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Treating not guilty by reason of insanity and socially dangerous subjects by community psychiatric services: an italian perspective

Il trattamento comunitario del malato di mente non imputabile socialmente pericoloso: la prospettiva italiana

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Abstract
Two years after the introduction of Italian forensic psychiatric reform, the new national residential network for subjects in security measures is now trying to develop and share common good practices of care, according to the contents of the new legislation. In this work, progressive steps of assessment and care of those admitted the new facilities named REMS will be illustrated, and the way new scenarios may impact on the role of the expert judgement in the Courts and their effects to forensic subjects' referral. Some critical points fostered by the new system, including criteria for admissions and clinical rationale for releases to lower levels of security, are discussed further in this work. It will be eventually described feasi ble solutions to overcome those issues, according to good evidence based practices.

Key words: REMS • risk assessment • risk managment • forensic psychiatric treatment

Riassunto
Il sistema trattamentale delle Residenze per l'esecuzione delle Misure di Sicurezza (REMS) pare avviarsi verso il superamento della difficile fase iniziale e prova ad interrogarsi sui suoi meccanismi di funzionamento interni ed esterni. In questa sede gli autori proveranno ad analizzare alcuni momenti del percorso di cura del malato di mente autore di reato socialmente pericoloso sottoposto a misura di sicurezza psichiatrica detentiva ed ad affrontare alcune criticità: dall'invio dell'Autorità Giudiziaria a seguito di accertamento peritale, sino alla sua dimissione a cura delle équipe dei Dipartimenti di Salute Mentale (DSM), facendo riferimento ai modelli teorici di assessment e trattamentali più accreditati e provando a fornire un loro contributo operativo efficace nel superare i diversi momenti problematici finora emersi.

Parole chiave: REMS • valutazione del rischio • gestione del rischio • trattamento psichiatrico-forense

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1. Introduction

The closure of forensic hospitals was first recommended by government in 2008, with Decreto della Presidenza del Consiglio, DPCM 01.04.2008, and it has been executed from 2014 onwards. Forensic hospitals, or Ospedali Psichiatrici Giudiziari, OPGs, have been substituted by an alternative network of residential care, SSN (Sistema Sanitario Nazionale, National Health System) based, care facilities called REMS - Residencies for the Application of Security Measures. The structural and functional characteristics of these facilities are defined by the Law and are aimed at assuring general security, individual care, rehabilitation programs in a community environment and small scale dimensions, as the maximum capacity is fixed at 20 beds each (Scarpa, Castelletti & Lega, 2017).

The basic principle for the closure of the OPGs wasn't only justified by the insufficiency of treatment provision of those structures. Five of the six OPGs were basically prison buildings, characterized by restrictive architecture and a shortage of medical staff (Scarpa 2005).

The novelty of the reform, introduced with Laws 9/2012 and 81/2014 is to give to the community mental health services the pivotal role of developing pathways of care for those found not guilty by reason of insanity and socially dangerous (NGRI) (Carabellese & Felthous, 2016). General psychiatric services, based on a network of community facilities, organized by the Departments of Mental Health, can provide treatment for patients not charged by Justice authority.

Their main tasks, established by the Italian reform of general mental health services contained in the Law 180/1978, are to give mentally ill users back their right to receive care on a voluntary basis with the only exceptions of severe, acute symptoms unrecognized by the subject and requiring urgent treatment (TSO Trattamento Sanitario Obbligatorio or Compulsory Medical Treatment) (Mandarelli et al, 2017).

For this reason, one contradiction of the forensic reform concerns how to match the principle of freedom to receive treatment with the obligation of restrictive measures, according to the Penal Code, ordered by a Judge when the person in charge is considered socially dangerous (Carabellese, Urbano, Mandarelli & Coluccia, 2018).

Law 09/2012, and the subsequent Law 81/2014, with the definitive closing of OPGs, state that new regional forensic facilities, the REMS, provide treatment for those in security measures with a high level of social dangerousness. Patients with a mild to weak degree of dangerousness should be treated within the network of community psychiatric services.

During the trial or at its end, Italian judicial system may apply two different measures.

