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ETHICAL ASPECTS OF COERCIVE SUPERVISION AND/OR TREATMENT OF UNCOOPERATIVE PSYCHIATRICPATIENTS IN THE COMMUNITY

Italian Report

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SUMMARY

1. Inventory of current practice and medical insights regarding coercive community treatment and supervision in Italy

1. 1. Introduction

The community mental health care movement began in Italy in the early 60s'. It was localised in North and Central Italy. In early 1960s, some sociologists and psychiatrists (following the analogous movement started in USA and GB in 50s') began to ask fundamental questions about mental hospitals. Granted that these were providing much treatment and care, was this the best way of supplying the services? And considering that the system cost a great deal to run, was it providing this treatment and care in the most economical way? More seriously still, was it actually doing harm to some patients at the same time? It has to be admitted that none of these questions were ever answered in a way that would be considered scientifically valid today. What happened was an ideological shift in which the "total institution" - a label devised by sociologists for mental hospitals, prisons, army and similar organisations - came to be seen as authoritarian, inefficient, and in many ways anti-therapeutic[1]. Early attempts to transform the mental hospital into a "therapeutic community" (Gorizia, Perugia, Arezzo) were soon overwhelmed by demands that nothing less than its abolition would do. "What happened in Italy in that period was the consolidating amongst little anti-psychiatric groups, student movement, feminist movement and major parties of the left. This phenomenon was typically Italian, even if everywhere in the West anti-psychiatric psychiatrists were labelled 'radicals'. But only in Italy, because of this consolidating, psychiatric reform little by little lost any technical and professional aspect and got strongly politicised."[2]

In 1978 Italy radically reformed its mental health system, abolishing psychiatric hospitals (except judiciary psychiatric hospitals) and establishing community-based, non-segregated and demedicalized care. The law nr 180 of 1978 which rules the mental health system forbade the admission of new patients to state mental hospitals, limited voluntary readmission of all patients to a period ending January 1, 1981, and restricted the size of general hospital psychiatric inpatient units to 15 beds per 100.000 inhabitants. Compulsory admission were allowed only in these small community-based units and with considerable safeguards. A subsequent law, nr 833 of 1978 set up the "Unità Sanitarie Locali" (USLs) - currently called "Aziende Sanitarie Locali" (ASLs) - which are local health districts, responsible for all hospital and community services for all specialities, including psychiatry. Each ASL has its own budget and administers a small area (at the present larger than originally). Each ASL sets its priority and decides its own allocations of resources. In

the past only few districts have made mental health services a priority, the majority have not. No monitoring or evaluation was built till 1989, making it difficult to determine whether the shift in mental health care was too extreme, leaving certain mentally ill persons without treatment. The primary problem was that decentralisation was not accompanied with necessary funding. It is to be emphasised that one of the main misunderstanding of the psychiatric reform in Italy was that community care would have costed less than psychiatric hospitals. It is true only if it means a de-professionalisation process - as it actually happened - whereby patients are transferred to the care of unqualified staff in group homes, or let be living alone or with relatives[3]. On the contrary well qualified community based care are likely to cost a great deal more than mental hospitals. Mentally ill, particularly in the South Italy, remained therefore committed to deteriorating mental hospitals because there was no other provision for them[4]. Because the law forbids admission of new mental patients, they are often described as “guests”. Many stay for weeks or months because there is nowhere else for them to go and they get often violent, aggressive or self-destructive to the community.

Homelessness, suicide, neglect and criminality has been consequently associated in the minds of many people with patients discharged from mental hospitals. Since 1978 Italian public opinion has continued to swing depending on the latest headline and whether the mentally ill patient is portrayed as a “victim” of the law nr 180 or a “victimizer” who is putting the public at risk. As a consequence in the last decade the debate on psychiatric care in Italy has been chiefly focused on the issue of hospitalisation and compulsory treatment.

More recently an ad hoc task force of the Italian Psychiatric Association has presented a target-project called “Tutela della Salute Mentale 1994-1996” which has been approved by the Italian Parliament. This project now constitutes the plan for a definite implementation of the mental health system. According to the target-project the mental health system should be strictly community based and organised in departments of mental health (DMHs). Each DMH should serve no more than 150,000 inhabitants and should be organised in four different levels:

- Mental Health Centre (MHC): the mental health centre is the basic structure which should co-ordinate the mental health policy of the district and provide population for the essential services of prevention, early detection and treatment of mental disturbances. The mental health centre takes care of psychiatric outpatients and minor mentally disturbed patients.

- Psychiatric Unit: Psychiatric Units in General hospital can have 1 bed per 10,000 inhabitants and they can accommodate psychiatric out patients who need to be hospitalised for any medical reason; they can also hospitalise those psychiatric patients who need to be watched over constantly and/or to be treated parenterally.

- Halfway house and part time hospitalisation (day hospital and day centre): these intermediate structures must take care of long-term outpatients with the aim to improve their compliance towards the treatment, to ameliorate their social skills and to promote rehabilitation. While the day hospital is more psychiatric oriented and aims at preventing hospitalisation, the day centre is essentially a rehabilitation structure.

- Therapeutic Community and other residential care: the therapeutic community is a protected place where psychiatric patients can be accommodated. Each therapeutic community can have at maximum 20 inpatients. Each patient should have its own plan of rehabilitation and she/he should be discharged and sent to the intermediate structures as soon as he achieves a minimum of autonomy.

