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Involuntary psychiatric hospitalization in Italy: critical issues in the application of the provisions of law

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ABSTRACT

Involuntary psychiatric hospitalisation in Italy raises some critical forensic issues. We analysed the sociodemographic, psychopathological, and behavioural characteristics of involuntarily hospitalised psychiatric patients, and the effectiveness of the juridical procedure of guarantee. Case files ($n = 2796$) related to involuntary psychiatric hospitalisation (IPH) at the Office of the Tutelary Judge of the Ordinary Court of Rome (Italy) between January 2013 and May 2016 were analysed. For each case file sociodemographic, clinical and procedural information were collected. The sample included 53.7% men, patients had a mean age of 41.8 ± 13.9. Most of the IPH proposal certificates reported more than one reason, among which the most frequent were symptoms referring to a psychotic dimension (54.8%), agitation (38.0%), and symptoms of bipolar and related disorders (26.3%) Female patients showed a higher prevalence of symptoms of the bipolar spectrum ($F = 29.7\%$, $M = 23.3\%$; $p < 0.05$), while male patients showed a higher prevalence of aggressive behaviour ($F = 7.7\%$, $M = 12.6\%$; $p < 0.01$). Over 85% of the IPH proposal certificates did not explicitly mention issues related to adherence to care, which is the second criterium requested for IH (treatment refusal) and up to 7.3% of the proposals were not properly motivated. However, only 0.8% cases were not validated by the Tutelary Judge. Possible issues in the IPH procedures emerged since a significant number of certifications showed poor concordance with law- criteria for involuntary psychiatric hospitalisation. Despite this evidence, the low rate of unvalidated procedures by the Tutelary Judge, suggests a possible limitation of this form of guarantee.

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Involuntary psychiatric hospitalisation; severe mental illness; provisions of law

Introduction

Coercive measures, such as involuntary hospitalisation, are often regarded as an inevitable and yet highly debated feature of psychiatric care, because of the serious ethical concerns due to their implications in terms of possible violations of personal rights, and limitations of individuals' liberties (Mandarelli et al., 2019; Svindseth et al., 2007).

In Italy involuntary psychiatric hospitalisation (IPH) is regulated by Law 833 of 1978, which assimilated the so-called 'Basaglia Law', as part of the deinstitutionalisation process of civil psychiatric care. The Law 833 provided the replacement of mental hospitals with a range of community-based psychiatric services, the development of psychiatric units in general hospitals for acute in-patient care (De Girolamo et al., 2007), with no more than 15 beds each, to prevent the establishment of large-scale, asylum-like wards (Amaddeo et al., 2012; De Girolamo & Cozza, 2000). It also established the transition from '*dangerousness*' to '*the need for treatment*' as a criterion for involuntary civil hospitalisation.

The criteria for IPH in Italy are the following: (a) the patient is suffering from psychic alterations that need immediate treatment; (b) the patient refuses the treatment; and (c) the patient cannot be adequately treated by other non-hospital-based means. The IPH decision involves 4 subjects, two doctors (one for the IPH proposal and one for the IPH confirmation), the

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city mayor and the magistrate, with the latter having the duty to evaluate the correctness and lawfulness of the treatment, having the certifications and ordinance available. Given the limitation of personal freedom inherent in IPH, these redundant forms of verification and guarantees are aimed at avoiding improper restrictions on patient's autonomy, and, in any case, to guarantee the protection of his/her rights.

Differently from other European countries, such as France and the Netherlands (Sheridan Rains et al., 2019), the presence or the consultation with a legal representative of the patient is not required. This procedure allows compulsory placement and treatment. Capacity to make informed decision is not a prerequisite, despite some studies having shown that a percentage of compulsory admitted patients retain their mental capacity to consent or refuse treatment (Carabellese et al., 2017; Mandarelli et al., 2018; Mandarelli et al., 2014).

A study comparing annual incidence of involuntary hospitalisation between 2008 and 2017 in 22 countries across Europe, Australia, and New Zealand found that the median rate of involuntary commitment was 106.4 (IQR 58.5 to 150.9) per 100,000 individuals, with Austria having the highest (282 per 100 000), while Italy showed the lowest rates (14.5 per 100,000) (Sheridan Rains et al., 2019). Higher incidence of IPH has been associated with a lower rate of absolute poverty, higher gross domestic product per capita, health care spending per capita, a higher proportion of foreign-born individuals in a population, and a large number of inpatient beds (Sheridan Rains et al., 2019). No evidence linking rates of involuntary hospitalisation to any other demographic, economic, or health-care indicator nor differences in legislation was found (Sheridan Rains et al., 2019; Salize & Dressing, 2004), however it is possible that such legislative aspects can contribute to influence the qualitative characteristics of patients undergoing IPH (Bersani et al., 2020). In European countries there are three main criteria for IPH: (a) mental illness and dangerousness -criterion (Austria, Belgium, France, Germany, Luxemburg, and the Netherlands); (b) mental illness and dangerousness- or need- for –treatment- criterion (Denmark, Finland, Greece, Ireland, United Kingdom, Portugal); (c) mental illness and need-for-treatment-criterion (Italy, Spain, and Sweden) (Dressing & Salize, 2004).