The first is given for those deemed dangerous and consequently have to be referred to REMS In these cases, subjects found not guilty by reason of insanity, present a degree of "social dangerousness" that cannot be contained in a general community facility. A different measure is provided for those NGRI whose dangerousness level makes them eligible to be treated in a community facility or in private accomodation. In these cases, the Judge applies a different non custodial security measure called "libertà vigilata", sort of probation. According to the Individual Care Plan, patients can receive their treatment in a public or private facility at lower lever of security. They are asked in this way to respect Judge's prescriptions and to be supervised by public community officers. There are no specific criteria for the application of custodial or non-custodial measures, except for restrictive measure inside the REMS, defined by the Law 81/2014 as "the last resort". One of the main innovative aspects of the new legislation concerns the presence of exclusive criteria to refer a subject to the REMS. Custodial measures shouldn't be adopted in those cases community treatment isn't ready to match and control subject's dangerousness. Decision on the nature of security measure measures, and consequently level of security often depends on the capacity of the general mental health services to provide a therapeutic plan for the patients in charge.

2. Therapeutical aspects for the socially dangerous subjects: heredited and new challenges

Providing care programs in the new REMS reflects complex and multidimensional features of the target subjects admitted there.

The REMS network, developed in a short time and covering the whole Country from 2015, faces the hard challenge to develop efficient forensic therapeutical strategies ever experienced in Italy. Moreover experiences from other Countries seem unfit to be simply imported into Italian mental health system (Carabellese & Felthous, 2016). The new system has very little to share with previous forensic hospitals, during which scientific and clinical evidences has been very poor and physical, procedural and relational issues unproper.

At the end of 2014 there were 672 inmates in the 6 OPGs. Law 81/2014 prescribed no referrals to closing OPGs after 1st April 2015, even for those with a high level of dangerousness admitted in the REMS.

The number of patients inside the 6 OPGs fell progressively until their definitive closure. It took almost two years to complete the discharge of all the remaining patients and only on February 2017 the OPGs were finally closed. Currently, there are 35 new REMS with security measures that host up to 600 patients. REMS have a significant turnover

and, until now, have discharged around 300 patients (Corleone, 2017).

The request of admission of new patients to the REMS who are declared socially dangerous is steadily increasing, so as the list of subjects deemed dangerous waiting to be admitted out the new residencies. This may seem a contradictory remark to make, as most of them are waiting in their own houses, in ordinary facilities or, in some cases, in prison or in wards for acute psychiatric patients in general hospitals.

Legislator's will pointed on discontinuity with previous asylum-like system. The terms of the reform are rooted on the regional basis of care, single residential units with small numbers, maximum 20-bedded, included into the organization of NHS (SSN, Sistema Sanitario Nazionale) Departments of Mental Health. Nevertheless, estimated functional capacity of 600 national beds is now a matter of concern, as a "waiting list" of those referred to admission is in constant increase. Magistrates, clinical teams, ask for shared criteria to filter those subjects more suitable for a REMS-based treatment, at the moment unavailable. The lack of shared criteria enhances the dispute on the characteristics of the candidates benefiting for a forensic residential period or, otherwise said, to set the level of proper "social dangerousness" to be treated in the REMS.

In the shortage of a national database, it is currently unknown how many of those in "libertà vigilata" are in community facilities.

A recent study promoted by the National Institute of Health has described the clinical-demographic features of OPGs inmates just before their definite closing (Lega et al., 2014). Mean age of the 473 participants was 42,5 years, about 75% of those were singles with no children. The forensic in-patient prevalence rate (forensic in-patients per 100,000 population) was found to be 1.7, lower than that found in 2001.

In this respect Italy is similar to other Southern European Countries also showing low prevalence rates. Women accounted for 7.9% of the patients hospitalized in the OPGs, whereas female patients were found to represent 6.8% of the forensic inpatient population in 2001. The average age was 42.5 years. Around 73% of the participating patients were not married and had no children, 50% lived with their birth family prior to admission. There were statistically significant gender differences: women more often than men succeeded in forming a new family and more than 50% of female patients had children. A social disadvantage emerged in the patient group with low levels of education combined with unstable work and economic conditions. Over 30% of patients had a severe physical illness, about 24% were obese and 80% were smokers.