THE PSYCHIATRIC SYSTEM IN ITALY[5]

		Real	Estimated Need
In-patients:		23,402	0
Psychiatric Units:		341	376
Beds in general hospital reserved to psychiatric emergency:		3,840	5,641
Beds in general hospital reserved to psychiatric long-term patients		3,599	5,641
Places in day-hospital and centre		4,788	5,641
Medical personnel		30,910	37,607
Beds in private clinics		8,862	-
Places in therapeutic communities		936	5,598

1. 2. Description of practice of coercive community treatment

Facing coercive treatments we should theoretically distinguish amongst: *1. Psychopharmacological therapies; 2. Other Organic Therapies; 3. Social Therapies; 4. Psychological Therapies; 5. Behavioural Therapies.* Often in Italy it looks as if coercive treatment only regards psychopharmacological therapies. There is a broad agreement that the psychiatric care needs in any case a very short coercion, that is the time needed to give the adequate medication. After this medication the patient should become collaborative and consequently neither coercion nor compulsion should be still necessary. One must face two biases: the first is that any non - pharmaceutical organic treatments (esp., ECT) are *per se* unethical; the second is to believe that psychotherapy and community treatments cannot be *per se* dangerous or at least dangerous enough to request the patient consent. The result is to exclude *a priori* the hypothesis of non-pharmaceutical organic treatments (even if in private psychiatric clinics ECT has kept on being performed and perhaps psychosurgery too) and to under-estimate risks of social and psychological treatments. These two biases are deeply rooted in Italian psychiatric culture: they are likely to come from a certain radicalism of the movement for psychiatric de-institutionalisation which strongly stigmatised any kind of physical manipulation, devaluated psychological therapies (and consequently they were supposed to be neither effective nor dangerous) and over evaluated social approaches to psychiatric treatments (seen as if they were always positive).

1. Psycho-pharmacological treatments are not usually considered at high risk for the patient. It implies that, according to the law, there is no need to ask for an explicit consent. Psychiatrists are not used to explain to the patient all effects of drugs supplied and to ask for his consent. The problem of consent/refusal/need for coercion arises only if the patient refuses explicitly to undergo treatment since he is not usually asked to give an informed consent. In the case of explicit refusal to take medication the current practice is to try to negotiate with the patient establishing a sort of behavioural contract, i.e. promising some facilities if he/ she accepts to take medication or treating to suspend assistance if he keeps on refusing. In emergency, doctors are used to propose compulsory hospitalisation to give to the patient appropriate cares. On the other hand out of emergency GPs and psychiatrists usually prefer to avoid compulsory treatment and clinical admission. Very often the psychiatric staff in the community accepts that the treatment is followed in a quite erratic way rather than proposing patients for compulsory treatments.

2. Other Organic Therapies: with this expression we refer to any physical therapy which is not based on drugs. In fact we can include in this group Electroconvulsive Therapy (ECT), psychosurgery, acupuncture and electrosleep. As we have just stated these therapies are not taken into account in the current ethical debate since they are considered either unethical or ineffective. ECT has had its own peculiar story. During the de-institutional movement it has been felt as the symbol of the psychiatric power and, even if most psychiatrists now admit its utility in

certain cases, it remains a sort of taboo in the current debate. In several cases however Courts of Law have expressed the conviction that ECT is a normal medical procedure which does not imply special risks for the patient. In theory it means that the consent for ECT could be considered implicit, if the patient is correctly informed on this therapy. Anyway no case of EC coercive therapy has been debated either by the public opinion or by specialists during the last 15 years.

3. Social Therapies: social therapies (part-time hospitalisation, self-help communities, substitute homes, non-residential self-help organisations, professional & para-professional organisations) have been often regarded during the last two decades as the real solution of the problem of mental health cares. It is worth noting however that the problem of the patient's coercion to undergo these therapies has never been raised. However, as we will show ahead, social therapies are often the result of any kind of "soft" coercion.

4. Psychological and Behavioural Therapies: also these therapies are not usually considered in the debate on coercive treatments except in the case of substance addicted people (drug abusers should undergo treatment in therapeutic community in order to avoid to be imprisoned). Even in the case of psychological and behavioural therapies a not-explicitly-declared "soft" coercion appears to play an important role in community care.

1. 2.1.coercive community treatment with the aim of preventing coercive clinical admission/treatment

In the philosophy of the Italian mental health system, hospitalisation for psychiatric reason should be considered as an *extrema ratio* when no other means are possible to help the patient. Every effort should be therefore done to prevent hospitalisation - voluntary and involuntary - for psychiatric reasons. It holds true even if the patient accepts to be hospitalised (actually it is controversial if the patient's generic interest is an acceptable reason for compulsory treatments and clinical admission. The vague concept of patient's interest seems to justify only voluntary hospitalisation, while compulsory hospitalisation should be justified by a serious risk for the patient' life or physical health).

In this sense a distinction should be drawn between:
- consented treatment
- refused treatment
- demanded treatment

Any treatment should obtain the patent's consent. That means that any lack of consent should be investigated as a failure of the system and/or of the psychiatric team.

Any refusal to be treated should be thoroughly understood. That means:

- To understand why the patient refuses treatment;
- To consider attentively and to take seriously the patient's reasons and try to give an effective answer to his doubts or problems;
- To keep in mind that in principle according the Italian Law the patient has the right to refuse treatment notwithstanding that the reason for making this choice are rational, irrational, unknown or non-existent. If the patient is competent he can decide as he likes without any need to give explanations to the medical staff (of course there is a possible catch 22 situation caused by this rule: a senseless decision can be used in principle by the court to support a judgement of incompetence, *see below*). Treating a patient without his consent or despite a refusal of consent will constitute the civil wrong of trespass to the person and may constitute a crime. The only reason why a patient can be treated without or against his consent is when he is not conscious and/or sound mind.

At last psychiatrists should always thoroughly evaluate any request to be hospitalised. The mere fact that the very patient ask for being hospitalised does not turn hospitalisation into an appropriate care for mental disturbances.

Sometimes a patient refuses any treatment and, despite any attempt of the psychiatric team to understand his reasons and to give an answer to his doubts, he keeps on refusing. In these cases three solutions are possible:
1. Let the patient drop out of the mental health system;
2. Treat him compulsory if he is judged incapacitated;
3. Try to coerce him in a more subtle way.