Despite the wide variation in involuntary hospitalisation rates across countries (Dressing & Salize, 2004; Zinkler & Priebe, 2002), compulsory commitment is commonly associated with a diagnosis of psychosis (Cunningham, 2012; Ng & Kelly, 2012; van der Post et al., 2012), with severity of psychiatric symptoms (Hustoft et al., 2013), male gender (Wheeler et al., 2005), low socioeconomic status (Webber & Huxley, 2004), and reduced insight (Kelly et al., 2004). In Italy, the PROGRES-Acute project (Preti et al., 2009) showed that schizophrenia spectrum and related disorders accounted for more than one-half of involuntary hospitalisations, whereas bipolar disorder accounted for approximately one-fifth, and personality disorder one-tenth. Depressive or anxiety disorders accounted for a very small percentage among involuntarily hospitalised psychiatric patients (Preti et al., 2009).

To the best of our knowledge, there have been no national nor international studies comparing the concordance between clinical and judicial evaluation underlying compulsory hospitalisation, nor investigating the effectiveness of guarantee procedures for the protection of patients' rights. The aims of this study are as follows: (a) to analyse the sociodemographic, clinical, behavioural and treatment-related characteristics of patients involuntarily committed; (b) to compare the concordance, if any, between medical proposal of involuntary hospitalisation and judicial evaluation; (c) to shed light on the presence of any critical areas in the application of the provisions of law.

Method

In the present observational retrospective study, we screened and analysed all the IPH case files between January 2013 and May 2016 deposited at the Office of the Tutelary Judge of the Civil Court of Rome (Italy). Data were collected and treated anonymously, after the approval by the Court Section President. A total of 2796 case files were analysed, of which 6 referred to 'unknown' patients, 1290 women and 1500 men, within a catchment area of 2,863,322 residents (Ministero della Salute, 2016).

For each case file we collected patients' age, sex, and nationality. In addition, we collected the date of IPH confirmation by the second physician, the date of the order issued by the city mayor, the motivations reported on the proposal certificate by the first physician, as well as those reported on the confirmation certificate by the second physician, we also checked the IPH duration.

To assess the reasons underlying IPH, we performed a content analysis of the proposal certificates accounting for the ten following diagnostic,

Table 1. Socio-demographic characteristics of the 2796 involuntarily hospitalised psychiatric patients, in Rome (Italy) between January 2013 and May 2016.

Characteristic	Total ($N = 2796$)	Women ($N = 1290$)	Men ($N = 1500$)	p Value
Age, years; *M* (SD), range	41.7 (13.9), 15–100	45.2 (13.3), 18–100	38.8 (13.2), 15–100	<.001[a]
Gender, %		46.2%	53.8%	
IPH duration, days; *M* (SD), range	8.3 (3.8), 1–56	8.0 (3.2), 2–35	8.4 (4.2), 1–56	<.01[a]
Homeless; *n* (%)	112 (4.9%)	47 (42%)	65 (58%)	ns[b]
Ethnicity				
• Italian	80.6%	80.5%	80.6%	<.001[b]
• Caucasian	10.3%	12.8%	8.1%	
• Asian, African American, Hispanic	9.1%	6.6%	11.3%	

Note. IPH: involuntary psychiatric hospitalisation; [a]p values by independent sample t test, [b]p values by Chi-square; ns: not significant. Gender data on 6 patients were missing.

symptomatic or behavioural domains, whether present: (*a*) psychotic symptoms, for diagnostic certifications referring to schizophrenia spectrum disorders, (*b*) bipolar spectrum, (*c*) agitation, (*d*) violent or aggressive behaviour towards people/environment, (*e*) depression, (*f*) treatment refusal/non-adhesion, (*g*) suicidality, including auto-aggression, suicidal behaviour or thoughts, (*h*) medical conditions/diseases, (*i*) substance use/abuse, (*l*) personality disorder. Moreover, we classified as 'improperly motivated' those certificates not satisfying the criterion of presence of psychic alterations that needed immediate treatment. In the frequent case of presence of more domains in the same certification, we considered them independently for the analyses.