Compared with patients suffering for severe mental disorders receiving treatment at the Mental Health Centres, the OPG population was found to be more disadvantaged and to suffer from higher rates of comorbid physical illnesses. Over 50% of participants had a diagnosis of schizophrenia or other psychotic disorder. Personality disorders accounted for about 20% of diagnoses, more than observed in previous surveys. The administration of the SCID-I detected a high comorbidity with Axis I disorders, especially substance abuse or dependence and psychotic disorders. With regard to the severity of psychopathological symptoms and functioning by diagnostic groups, schizophrenic patients had more severe symptoms on the Brief Psychiatric Rating Scale (BPRS) and compromised functioning on the Global Assessment of Functioning (GAF). Rarely was the index crime the first manifestation of a psychiatric disorder: the mean duration of illness before admission was over 18 years, 75% of patients had been treated for a mental disorder in the past and over 60% had previous contact with the Department of Mental Health, often problematic contacts (30% of the sample had at least one forced hospitalization).

More recently, a small survey aimed to describe clinical and demograhic characteristics of has been done with the inmates in Nogara REMS, Veneto region. Patients' features indicate prevalent problems of adherence at therapeutical plans and behavioural misconducts (Castelletti et al., 2017). In most of the cases, these are subjects already in charge with public psychiatric services (Carabellese, Rocca, Candelli, Catanesi, 2014), with psychopathological multidimensional problems, including comorbidity with abuse of substances, personality disorder and cognitive impairment.

Criminological profile highlights a prevalence of crimes against persons (89%) of those about one quarter with lethal consequences. In half of cases victims are family members, and criminodynamics of the events recognize a psychotic mechanism of behavior. The descriptive analysis of these samples indicate areas of intervention for prevention policies for those at risk of aggressive behaviour (Carabellese, et al, 2015).

Different subsamples of inpatients are described in these early data. One is given by the combination of severe psychopatological characteristics and severity of crime, as homicides or attempted homicide, with prolonged period of staying due to long-lasting original security measure given by the Judicial Authority. A larger second group is composed by difficult patients, with a history of irregular caring relationships with community services, poor compliance, unstable familiar and affective environment, clinical, heterogeneous criminological profiles.

They share historical troubling relationship with community services, resulting in a large amount of unmet social and caring needs, frequently in causal relationship with the index crime. The clinical and criminological variables of the forensic population require a pattern of treatments that may be effective in such a complex environment (Scarpa F, Bonagura V, 2015).

3. REMS inmates and their specific therapeutical needs

Working with those referred to a forensic facility requires long periods of admission, longer than with general psychiatric clients. Particularly with subjects with a severe index crime and a severe diagnosis time of recovery may be prolonged, due to slow process of improving states of insight and self-confidence. For most of these subjects, it is a matter of "incorporating a crime into a non-criminal identity" (Drennan & Alred, 2012). The extent of the trauma to oneself that the offence has caused can itself be an obstacle to recovery.

Those with a milder index crime, frequently combined with a less severe mental impairment, are initially admitted with a temporary security measure: these forensic users require usually shorter periods for recovering from their relapses. They frequently present high rates of comorbidity, mainly with substance abuses and cognitive impairment, so enhancing the need to improve networking collaborations with target community services.

A reason of concern is due to the legislative frame of the subject admitted in security measure. Rocco's Penal Code (1930) has not been modified, so that the forensic clinical team has both therapeutical and custodial duties to the inmate, resulting in substantial management problems in those cases avoidant any therapeutical proposal (Catanesi, Carabellese, La Tegola, Alfarano, 2013).

Moreover, the Judicial Authority may apply undetermined periods of forensic hospitalization for those admitted through the application of temporary security measures, so contributing to give to forensic care plans a sense of instability and partial control.

The concept of Social dangerousness is in the Penal Code, Article 203, as the "general capacity for a subject to reoffend or committing new crimes". It is currently considered an insufficient criterion to establish appropriate referrals to forensic facilities for its vague, non specific notion (Rocca, Candelli, Rossetto & Carabellese, 2012). It is also a source of diffidence and stigma for most of professionals working in the mental health field who strongly reject any link with custodial practices. According with this background, in our clinical practice it may be useful to work critically on the judicial judgement of social dangerousness as starting point for creating clinical sense and promotion of self care for those admitted the REMS. That notion, cleared from any stigmatizing intent and declined for therapeutical interventions, may represent a starting point for gaining patients' insight. Their life failures are mostly caused by deviations, social exclusion, economic failures, social disadvanteges, health problems, personal progressive loss of hope and control over life., A cognitive reference to the provision at the base of REMS admission can ease users and their team with the work of gaining insight on goals of the forensic care pathway (Barker, 2015). Conversely, scotomization of the measure at the origin of the referral is at risk for mechanisms of denial and minimisation in the patient, althought clinical teams has the right to choose forms and timing to face and share analysis of internal and external factors at the base of the forensic measure (Scarpa, 2015).