Drop out patients are not considered in the present research (they are however at least the 20% of those patients who get in touch with the mental health system according to many studies[6]). On the other hand compulsory treatments are usually avoided unless there is an immediate and concrete risk for the patient's life and/or for others. Bribing/ blackmailing/ encouraging the patient to undergo treatment is therefore the usual way to prevent hospitalisation when the patient does not accept voluntarily to be treated. "Consent can sometimes lack or not to express the patient's free conviction since vitiated by elements of psychopathology. It is up to the psychiatrist to check it and to take any possible measure to turn the dissent (as a symptom of illness) into consent. Such measures should be considered as psychotherapeutic means in the broadest sense, having certain special features:
- consent is not their starting point (as it happens in any other medical field) but their goal;
- they get over the emergency and have clearly the objective to overcome this first phase."[7]

These "negotiated" treatments are very often a prevention of compulsory clinical readmission. Besides treatments can be negotiated only with those patients who have been already "hooked" by the mental health service.

Another group of patients who can positively respond to this strategy are patients still involved in the social network (young people who still go to school or live in their families, people who work or are somehow involved in social activities). In this case the negotiation concerns the whole social context of the patient. It is worth noting that from an ethical point of view this kind of negotiation runs the risk to break confidentiality when the patient has not given permission that information be divulged to anyone. Simply contacting relatives, friends or employers in order to pressure the patient to accept treatment is rather ethically controversial.

1. 2. 2.coercive community treatment with the aim of being an alternative to coercive clinical admission/treatment

Coercive community treatments with the aim of being an alternative to coercive clinical admission/treatment are not common. In principle those psychiatric patients who refuse to take their medication and as a consequence become dangerous for themselves and/or others can be obliged to undergo an injection of long-acting preparation of antipsychotic drugs or to undergo a psychological treatment. However the law n180 which rules compulsory clinical admission does not provide for the possibility of compulsory treatments of out-patients, although it means that they are not theoretically prohibited. Actually compulsory treatments of outpatients rarely occur. Since legal procedures are supposed to be the same for compulsory hospitalisation, psychiatrists usually prefer to hospitalise those patients who absolutely need to be compulsory treated.

The only experience of compulsory treatments of psychiatric outpatients concerns pharmacological treatments. Psychological and social methods are not usually considered as possible object of compulsory treatments, at least in the field of psychiatric care (actually compulsory psychological and/or social treatments are provided for drug addicts). These few experience of legal authorised compulsory treatments of outpatients have been done in North Italy (District of Trieste) by Prof. R. Di Stefano.

In Rome in the early 80s' a few cases were submitted to the major (according to the laws nr180/78 and 833/78) by Prof. M.Marà. Authorisation was refused since it was said that the matter was not clearly ruled by law. Prof. M.Marà's position was quite clear, although rather radical: "Science is always research made by means of experiments. The field of our science is the environment where the individual's personality becomes organised or disorganised. When after the first crisis we hospitalise a patient, or we treat him at home using anti-psychotic drugs, if we extend hospitalisation or pharmacological sedation, we loose a crucial opportunity to let the patient feel that we have at least partly understood the message he oddly tried to communicate by his crisis. The crisis is the bang which results from a compression; it is the explosion of an almost infinite imagination closed in a container: the environment, too finite, too containing, too oppressive. Crisis is a cry for help. Help for what? It seems to me clear that the first need is freedom. As if he were asking: 'Get me rid of this oppression since I can't alone!'. And after the treatment we propose him the

therapeutic community. The therapeutic community is open and it must be. Sometimes certain patients run away, they ask for being locked up, they need to be locked up. Open structure with open workers, in open relationships. 'But it is dangerous' - one can argue. So what? No masks here! Look for another work then!"[8]

1. 2.3.coercive community treatment as a follow up of coercive clinical admission/treatment

It is quite difficult to evaluate the role of coercive community treatments as a follow up of coercive clinical admission/treatment. In fact it involves the same definition of rehabilitation. The definition of rehabilitation reflects its central position in community care, but also its unclear boundaries. Actually the concept of rehabilitation is deeply changed during the last two decades. Before the law nr 180, rehabilitation implied the preparation of patients living in psychiatric hospitals for their transfer in the community. The separation between treatment, rehabilitation and ongoing care was quite clear, involving different interventions and different professions. The advent of a community based system, aiming to provide comprehensive and continuing care, co-ordinated by identified GPs or teams in the least dependent setting, has required a re-definition of the role of rehabilitation as well as evaluations of their effectiveness. Rehabilitation is actually a complex network of negotiation/ coercion/ encouragement so that, when a patient accept to be in the rehabilitation path, it becomes difficult to understand what coercive treatments can mean, which boundaries they have. In a therapeutic community, for instance, there is undoubtedly a grey area of psychological pressure made by the group that cannot be simply labelled as a coercive intervention even if it is clear that patients are not really autonomous.

1. 3. Actual use of coercive community treatment

Since the law nr 180 of 1978 the philosophy of the Italian Mental Health System has been that to substitute the idea of treatment with the concept of "therapeutic path". Till 1978 the inpatient treatment was regarded as the necessary first step in a long chain of therapeutic procedure. The philosophy of the new psychiatric model introduced by the law nr 180 was quite different. Hospitalisation should be considered an exception in the therapeutic chain and not at all the necessary first step. The trend over recent years has been to admit patients in psychiatric units of general hospitals when it is absolutely necessary, treat patients aggressively and then discharge them to the next appropriate level of treatment. Hospital care may be indicated when patients are too sick to care for themselves or when they present serious threats to themselves or others; when observation and medical diagnostic procedures are necessary; or when specific kinds of treatment such as electroconvulsive therapy (currently quite infrequent in public hospitals), complex medication trials are required. There is consequently no need to consider hospitalisation as a moment of the story of a psychiatric patient. In the same time the mental health system should offer valid alternative to hospitalisation. "The health system is required to propose a therapeutic path. If this path starts without the patient's consent, it should be considered a failure of the system"[9]. The therapeutic path cannot therefore admit compulsory/coercive treatments (other than as a sign of its failure); on the contrary it can obviously conceive negotiated treatments. Briefly the idea of "therapeutic path" includes two very important concepts:

a) Therapy is not a single action/intervention but is the result of a complex series of activities;

b) Time and timing are crucial in psychiatric cares and cures.

