mean that each patient deserves tailor-made attention, ungrateful to define what is best for him. It would in fact require that each patient has an individualised treatment plan, which not only takes into account his or her medical needs, but is also flexible in changing according to the patient's progress or regression. This individualised approach could counteract the tendency towards standardisation and normalisation that Foucault would have criticised, giving voice to the patient as a human being and not as a mere pawn.

Furthermore, the proposal to establish a National Agency for the Monitoring of REMS (ANMR) is another key element. The duties of the ANMR should include not only bureaucratic monitoring, but also transparency and the active participation not only of experts in law and mental health, but also representatives of patients and their families. This would identify a monitoring that is not one-way, but rather a dialogic process that takes into account the experiences and needs of those directly involved.

In order to avoid a new Foucauldian era, the law is therefore required to go beyond mere reform of infrastructure and modes of action, and adopt a paradigm shift in

institutional culture and ideology.

A further aspect that serves as a defence against the critique of bio-power is, as has already been defined, that of integration between the healthcare and judicial systems. In order to prevent REMS from becoming places of mere detention masquerading as treatment, it is essential that cooperation between these two institutions is geared towards rehabilitation rather than mere risk management. The multidisciplinary teams envisaged by the law, composed of psychiatrists, lawyers, social workers and cultural mediators, are designed precisely to ensure that any decisions made regarding patients take into account not only their psychiatric conditions, but also their fundamental rights and prospects for reintegration. In fact, if one thinks of the case study analysed in the following thesis, the reason for the Genoa REMS as an 'enlightened' REMS lies precisely in its openness to dialogue with the magistrates, and its ability to see beyond single-disciplinary logics.

Law 81/2024 thus aspires to inaugurate a new phase, one that definitively abandons the Foucauldian paradigm of control and surveillance, and instead moves towards a system that promotes mental health as a fundamental human right. This requires a change of mentality not only in the institutions, but also in society at large. The law, therefore, does not merely propose a technical reform, but seeks to inspire a cultural change that recognises the complexity of mental health and promotes integration rather than isolation.

Finally, to ensure that this change is sustainable, the law provides for continuous monitoring and the possibility of adapting regulations according to the results obtained. This dynamic and flexible attitude will ensure that the law does not remain static, but constantly evolves in response to new challenges, always with the dignity and rights of the patient at its core.

In this respect, Law 81/2024 is not only a necessary reform, but also an epoch-making opportunity to demonstrate that it is possible to move beyond the era of biopower and open a new chapter in the management of mental health, one in which power is employed not to control, but to emancipate and support.

### **Conclusion**

In concluding this thesis, it is essential to reflect on what has emerged from an in-depth and critical analysis of such a complex and multi-layered issue as the management of psychiatric offenders. The academic process that led to these conclusions was not linear, but followed an articulated path that sought to include history, philosophy, law, psychiatry and an international comparison. This multidisciplinary and polyphonic approach was chosen because when speaking of the right to mental health one cannot stop at the first word, and articulating an entire research paper from the mere point of view of the jurist would have been somewhat sterile as an argument and, in my opinion, useless from the point of view of practical application. In fact, the aim is to provide not only a theoretical, but also a practical and innovative answer to the problems that still plague the Italian system of the 'new' Residences for the Execution of Security Measures (REMS).

The beating heart of this research lies in the desire to deeply question the structural and legislative shortcomings that characterise Italian law, in order not only to speculate flaws and propose corrections, but to question the status quo, to subvert, those practices that, instead of curing, risk perpetuating suffering and stumbling into the violation of human rights.

My thesis sets out to analyse an issue related to a minority that still has little say in the major priorities of states, and to seize the moment to propose a legislative reform that can truly transform Italy into a model of excellence in the treatment of psychiatric

offenders.

The decision to begin by retracing the historical stages from the Giolitti Law of 1904 up to Law 81 of 2014, was not meant to be a mere chronological incipit, but to understand how biopower, a pivotal concept in Foucauldian thought, has shaped the laws and practices relating to the management of madness and deviance. Foucault's criticism of the discipline, presented in his books *History of Insanity in the Classical Age* and elsewhere, provided the framework for understanding the power relations that still underpin our legal and medical systems today.

The focus then shifted to a case study which is not only a *unicum* in its psychiatric and legal complexity, but also highlights the inefficiency and inconsistency of the system. Patient M.A., with his prolonged stay at the REMS in Genoa for 7 years now, becomes the *casus belli* to lay bare a systemic crisis that can no longer be ignored. And this is how we define an answer to the research question from which we started: the delay in M.A.'s journey is not only the result of his serious psychiatric condition, but is the epiphenomenon of a wider crisis, characterised by inadequately prepared structures, regulatory fragmentation and a system that fails in its rehabilitation and treatment mandate by stumbling over fossil bureaucracy and non-existent discipline.

Starting from these reflections, the formulation of Law 81/2024 is an attempt to create, based on the previous legislative model, and with the tools I possessed, a bridge between theory and practice, between the past and the future.

I wanted this proposal to try to be as detailed as possible to avoid the accusations of regulatory vagueness that one too often comes across, articulated in articles and paragraphs, developed with the attention of a jurist but with a Foucauldian philosophical skeleton, to ensure that every aspect was taken into account and that nothing was left to chance. Proposals to set up a national REMS monitoring agency, establish national

standards and operational procedures, and ensure continuous and efficient staff training are just some of the elements which will, if well implemented, they can radically revolutionize the Italian system and elevate it to a paradigm of excellence.

Finally, the decision for a final comparative law scene with the cases of the Netherlands, Austria and Portugal was not dictated by mere comparative curiosity given a broader background of studies such as mine, but by the desire to show that Italy, despite its current shortcomings, has the potential to emerge as a leader in this field.

The comparison revealed not only differences, but also potential synergies and best practices that could be adopted to further improve our system.

This is not a point of arrival, but a starting point. In fact, I have deliberately chosen not to go into too much detail, not because I lack the issues to be addressed or the tools to do so, but because I believe that each issue deserves in-depth and specific attention, which I intend to explore calmly and meticulously in my future studies.

Ultimately, this thesis is not just a contribution to academic debate, but a call to action.

An invitation to reflect, to discuss, and, above all, to transform. As Heraclitus said, *πάντα ῥεῖ*, everything flows, and it would indeed be wrong to see the legal changes that have taken place over the years as errors: history is a flux, and change is the only constant, but it is up to us to learn to always head in the direction of progress.

With this thesis, I hope to have laid the groundwork for further change that, albeit gradual, may lead to a more humane, fairer and more effective management of psychiatric offenders.

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