4. Pathways of care in the REMS: what's specific

Concept of social dangerousness is elusive for the forensic teams trying to give clinical meaning to judicial terms. Avoiding any attempt to simply import concepts and practices developed in other cultural and social contexts into italian practice, the clinical practice of violence risk assessment in forensic settings can be a useful practice to dismantle the vague nature of social dangerousness and convert it into clinical concepts, terms, plans (Bonta, 2002; Heilburn et al., 2010; Castelletti et al, 2013, 2016; Lega at al., 2014; Carabellese, Mandarelli, 2017a).

A multidimensional approach unprovided by specific tools monitoring behavioral variables is at risk of unreliable therapeutical plans. In this way, forensic clinical staff is called to identify major dimensions involved in the forensic case, including anamnestic, current clinical characteristic, socioeconomic context, service provision.

A better definition on the rehabilitative goals to reach can be a helpful approach for the patient as well, who has more opportunities in this way to receive a comprehensive information of caring plan.

From a national perspective, the risk for a forensic patient to drop out from a rehabilitative program is at community level, during his admission in a residency or more frequently when released to a private accomodation (de Girolamo et al., 2016).

A lack of multidimensional approached including systematic assessment of risk factors for recidivism reduce the recognition and management of symptoms and their causal effects on behaviours. This may be even more important if assessment tools are applied to different settings. A lack of integrated and shared information and strategies across teams and with other institutional partners involved in the case may induce negative feelings in case of clinical and criminological relapses. This may induce teams involved in a forensic case to interrupt the community experience and refer eventually to forensic residency again. Otherwise, clinical teams trained for a multi dimensional assessment and management have more possibilities to prevent clinical and behavioural relapses and to focus on areas of interventions more sensitive for the subject's global outcome (Lindqvist & Skipworth, 2000; Monahan et al, 2001; Kennedy, 2002; Monahan et al, 2005; Moore & Drennan, 2013).

Historical information is of greatest importance in forensic psychiatry, to understand the current and future criminogenic potential of the subject, to make an assessment of potential future recidivism and moreover to identify those areas of interest and motivation not fully expressed in the past (Maden, 2007).

Clinical risk factors and future management risk factors provide key informations on development of pathways of care, inside the forensic facility and further at community level, so as to prevent relapses, readmissions or, worst case, reconvictions (Michel, 2013).

All processes regarding risk assessment and management should enhance active patient involvement, promoting transparency with the forensic client aimed at reducing frequent suspicious feelings of the patient to wards staff members. Moreover, it may facilitate patient's collaborative approach to care plans.

Law 81/2014 states the mandatory introduction of Individual Treatment Plan for community and forensic teams, as guarantee of early partnership in care. A patient's prompt participation into definition of areas to recover may facilitate a proper time of admissions into residencies. It also strengthens a dialect approach to the forensic patient, usually practised in the fields of needs assessment (Thomas et al., 2013) but also extended to the field of risk assessment.

Risk assessment tools may find application as mediators of individual or group psychotherapeutical settings, in a work of progressive disclosure of patients' denial areas or scarce insight. Shared use, operative intuition, dialectic approach, structured instrument for planning team's work to

include all community partners as early as possible: risk assessment structured judgment techniques are broading their fields of use and application (Hart & Logan, 2011; Robbè, de Vogel & Douglas, 2013).