According to this approach coercive treatments should be in general considered as a mistake of timing, namely a treatment out-of-time.

From a certain point of view one can therefore judge any request of coercive treatment to be a failure in the Mental Health System.

This strict position is rather controversial. Many authors argue that coercion (and not compulsion) con occur only when the patient has acquired enough power to resist to medical power. Coercion is the result of a negotiation in which the patient choose the best possible choice for him. In this sense the need for coercion can be considered to be a symptom of a new autonomous position of the patient. As stated by Dr Luigi Benevelli "In the philosophy of the Italian Reform, the relationship between health service and patients tends to be based on a life path and consent is not focused on a single episode or act"[10]. As a consequence even coercion cannot be considered as a single episode but it should be included in the therapeutic path as a moment which aims at promoting the process of patients' empowerment.

1. 4. What kinds of treatment-plans exist?

Officially no treatment plans or guidelines concerning coercive treatment of psychiatric outpatients are available. At any rate analysing the current practices of coercive psychiatric treatments in Italy, three different strategies can be described:

1. The strategy of the "therapeutic menu".

As we have stated the philosophy of the Italian psychiatric reform is to substitute the idea of single treatment with the concept of the "therapeutic path". That means that different approaches should be considered in different periods of the treatment. These different approaches should be integrated to each other. Eventually the philosophy of the therapeutic path is goal-oriented rather than to be directed toward an abstract model of mental health. This usually involves obtaining active co-operation on the part of the patient; establishing reasonable goals and modifying the goal downward if failure occurs; emphasising positive behaviour instead of symptom behaviour; and setting a time frame, which can be obviously modified later. The refusal to undergo treatments (e.g., to take medication regularly, to frequent a day hospital or a mental health centre, to follow a psychotherapy, to participate to activities of a therapeutic community) should be often considered a sign that the approach chosen does not suit the patient. As stated by Prof. Pierluigi Scapicchio, president of the Italian Psychiatric Association: "I think that coercion is very often a false problem. Unless the patient is severely burned and run the concrete risk to harm himself or others - and in this case we should face the issue of compulsory treatments - the need for coercion actually means that we have not chosen the right approach. In these cases the answer is not to coerce the patient but to switch to a different approach. It is quite difficult that a patient refuses any kind of therapeutic proposal. What we need therefore is a rich therapeutic menu where the patient can choose."[11] Prof. Salvatore Merra, chairman of the largest mental health department of Rome, the MHD of the ASL Rome C, adds: "The need for coercion is often the result of mental rigidity of the therapeutic staff that has not be able to offer to the patient a real alternative to the refused treatment"[12]. The same concept is well expressed by Dr Fabrizio Asioli and Dr Dino Berni of the Day Centre of Reggio Emilia: "During the last six years we have followed 90 out-patients. Twenty of those out-patients refused treatments and left the centre. In all these cases we have always found problems in the medical staff. There have been at least three different kinds of problems: 1) Conflicts between the psychiatrist who sent the patient and the staff of the centre; 2) Overstimulation of the patient. The staff of the centre enthusiastically overwhelmed the patient with too many proposals; 3) Understimulation of the patient. Young patients still social competent who do not feel that the therapeutic menu of our centre suits them." [13]

2. The strategy of negotiation

The strategy of negotiation is not actually alternative to the strategy of the “therapeutic menu” but it is its logical development[14]. Usually any effort by even voluntary patients to terminate treatment or miss appointments is regarded as psychopathological, not a patient’s right to free choice. Counter-intuitively the basic assumption of this strategy is that psychiatric patients (above all those with a long story of institutionalisation or multiple service users) are passive and that they are used to accept treatment. A “good psychiatric patient” is likely to be a chronic psychiatric patients with few changes of recovering. On the contrary the appearance of a resistance to treatment means that those patients are acquiring a more autonomous status. The patient’s increased autonomy allows him to be an actor in a behavioural contract. The second assumption of this strategy is that the capacity to resist to treatment is directly proportioned to the social power of the patient. As stated by S. Podrecca, G.De Isabella and R.Lorenzi: “ When a patient is able to face it, we think is very useful to introduce negotiation in the therapeutic relationship”[15]. The social power of the patient is a valuable of his position in the social network. The first step deciding to try to coerce a patient to undergo a treatment is therefore to evaluate his social power, i.e., the social network in which she/he is involved. The description of the social network requires to define[16]:

1. Social support
2. Social links
3. Social competence
4. Social status
5. Coping with the social role

Only after having understood this complex network of relationships we can try to coerce a patient interfering with crucial points of his/her social network without harm him/her but improving his/her capacity to be autonomous. It is worth noting that coercion in this strategy is a treatment in itself and therefore it should be attentively graduated like a medication.