Statistical analysis

Statistical analysis was performed through the Statistical Package for Social Sciences version 20.0. All tests were 2-tailed, with α value set at 0.05. Independent sample t-test was used to compare parametric quantitative data, and Chi-square test with Yates correction for 2×2 tables, or Fisher's exact test, as appropriate, were used to compare categorical variables.

Results

The sample of 2796 case files related to involuntarily hospitalised psychiatric patients in Rome (Italy), between January 2013 and May 2016, comprised 53.8% ($N = 1{,}500$) men and 46.2% ($N = 1{,}290$) women, of average age of 41.8 years (SD = ±13.9). The socio-demographic characteristics of the study sample are summarised in Table 1. Most involuntary hospitalised psychiatric patients were Italian (80.6%), 10.3% were non-Italian Caucasian, and 9.1% belonged to other ethnic groups (Asians, African Americans, Hispanics). Among involuntarily non-Italian psychiatric patients, women were more frequently Caucasian, while men belonged to other ethnic groups (Table 1).

We found on average 4.1% of IPH involved homeless people, with no substantial variations across the years 2013–2015 (2013 = 4.7%, 2014 = 4.2%, 2015 = 4.7%), and a lower percentage in the early part of 2016 (0%). Mean IPH duration was 8.3 days (SD = ±3.8; median = 7 days), with male patients showing an average length of hospitalisation slightly longer than women (mean difference, .41 days, 95% C.I. .13–.69) (Table 1). The prevalence rates of IPH over the years we examined were: 3.04 per 10,000 in 2013, 3.06 per 10,000 in 2014, and 2.60 per 10,000 in 2015.

The analysis we conducted on the IPH proposal certificates, aimed at identifying the reasons underlying the request for involuntary treatment, showed a great variability in terms of motivations and lexicon. The physicians who requested IPH chose a variety of reasons, including categorical psychiatric diagnoses, dimensional psychopathological symptoms, and behavioural disturbances, to describe the 'psychic alterations' that the law requires as the first IPH criterion. Most of the proposals reported more than one reason, among which the most frequent were symptoms referring to a psychotic dimension (54.8%), agitation (38.0%), and symptoms of bipolar and related disorders (26.3%) (Figure 1). Among psychiatric diagnoses, depressive disorders/dimension appeared in 4.6% of the sample, substance-related disorders/substance use in 2.6%, personality disorders/personality traits in 2.0%. We found in 14.7% of the proposals an explicit reference to the refusal of therapy or to nonadherence, which is the second criterion required by the Law.

In 10.4% ($N = 289$) of the proposals we found an explicit reference to aggressive behaviour, violence towards others, or a reference to dangerousness. Among these 197 (7.0%) of the proposals referred just to dangerousness/aggressive behaviour and to the presence of a mental illness.