The therapeutical setting for NGRI patients and those considered socially dangerous is done by an expert who decides of assessing the level of dangerousness from the Judge (Carabellese, 2017b). In many cases there is no agreement between the evaluation of the expert, and consequently the decision of the Judge, and the availability of a REMS bed. At the same time it is possible to have opinions which differ between the Court expert, normally a forensic psychiatrist, and the Mental Health Services' specialist regarding the adequacy of the facility, the clinical condition and the patient's needs. Court experts generally develop their assessments according to their expertise, at the expense of evidence based assessments. In a reformed forensic panorama, expert evaluation needs to link reason of insanity judgement with therapeutical recommendations. Instruments for violence risk assessment may be useful to cover this gap: they enhance the possibility to talk a common language ranging from capacity of the subject to the development of a pathway of care.

Structured assessment of forensic patients is a quite new practice in the Italian system: forensic experts, for example, use mainly diagnostic tools for the patients evaluation. They don't require specific tools for the assessment of the functional aspects of the mind, the capacity for standing on trial and the degree of dangerousness. Violence risk assessment doesn't receive specific attention and has only recently been introduced the REMS and the community services. The Historical Clinical and Risk Assessment of Violence (HCR20) is the most studied and adopted tool (Douglas et al., 2013).and the v3 version is currently under translation to be adopted in Italy.

In many Regions and/or Local Health Units of the National Health System special Forensic Units have been set up, flanking the role of the experts of the Courts. They report to the Judges whenever asked for information regarding the progress of the treatment, in terms of clinical status of the patients, they give advice to the psychiatrists and the healthcare workers looking after the patient. Most recent versions of structured judgment tools hit the mark of organizational and therapeutical aspects introduced with the new national legislation. Case formulation in forensic psychiatry is the result of two decades developing of risk assessment tools, and enables the clinician to put together the theorical and structured approach, or nomothemic moment, with the empirism of the clinical work for the individual patient (Haque & Webster, 2013). Formulation is developed as circular, coherent operational team activity aimed to produce clinical treatment acts to verify hypothesis with the clinical observation. It gathers systemic information and clinical team observations to plan projects, make clinical interpretations, and to practice on future patients' most likely scenarios. Clinical formulation assumes a narrative form, in which diverse and diachronic aspects of the patient are put together to be coherently assembled (Hart & Logan, 2011).

In forensic psychiatry, it's even more cogent than in general psychiatric to try to get meaning from patient's early past events, generally of traumatic nature, attachment styles and caregivers, and current treatment needs (Schimmenti, Carabellese & Caretti, in press).

5. The individual caring plan

Clinical teams operating in the REMS frequently deal with subjects with a history of severe life's failures regarding their internal resources and external ones, like the affective and familiar network. They live in a life signed by hopelessness, as their attempts are destined to be frustrated. This feeling is sometimes strengthened by social and institutional network, as personal stories of these subjects are rich of failures in the affective relationships, working activities, alliance with health services, and substances' addiction remedies. It enhances the clinical need to put together different information and points of view to create a coherent story. It includes heterogeneous contributions, reflecting the heterogeneity of the sample of people referred to the forensic facility. For most of them, an approach recovery-oriented as Good Lives Model can produce positive outcomes (Ward, 2002).

Most of REMS patients have problems in their vital research of "primary goods", that is "activities, experiences, or situations that are sought for their own sake and that benefit individuals and increase their sense of fulfilment and happiness" (Whitehead, Ward & Collie, 2007) and include things like autonomy, relatedness, knowledge, mastery, play and physical health.

For these Authors, problems derive from wrong strategies to obtain those goods, as: neglect of important primary goods, use of ineffective strategies to secure goods, conflict of strategies to secure goods, inability to implement strategies for securing goods. For those clients with a profile of personality disorder, and frequently comorbidity with substances abuse, the need principle derived by the RNR, Risk-Need-Responsivity approach (Andrews et al., 1990) may be useful, as offender assessment and management should focus on criminogenic needs, i.e. should target causal risk factors for antisocial behaviour.

According to the responsivity principle, services should be delivered in ways that maximize their effectiveness, meaning that the focus of management programs should be on skills acquisition, prosocial modeling and problem solving.

Design and management of programs delivered to offenders should match their individual learning style, motivation, abilities and strengths. Structured clinical judgement, especially if integrated with a structured assessment of protective factors (Robbè et al., 2013), has the potential to integrate apparently different approaches, and gives to the clinical team the possibility to integrate recovery oriented approaches and risk assessment and managememnt strategies according to individual features of the subject.