Dr G.Gabriele, a psychologist, states: “We should examine very important aspects: for instance the capacity to choose between two alternatives. When they are obliged to choose, psychotic patients often go to crisis: in their mind to choose means to take charge of responsibility to cause a catastrophe. A patient might say: ‘ I would not like to come to the centre. If I come to the mental health centre, my father will die’. The community worker should act as a surety for the patient: he will stay with the father while the patient goes to the centre. As soon as the patient arrives, he can call home to check that there is no danger. Of course this approach is possible only if there is an emotional link between client and community worker, such as a mutual guarantee. [...] Power is another big problem. We need to diminish the hierarchical organisation of mental services and renounce to some professional privileges if we intend to give back to the client part of his bargaining power and part of that power that social stigmatisation has taken away from him. Rehabilitation needs reciprocity. If we can listen at the client, he often suggests the best solution while he is apparently refusing the treatment”[17].

3. The strategy of wait

The strategy of wait is well described by Graziella Morandini and Flavio Nosè, chairpersons of a Mental Health Service in the district of Venice[18]. Actually they presume that any refuse to treatment is a symptom of an error of timing, at least when it occurs in patients already treated by the mental health system. The psychiatric staff should try to understand the particularity of any patient and consequently his/her structure of timing. They propose that the same classification between *in* and *out* patients is a bias. Actually in their opinion the real dichotomy is between autonomy and dependence although without any possibility to draw clear boundaries. Patients who refuse treatment are actually demanding more time to decide and we should respect this request. From a practical point of view these authors propose to avoid any kind of direct coercion, possibly interpreting the reason of the patient's refusal, trying to improve the therapeutic alliance with the patient. They suppose that an attitude of "warm" wait and empathic understanding can be the effective answer to a refusal to be cured. The case of *Sergio* - as related by Dr G.Gabriele - can be explicative of the strategy of wait: "*Sergio* is an out-patient of our therapeutic community who has just been discharged by the psychiatric unit of the general hospital. He feels very bad. He is completely taken by his delusion, he refuses to take his medication. The first member of the community staff who tries to get in touch with him is verbally attacked by *Sergio*. So he gives up and, after a hour, asks another worker for contacting *Sergio* and trying to understand the reason of his aggressiveness. Little by little all community workers come up to *Sergio* showing interest, each one using its own method (a coffee, a cigarette, a walk, a chatter). During this period *Sergio* is involved in the community's activities. When *Sergio* appears to be more quiet and able to explain himself (and that is about 6 hours later) the first community worker who got in touch with him, and another member of the staff who has a good relationship with him, call *Sergio* to face the issue of medication. Now *Sergio* accepts to take his medication and admits to have spent an awful night in the hospital and to have felt the first worker as a persecutor. At this point *Sergio* can go back home quietened, also because he has had the possibility to make peace with the same person to whom he showed all his rage"[19].

The strategy of wait seems to be typical of a certain "psychoanalytic milieu" in the Italian institution. Coercive treatments are excluded by this strategy although one could ask if the same wait can be already considered a kind of psychological coercion. Actually this strategy can work only if there are solid emotional links with the patient and then - in our opinion - the coercion keeps on existing and it is actually based on transfer mechanisms. This strategy is also typical of coercion in group therapy, when the patient's refusal to take part to the session is interpreted rather than taken seriously into account (of course a psychoanalyst could argue that interpreting actually means "to take seriously into account"!). "During an individual psychotherapy, the patient can express dissent by discontinuing the therapy; a different situation occurs in those group therapies which

explicitly provides by contract that the group can prevent the abandonment of one of its member or to pressure for his return. Some ethical doubts can arise on the correctness of these manoeuvres which try to limit the patient's free choice. "[20]

1. 5. What are the experiences?

Psychiatric out-patients can be classified in three very different categories:
- satellites of the hospital (revolving door patients and multiple service users)[21];
- long-term out patients
- minor disturbed patients

We have chosen to give a few examples of real current practices of coercion in these different categories and in four different contexts.

The first one is treatment of anorexia in two specialised centres. The second one is a community for the rehabilitation of long-term psychiatric outpatients. The third one is a therapeutic community for former psychiatric inpatients. The fourth one is the largest department of mental health of Rome.

1.5.1. Case 1: Anorexia

In Italy the rate of anorexia has been calculated about the 5-10% among teen-agers[22]. Anorexia holds an odd place in psychiatric nosography and treatments. First its causes are quite controversial: multiple endocrinologic abnormalities exist in these patients, although most psychiatrists believe they are secondary to malnutrition and not primary disorders. Actually even if most authors favour a primary psychiatric origin, no single psychiatric hypothesis satisfactorily explains all cases. Anorexia is therefore on the verge between "mental" and "organic" disorders. Secondly the goal of treatment of anorexia is not mere psychological (also if psychological changes are obviously crucial) but is the restoration of normal body weight. Because of these particularities anorexia is often neglected in the ethical debate in psychiatry, as it were not a real psychiatric issue. On the contrary anorexia is one of the most crucial issues in psychiatric ethics. Together with suicide, anorexia is the only psychiatric disturbance with a significant rate of death (about 6% according to the current data). Patients with severe malnutrition must be hemodinamically stabilised and may require enteral or parenteral feeding. This is the reason why forced feeding is often recommended in life-threatening situations. Forced feeding in anorexia is therefore a classical case of compulsory treatment in psychiatric practice. Between the choice of compulsory feeding and the choice to let the patient die one should consider the large area of negotiation. This area represents one of the most interesting field of coercive treatment of psychiatric out-patients[23].

- a) Centro Auxologico Italiano, Ospedale S.Luca - Milano

The Auxologic Centre of the S.Luca Hospital in Milan is one of the most important centre in Italy devoted to the treatment of anorexia. Chairman of the Centre is Prof. Franco Cavagnini. Their approach is essentially behaviouristic. Patients are examined in a day hospital during the diagnostic period. Then patients with anorexia are hospitalised but only if they accept to be treated. If they do not accept to be treated the negotiation begins. Negotiation is possible only if the patient has established a good relationship with the

medical staff during the diagnostic period (actually the diagnostic period has the meaning to link the patients rather than to diagnosis the illness). They face the patient with the fact that she/he should give the doctor any justification to keep on using the national health service, since she/he should be discharged in absence of any result. If the patient accept to negotiate the medical staff does not focus on physical or psychological treatments (although they are obviously proposed to the patient) but only on the weight. They decide with the patient an "acceptable" weight, i.e., the weight that justifies expenses from the National Health Service and that does not hurt patient's feelings. The agreement is that this weight must be achieved and kept in any way. If the patient does not succeed in eating enough she/he accepts to be hospitalised to be fed artificially. Any further step of the treatment will follow the same schema, trying to re-negotiate a highest weight each time the maximum accepted by the patient.