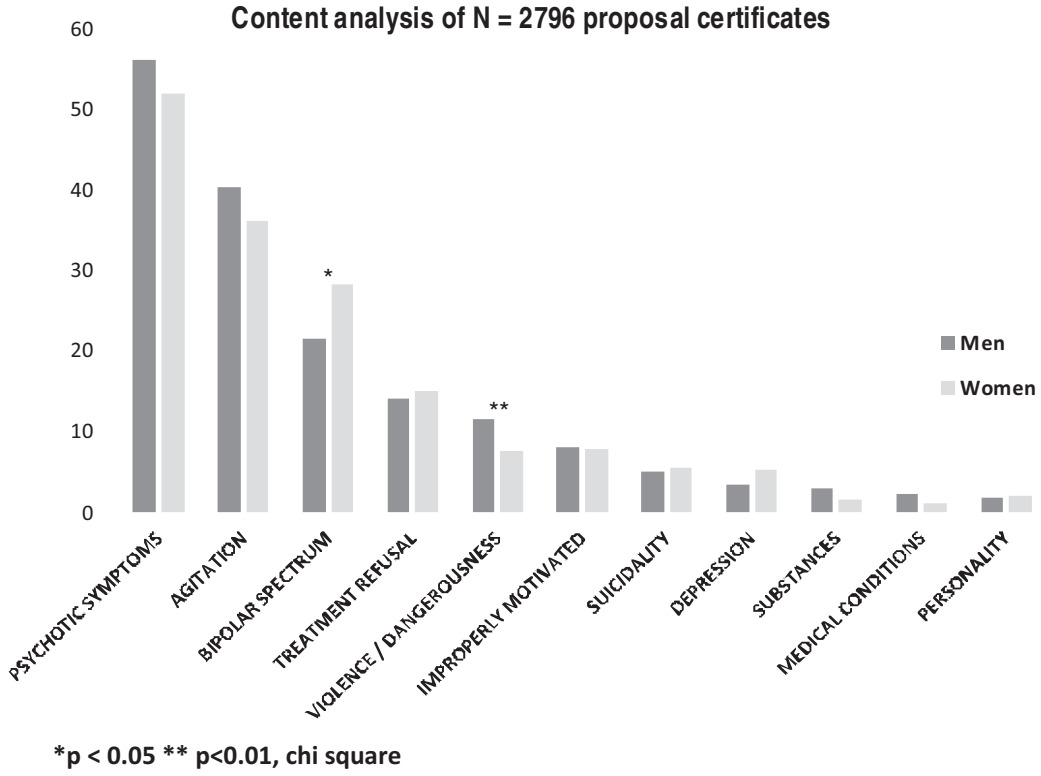

Figure 1. Reasons for involuntary psychiatric hospitalisations in Rome (Italy).

Suicidal thought or suicidal behaviour was reported in 5.9% of the proposals. Interestingly, among these $N = 25$ (.9%) motivated the IPH request just for the presence of self-harm, without mentioning the presence of a mental illness. A medical disease appeared as an IPH motivation in 1.8% of the proposals. Two hundred and four (7.3%) of the proposals were improperly motivated.

Chi-square disclosed that involuntarily hospitalised female patients showed a higher prevalence of symptoms of the bipolar spectrum (female = 29.7%, male = 23.3%; $p < .05$), while male patients showed a higher prevalence of aggressive behaviour (female = 7.7%, male = 12.6%; $p < .01$) (Figure 1). To analyse the impact of specific psychopathological/behavioural dimensions we also analysed the frequency of proposals that satisfied one of the ten dimensions considered. The following distribution emerged in descending order: psychotic symptoms $N = 715$ (25.6%), bipolar spectrum $N = 347$ (12.4%), agitation $N = 331$ (11.8%), suicidality $N = 20$ (.7%), depression $N = 13$ (.5%), violent or aggressive behaviour $N = 13$ (.5%), treatment refusal/treatment adhesion issues $N = 5$ (.2%), personality disorder $N = 3$ (.1%), substance use/abuse $N = 0$ (0%) and medical conditions/diseases $N = 0$ (0%).

In 97% of the confirmation certificates there was no mention of any diagnostic judgement made by the second physician, who in most cases simply filled in a pre-printed form.

Twenty-one (.8%) cases were not validated by the Tutelary judge, of which 16 based on a mere temporal criterion (notification over the 48 h from the hospitalisation of the patient), and 5 because the motivation was deemed insufficient.

Discussion and conclusions

The results we found in the present study contribute to shedding light on critical issues of IPH in Italy including the underlying clinical reasons and the efficacy of the jurisdictional guarantees provided by the law. The large sample size, consisting of 2796 case files of IPH in the city of Rome between January 2013 and May 2016, provides sufficient data to make considerations on a system based solely on mental illness and need for treatment criteria.

The IPH prevalence in the city of Rome was relatively low, showing a reduction over the years we examined in the present study (from 3.04 per 10,000 people in 2013, to 2.60 per 10,000 people in 2015). A previous Italian study (Gaddini et al., 2005) showed

an approximate admission rate to acute psychiatric wards, including voluntary and involuntary patients, of 31.8 per 10,000 residents in the city of Rome in 2002. Another study underlined the low Italian rate of IPH (Sheridan Rains et al., 2019), hypothesising that this result might be due to the reduction in bed capacity established by the Law 180, as well as the presence of a local psychiatric culture which values deinstitutionalisation and reintegration in the community. For every 100,000 inhabitants Italy has 46 psychiatric beds, as compared with 58 in the UK and 77 in the USA (WHO, 2001). Despite agreeing on the importance of the cultural component in contributing to this phenomenon, we do not deem the reduction in bed number plays a significant role. Others have already pointed out (Hotopf et al., 2000) that bed shortage should lead to an increase in involuntary psychiatric admissions because of premature discharge, so the lower number of IPH could be explained by improved community care and possibly also the lack of a dangerousness criterion.

We found that most of the proposals included symptoms or diagnoses referring to schizophrenia spectrum disorders, which is a result that resembles other similar studies on IPH, and underlines a specific issue in the treatment of psychoses (Cunningham, 2012; Ng & Kelly, 2012; Preti et al., 2009; van der Post et al., 2012). Another interesting result concerns the gender differences we found in the reasons underlying IPH. Involuntarily hospitalised male patients showed a significantly higher frequency of violent or aggressive behaviour compared to their female counterparts. Involuntary hospitalised female patients presented higher bipolar spectrum disorders or symptoms. No other significant gender differences emerged in the other 9 dimensions that we analysed. An association between IPH, male gender and aggression has already been reported (Canova Mosele et al., 2018), our results confirm these data on a larger sample, such as the role of bipolar spectrum disorder symptoms in predicting compulsory admissions (Montemagni et al., 2011; Walker et al., 2019), using a methodologically different approach.