As in any psychiatric institution, clinical teams working in the REMS start working to the individual therapeutical project putting a diagnosis. When used in a broader way, including all DSM axis concerning functioning, social and working attitudes, diagnosing enables teams to produce their causal hypothesis on a sound basis (Foresti & Rossi Monti, 2002). It is a function of a thinking team, in which symptons aren't factors to check off the list, but expressions

of patient's background, in relation with his/her internal and external characteristics.

Dynamic diagnostic system, producing formulation and treatment programs in his circular proceeding, keeps open the possibility to monitor, test and re-assess strategies in an open model. This function allows the clinician to check the quality of formulations and possibly to adopt new informations gathered by clinical observations (Eels & Lombart, 2011). A REMS admission can be in this way a period for patient's life to recover from general pessimism around his life biography and personal identity and, eventually, to take responsibilities for his/her life choices. For the team and his community partners it is a setting to develop, in the general formulation model, explanatory hypothesis on what has occurred to the patient, with attention to be paid on precipitants events/factors, patient's resources and strengths, and on listing obstacles that may impair treatment outcome.

REMS' coherent mission and vision are protective for its internal and external functioning, for example towards court expert assessments, in terms that if the new REMS have the priority to guarantee "care and control", they can't be filled by subjects with low rates of unmet caring needs (Carabellese, 2017c; Felthous et al., in press).

It also limits service competences, creating a barrier against the neverendind mechanism of reproducing asylum-like situations, represented by methods of delegation and neglect, as Law 81 has correctly pointed out.

Individual Care Plan (*Piano Terapeutico Individuale*, PTI), is the main instrument REMS and community teams share to develop a common strategy for the patient pathway of care. It presents two risks: to become solely the REMS' PTI, contributing to the isolation of forensic system facilities with the general community services, or to be a bureaucratic paper no one really cares. To avoid worst scenarios, the PTI has to be open, inclusive, dialectical with institutional community partners. It may become a useful tool if it preserves potential to create valid and shared operational hypothesis, diagnostic and therapeutical formulations.

Its proper use may facilitate releases to lower levels of security, when decisions are linked to clear therapeutical goals to reach. It may also be a precious instrument to assess the "social dangerousness" of those in *libertà vigilata*, living in the community.

Actually, a defined shared individual care program is the main tool to help clinicians in the definition and assessment of steps of care, and conversely those aspects non-negotiable with the subject.

It may be a useful instrument even for subjects in *libertà vigilata* living at home or in community residencies, often lacking of specialist evaluation of their social dangerousness. The most common outcome in these cases is leaving situations as they are, so prolonging judicial measures like *libertà vigilata ad libitum*, without an ending, as shared criteria to assess the need of prolonging or stopping the measure are lacking.

The growing number of community forensic population represent a challenge to clinical teams, forensic experts and magistrates to cooperate in the development of shared assessment strategies to avoid neglect of those in probation. It is necessary in this way to abandon past hospital based model and, at patient's level, to enhance his active role towards the rehabilitative offer. In our opinion, it's prioritary to introduce in the daily practice instruments that may facilitate the dialectical interface between the team and user. Definition of areas of intervention should be shared with patients, promoting their active position into therapeutical processes.

At the Nogara REMS, we have started introducing the forensic version of the Camberwell Assessment of Needs, CANFOR, as a tool for dialectical interventions with the patient in the systematic analysis of social and caring needs (Thomas et al., 2003, Castelletti et al., 2015). Social and clinical characteristics of those referred to the REMS are suitable for a clinical approach sensitive to issues like hope for a better future and regain of identity.

REMS have the potential to become a precious experience for patient's recovery, for those of the familiar network, and for mental health services as well, frequently tired and hopeless towards forensic cases perceived as chronic and unrecoverable.

6. Towards a forensic psychiatry network

REMS system and community facilities has been running for two years, but the OPGs were not closed until January 2017. Till current times datahaven't recorded serious incidents inside the REMS, among the patients or against the staff, nor has there been noted an increase in adverse events among the patients admitted to community facilities. There, management difficulties can sometimes arise in the course of the patients' treatment due to the fact that those with legal restrictions live alongside those who are not charged of any crime.

One of the complaints made by the staff, and very often by the management itself is that personnel cannot be held responsible for the treatment of the patients and, at the same time, for their custody and supervision in order to be confident leaves and reconvictions related risks.