- b) Clinica Pediatrica, Università di Parma

In the Paediatric Clinic of the University of Parma is located another well-known centre for the treatment of anorexia. The Centre is run by Prof. Lucia Ghizzoni. They are more analytically oriented than the centre of Milan. Patients with a diagnosis of severe anorexia are hospitalised, sometimes compulsory, and they are compulsory enterally or parentally fed. When the patient has gained four or five kilos, i.e. she/he are not any more at risk to die, the negotiation can start. Even in this case the negotiation is based on the principle of establishing an "acceptable" weight that the two parties agree to maintain. However it is worth noting that the threaten used is quite different. The medical staff has already begun an artificial feeding and they threat to keep on the treatment unless the patient accepts to negotiate. Apart from troubles caused by artificial feeding, patients are worried not to be able to control the food intake. This often allows to reach an agreement that permits the patient to be de-hospitalised and to follow a treatment in the community (always under the threaten to be hospitalised to be artificially fed). A crucial point that psychiatrists of this centre emphasise is that hospitalisation (even compulsory hospitalisation with compulsory feeding) can be a real need for these patients that hate to feed themselves but, often, do not wish to die. Compulsory treatments could therefore be a way of getting these patients rid of their catch 22 situation. This is the reason why psychiatrists of the centre of the University of Parma stress the fact that we should always leave the patient the possibility "to choose a compulsory treatment".

1.5.2. Case 2: Progetto "Fondo Ostie"- Mantova

The project of psycho-social rehabilitation "Fondo Ostie" is one of the most interesting project of community care in Italy. It has been run from 1986 by Dr L.Benevelli, a former Italian MP involved in the psychiatric ethical debate and expert in psychiatry of community. "Fondo Ostie" is an attempt to give to psychiatric patients the basic social skills to face the every days life. About 30 patients are participating to the this project: 10 former inpatients of the mental hospital of Mantova and 20 outpatients coming from the local district. The "Fondo Ostie" project clearly shows what we meant stating that the philosophy of the Italian Mental Health Services is the "therapeutic path". Patients who arrive in community are all severely disturbed and they are not autonomous at all. But what is real important is that they are not yet supposed to be

autonomous even in principle (this is the crucial passage from a theoretical point of view). To achieve autonomy is consequently the main goal of the treatment. To achieve autonomy means to built the material basis of autonomy, namely to be autonomous means to have some social power. At the very beginning patients are without any power. They are not able to do anything: they cannot go to a bank to open a bank account, they cannot provide for their meals, they cannot post a letter or pay a postal order: in a word they are total powerless, at least from a social point of view. The goal of the project is to teach them these simple but essential social skills through a community life. What is interesting for the present research is as patients get more experts in social skills as they get more sensitive to social disapproval and than to coercion. In fact the social network that the rehabilitation project has built around them is in the same time the key of rehabilitation and the possibility to negotiate with them treatments. It is worth noting that in this scenario the same negotiation is a goal of the treatment. It is actually a sign of a new autonomous attitude of the patient. Therefore the very appearance of coercive treatments, i.e. negotiated treatments, can be considered a symptom of a positive outcome in the therapeutic path of this community.

1.5.3. Case 3: Comunità Terapeutica "Primavalle" - Roma

The case of the therapeutic community "Primavalle" is quite different from the therapeutic community of "Fondo Ostie". Since its birth in 1981 (it is one of the oldest therapeutic community in Italy) the community "Primavalle" has been strongly involved in the political debate on psychiatric legislation and it has been run for years by enthusiastic pro-deinstitutionalisation psychiatrists. Its chairman, Prof. M. Marà, is one the most important representative of the anti-institutional movement "Psichiatria Democratica". The philosophy of this community is strongly social-oriented: "The therapeutic community is considered not as a tool near others of therapeutic instruments, but essentially as a place where more people can perceive and feel, under specific conditions, a different presence. It can be affirmed therefore, that the community, conceptually intended, will be as such only when it will have participated in the formation of individuals with their own specific personalities"[24]. In this community coercion is made by the social pressure: the tool of this pressure is the assembly. "The assembly is the centre of the community life. [...] The assembly is one of the fundamental tool to reverse the situation of psychotics. [...] We know that the basic anxiety of human beings is to be abandoned: by others, and we call it isolating; by ourselves, and we call it madness; by everything and everyone, and this is the death. These three kinds of abandon feed reciprocally themselves: isolating drives us crazy; madness can made us killers. During the week we have to implement the decisions taken by the assembly, always together with patients, with each patient, even physically, bringing him with us or going us in face to his bed, constantly. During the next assembly his/her resistance will be decreased since she/he will have verified not to be cheated."[25] . Methods of coercion are chiefly based on the assembly, i.e., on the social approval/disapproval of each behaviour. Actually the issue of coercion is not really debated in the community since they feel coercion as a sort of moral obligation towards the community members. Prof. Marà was one of the few Italian psychiatrists who tried to use compulsory treatments of outpatients but his attempt failed in the beginning of 80s' because of the refusal of the City of Rome because of the not clear formulation of the mental health legislation.