The analysis we did on the contents of proposal certificates found a significant variability in diagnoses and motivations underlying IPH request. This result possibly reflects the absence of specific diagnostic requirements provided by the law as well as a significant variability in the clinical conditions motivating physicians to propose a provision that has a deep impact on patients' personal freedom. Law 833/1978 neither provides a specific psychopathological dimension or of their possible impact on patients' behaviour, as a criterion for IPH, nor includes a dangerousness criterion. For example, there is no reference to the risk posed by aggressive behaviour or self-harm, which is different from other legislations of several European and Northern American countries (Dressing & Salize, 2004). Specifically, the wording 'psychic alterations' appears to be rather generic and could lead to judgement discretion, as the high variability observed in our data suggests

A significant result that emerged by analysing the Tutelary judge's case files was the lack of a clear evidence of a second clinical assessment in 97% of confirmation certificates, as indicated by no description of any diagnostic or behavioural element. Since the presence of a second doctor confirming the conditions underlying IPH is one of the main guarantees provided for by the law, the evidence of an almost constant lack of an explicit second diagnostic judgement indicates that in practice this form of guarantee fails. Most validating doctors limited themselves to filling in a pre-printed form in which the 3 law criteria are merely reported. It is possible that, considering the real and sometimes serious difficulties that occur in situations that lead to the IPH request, the second doctor, instead of evaluating independently, implements his decision based largely on what has already been evaluated by the first colleague. In doing so, however, the risk of not adequately guaranteeing the patient's rights to two independent assessments appears to be concrete.

A result that deserves attention is the 7.3% of proposal certificates ($N = 204$), that we judged improperly motivated. Possible examples of such cases were proposals merely based on 'psychosis' or 'agitation', therefore completely omissive with respect to the need to specify a serious acute mental alteration, the need and type of treatment, as well as the impossibility to intervene by non-hospital means. Moreover, we found that these improperly motivated proposals, were always confirmed by the second evaluating physician, who never amended such errors, because they used the pre-printed form.

We found interesting results also concerning the further form of guarantee, that of a legal nature consisting in the verification of the medical proposal and confirmation, as well as of the order of the city mayor by the Tutelary judge. In just .8% of the cases ($N = 21$) the magistrate did not validate the order issued by the city mayor. This result can be interpreted considering the limited possibility of the judge to get into the substance of the medical question. The

main reasons for non-validation were administrative, specifically failure to comply with the deadlines imposed by law. Nonetheless, in 5 cases the Tutelary judge requested an additional medical investigation to verify what were the patient conditions that required IPH.

From the analysis of the patients' case files, in none was it explicitly reported that the request of involuntary hospitalisation or its prolongation had been accompanied by 'initiatives aimed at ensuring the consent and the participation' of the patient. A small, albeit significant proportion of involuntary hospitalisations appeared to have been performed exclusively because of a dangerousness criterion: self-harm ($N = 25$, .9%) and aggressive behaviour ($N = 36$, 1.3%). This result is in line with another Italian study on involuntary hospitalisation (Oliva et al., 2019), but it continues to be unexpected and involves a necessary reflection on the sustainability and limits of a system that does not provide a dangerousness criterion for IPH. Our data seem to indicate that, at least in some cases, the dangerousness criterion is nevertheless used even in a system that explicitly excludes it. This evidence can be a direct consequence of the psychiatrists' duty of care which includes, apart from the safety of patients, the obligation to protect third parties from possible aggressive behaviour of patients.

Conclusions

Although our country provides for guaranteed measures to avoid improper restrictions of personal freedom and autonomy, as well as to ensure the protection of the rights of patients affected by mental disorders, these seem to only partially fulfil the proposed tasks. Our results showed that administrative issues are among the main reasons that prevent the tutelary judge from validating the IPH. To overcome this limit, we could provide an improvement in the quality of the proposal and in the confirmation certifications, which should clearly indicate the presence of the three legal criteria and should not be represented simply by the filling in of a pre-printed form. Finally, the presence, albeit in a small proportion of IPH certificates, of the dangerousness criterion, in a legal system that explicitly requires the need of treatment, prompts a reflection and suggests a revision of the legal criteria currently applied in our country.

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The authors have no conflict of interest to declare.

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