Recently, patients admitted to forensic residencial treatment show diverse problematic features, not only regarding their mental state: most of them are foreigners, without a residency permit, with personality disorders, sometimes having psychopathic traits, dual diagnoses, organic comorbidity or intellectual impairment. The case mix inside the REMS and the community facilities could become one of the critical factors leading the system to modify forensic network. Most of Italian regions have adopted a system of facilities at lower level of securitynspecifically developed to non custodial, measures like Puglia and Tuscany .

The Puglia region has established two REMS and a network of specialist residential facilities for those in non-custodial security measure, aimed to create different levels of care and supervision that may better suit different clinical characteristics of regional forensic psychiatric sample.

If the patient under non-custodial measure fails to respect the Judge's prescriptionshe could be referred to the REMS. However, time required to adopt these decisions is very lengthy and meanwhile patients are still in the facilities or sometimes in an acute ward or at their private accomodation, waiting to be admitted to a REMS. Different evaluations on how to set the actual level of security for a patient may sometimes become a field of controversy or debate between forensic, general mental health services and Court experts. Judge's requests to forensic and general men-

tal health services may be compelling: this to avoid that a person declared socially dangerous spends too much time a condition of lack of any supervision or control. For this reason, it is common for the Judge to ask the expert, and/or the psychiatric services, to develop a prompt and functional PTI, generally by referring the subject to a facility where restrictive prescriptions can be applied.

One more critical aspect regards the cost of the whole system: many facilities of the private, or non-profit sector, have been obliged to increase daily costs that often exceed 200 euro. The next years will be crucial for the adjustment of the system and the improvement of practices. The Italian reform of forensic sector may be a pilot experiment for other Countries towards the de-institutionalization of treatments for those who have committed crimes without resorting to hospital based care.

7. Conclusions

Two years after the radical reform interesting forensic sector in Italy, new REMS network has improved organization and internal functioning, derived from international experience on physical, procedural and relational security (Kennedy, 2002; Scarpa et al., 2017). It has also supported the pressure derived by the impact of Laws 09/12 and 81/14, inspiring the pivotal role of community teams for forensics.

Currently, data record highlight good functioning of the system in terms of releases and rates of readmissions and reconvictions (Corleone, 2017). Early positive outcomes require an implemented collaboration with judicial and prison system, general mental health services, public officers, stakeholders.

The spirit inspiring the closing of forensic hospitals has his roots in the reformist period that brought to definite ending of the civil asylums, forty years ago (Di Lorito et al., 2017). That model enhances the centrality of social psychiatry as necessary condition to operate recovery oriented treatment plans.

New Italian forensic practice has to deal with this view, in a way that may work efficiently with reformist issues. About risk issues, forensic and general psychiatric network may take benefit from an integration with recovery oriented models, looking at the risk taking paradigm and strength model (Slade, 2005). Concept of risk, in this manner, is viewed as life challenge for prosocial goals, real social integration, autonomy, advocacy and protection of the rights (Maone et al, 2015). Combination and integration of both concepts of risk, according to patient's features, his environment, service provision, quality of networks, may better suit the specific institutional and cultural italian ground for security measures.

Inclusion of different ways of conceiving risk may foster patient's active involvement into pathways of care and a more active participation of staff members to care programs as they *per natura* better identify themselves as mental health staff members despite custodial agents. Closing of OPGs has put the duty to adopt evidence based strategies of violence risk assessment functional at the development of risk management and caring strategies (Lindqvist & Skipworth, 2000; Monahan et al, 2001).

It is prioritary in this way the introduction in the daily practice of reliable instruments of violence risk assessment, bearing in mind that they have statistical limits and their use may present side-effects in terms of prolonged hospitalizations (Hillbrand &Young, 2008; Douglas et al., 2017)

In many regions and at national level, an agreement is requested to promote quality networking of the main actors and the interested stakeholders. The Juridical System (i.e Courts and Surveillance Judges), Community Psychiatric Services, lawyers, forensic experts and Social Services work together with the aim of developing shared practices to provide effective assessments and regulations.

We are confident that closure of forensic hospitals represents a valid opportunity for Italian psychiatry to plan and allocate proper resources to sustain the reform, including training and education for all professionals involved in processes of care.

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