1.5.4. Case 4: Dipartimento di salute mentale ASL C - Roma

The Department of Mental Health of the ASL Roma C (RHAs district C of Rome) corresponds to a wide area of the suburbs of Rome and is the largest mental health department in the district of Rome. It is run by Prof. Salvatore Merra. Patients chiefly come from the low middle class and are at the first generation of urbanisation. Outpatients presents any kind of mental pathology, from psychosis to neurosis and personality disorders.

Patients suffering from personality disorders are often young people addressed to the mental health department by the school authorities, by the court or by the police. These patients are often invited to undergo a psychotherapy and it seems clear that it is a matter of a sort of coercion even if these patients show to accept treatment. “Actually coercion is a mere pretext - states Dr Giuseppe Inneo, responsible for psychotherapies - These youngsters just accept to establish a first contact with the department. If we are not able to create a solid therapeutic relationship in few sessions, they will abandon the treatment and we have not real power to stop them. The therapist should be aware of his own limitations; if these are ignored then the possible consequence is resignation or burnout. The overestimation of his power and his therapeutic skills can result in the abandonment of the patient. The acceptance of the symbiotic needs of the patient is more essential than the capacity to express a valid coercion by suggestive or behavioural techniques” [26].

As far as psychotic patients are concerned a peculiar role in coercive treatment is played by families, according Prof. S.Merra, the chairman of the department: “We have well established guidelines about how to work with families when patients refuse treatment. We try to emphasise a partnership model, which fully recognises relatives’ expertise in dealing with the patient. The aim is not to treat the family, but to enlist their collaboration in providing a comprehensive system of support which minimises the risk of relapse and social disability. We should distinguish two different situations: 1) The family is already in an intervention program when the patient refuses the treatment; 2) The patient refuses the treatment when we approach the family. In the first case we have already carried out a detailed assessment of the family’s resources, its current problems and its attitudes associated with the psychotic member. When the refusal occurs, we have a full scenario which often allows us to use behavioural strategies to cope with the patient. If there is not a crisis (crisis are actually very infrequent) we plan a few individual family session which have been proved to be more effective, probably because work can focus closely on issues of specific concern to the family in relation to the patient and his refusal to collaborate. In the second case, when the patient refuses therapy during the first contact, we do not focus on this refusal but on the whole social and familiar context trying to understand what that refusal means in that particular situation.”[27]

1.6. Clinical insights

In the last two decades there have been worrying indications that new services for mental health might be neglecting the care of long-term severely ill patients for the soft option of those with milder neurotic or personality disorders. Research on community psychiatric nursing showed a steady trend for activity to move from the first category to the second[28]. Yet the most significant aspect of the clinical evaluation of any community service is the way in which it deals with the chronically handicapped' particularly people with severe psychosis. With the closure of mental hospitals, patients have been widely dispersed into community based services. To monitor the condition of these many vulnerable people is an enormous task and it is far from clear that most services have the resources or even the will to undertake it. More critically, there can be little confidence that, when an unsatisfactory situation is discovered, effective action is taken to change it. The main reason for this concern is that under the reformed conditions, and particularly with the transfer of all community care to local authorities, every intervention has to be costed and charged to a fixed budget. In these circumstances, patients with severe chronic psychosis or dementia are very unwelcome: if they are properly cared for or rehabilitated, they need a great deal of time from professional staff over very long period. One administrative response to this has been - as we have stated formerly - a de-professionalisation process. There has been little evaluation of the consequences of this change and none from a long-term point of view. For instance it seems crucial that minor mental disturbances are faced by GPs and that GPs are able to detect early symptoms of serious mental illness. Currently it has been esteemated that about the 65% of pathologies seen by GPs has psychological origins and about 35% of serious mental disturbances are not at all decteted by GPs[29] . It is obvious that in such a context psychiatrists and psychiatric teams in the community are overwhelmed by different requests and are somehow encouraged to take care of the less severely disturbed patients.

The new target-project "Tutela della Salute Mentale 1994-96" promises to improve care for chronically mentally ill. At any rate there is still much to be done on the evaluation of specific treatments which are likely to be used in community settings. One of the most important of these is the depot injection form of neuroleptics for psychosis. The use of these drugs could substantially reduce the number of relapses requiring coercive/compulsory treatements and clinical readmission in residential care. Unfortunately, many studies have not been performed in realistic conditions, emphasising that evaluative research must be carried out in a relevant way if it is to be useful. There is much evidence that family intervention can significantly improve the outcome for many patients; what has not yet been shown is how this can be supplied within a normal district service over a long period. Another crucial topic is that of psychotherapies. It seems clear that psychotherapy is effective in dealing with certain mental disturbances but the ratio cost/benefit

appears to be controversial and, above all, the cost of training and supervision of therapists is likely to be too high for the Health System.

Briefly many clinical unanswered questions about community care remain and need to be submitted to systematic evaluation. How will fund-holding practices deal with patients whose care is very expensive and prolonged? Will they be denied contact with psychiatrists (for which the charge varies enormously between different health authorities) and - if it happens - what difference will it make? How will acute problems be managed when the number of available beds for psychiatric reasons in general hospitals is strictly ruled by law? If it is demonstrated that patients and relatives are suffering because beds have been cut below a reasonable minimum, will providers respond by increasing them? How are the views of the public (and not a just vocal minority who claim to represent them) being sought? What are the consequences for patients when social workers are unilaterally withdrawn from multi-professional teams by local authorities? What are the ethical boundaries of means of social coercion and pressure? Can community based psychiatry run the risk to turn care into a method of social control?

1.7. Practical and ethical problems and dilemmas

1.7.1. Relevance of ethical principles

- **Autonomy of the patient vs. best interest, benefit:**

The laws 180/78 and 833/78 clearly affirm superiority of the principle of autonomy on the principle of benefit. Neither patient's good nor the collectivity's needs are ever a sufficient reason to justify compulsory or coercive treatments. The same concept of "danger" for oneself of for others formally disappeared from the Italian legislation. According to the Italian law in case of conflict one should always give prominence to the patient's autonomy. The same procedure for compulsory treatments is so bureaucratic and complex to discourage anyone. However many authors[30] have noticed that the Italian law also states a "right to be cured" and defines health as a social good. It implies a community-oriented view of health. Conflicts between the State's duty to preserve and promote citizens' health and the individuals' right to self determination appears therefore to be unavoidable. Some authors[31] have also emphasised the shift from health care to "health protective behaviours" in the Italian society. The same would hold true for mental health where sickrole behaviours are turning into illness behaviours (for a sociologic definition on these two behaviours one can refer to the classical work of S.Kasl and S.Cobb[32]; regarding the relationship between health behaviours and autonomy, the study of Seeman & Seeman[33] remains of crucial importance). Practices of self managent of health are increasing in the psychiatric field[34] and methods of self care and self medication should be thoroughly evaluated in comparison with the traditional health care system. According to a recent survey[35] there is a huge area of non-compliance and self-medication amongst minor mental disturbances. Briefly, the shift from the *demanding patient* to the *challenging patient*, as defined by E.Friedson[36], promises to change all our current standards in medicine, even in the psychiatric practice.

- Resource allocation

The deployment of limited resources for competing needs within health care increasing political and social strains over the coming decades. Health professionals have an ethical duty to act as advocates of patients whose needs they know well, but also to participate in an overall evaluation of health priorities. This holds true for psychiatry too.

Analysing problems and failures of the Italian Mental Health System, the crucial point appears to be that of allocation of resources. In the past psychiatry has not been considered as a priority. The National Health Plan has never provided for a specific balance-sheet item devoted to the mental health. In 1988 the Minister of Health, Mr Donat Cattin, proposed to fund the Mental Health Services with 1000 billions of lire, that was the 4% of the whole amount devoted to the National

Health System. Unfortunately the law was not enacted. In 1990 an act was passed by the Parliament that engaged the government to fund adequately the Mental Health Services using tied-up funds. It is worth noting that in this act the need to make mental health care a priority in the allocation of resources was emphasised. However even the current target-project "Tutela della Salute Mentale 1994-96" has not been funded by law (and actually this is the main reason of worrying). According to some authors the real need for the Italian psychiatric system should not be less than the 5% of the whole National Health Budget[37]. It is also worth noting that, although the law 180/78 formally closed mental hospitals, till 1994 about 25,000 psychiatric in-patients kept on living in former mental hospitals, as "guests", and the 80% of the total budget for the mental health system is still allocated in these hospitals[38] .

- Other principles, like social responsibility, justice, others:

The Italian Constitution states that health is a social good. Principles of social responsibility and solidarity are invoked by those who promote social approaches to treatments. The notion of "social consent" has been recently debated[39] by A.Fiori, a catholic ethicist and chairman of the Department of Legal Medicine in the Catholic University of Rome "S.Cuore". Social Consent - according to this scholar - is the implicit consent given by a social group to a particular medical practice. Social consent gets informed thank to scientific education and popularisation which therefore constitute an ethical duty/right of the whole society. The concept of a "social consent" can get rid from some difficulties met trying to conciliate autonomy and patient's benefit. Social consent could be invoked to base coercive treatments of psychiatric patients in the community, at least when these patients are still part of a social network. In these cases the consent given by the community could somehow substitute the personal consent, according to a sort of principle of sussidiarity. Anyway this approach appears to be highly controversial and full of ethical risks.

1.7.2. Practical problems

As we have already shown that many practical problems have been raised by the new psychiatric system. Summarising they are chiefly of two kinds:

1) Lack of legislation and funding

The laws 180/78 and 833/78 are two outline laws which needed local laws (regional laws) to get applicable. Unfortunately both laws did not give clear general rules about their implementation (there are some reasons to explain it: the law 180/78 was rapidly enacted to avoid a popular referendum against the former legislation and the law 833/78 was chiefly oriented on general practice). Briefly neither the law 180/78 nor the law 833/78 planned psychiatric community care

and services, defining structures, personnel, responsibilities, authorities and funds. Not yet the body of civil and criminal laws somehow concerning psychiatry was changed (e.g., laws on competence and incompetence, mitigating circumstances for psychiatric reasons, criminal mental hospitals,.) and it obviously provokes some paradoxical situations.

Regional law have been erratically enacted and above all they have been quite different from Region to Region. The mental health system has been effective in few Regions (e.g., Friuli, Veneto, Emilia Romagna, Toscana, Marche) [40] which enacted well done local laws while the majority of them did not enact any laws till few years ago or enacted laws too vague and/or not adequately funded. A recent survey[41] carried out by a special task force of the Medical Association in the Region "Campania" well shows what kind of problems have been met in implementing the psychiatric legislation. The Region Campania enacted a regional law on psychiatric community care only in 1983 (5 years later than the national law!). At any rate this law, the laws Lr 1/83, was one of the most complete and clear regional law on psychiatric system: unfortunately it was not adequately funded. The result was that 2000 in-patients still remained in 1994 in former mental hospitals (almost completely abandoned!) and no real rehabilitation plan for chronically mentally ill was launched. On 61 planned, 58 Mental Health Departments were started but only 27 had sufficient funds to stay open night and day (as the law ruled). Only 9 day centres and 6 halfway houses were started against an esteemed need of 29 semiresidential structures.

As far as the subject of the current research is concerned, it is to note that lack of legislation and funding seriously biased the issue of coercive treatments. No regional law dealt with compulsory/coercive treatments in the community. They did not fill the gap of the national laws and did not promote new behaviours in care providers. The lack of clear rules left to the psychiatrist the whole responsibility to decide legal and ethical differences between compulsion, strong coercion, soft coercion and simple negotiation. The lack of funding and implementation of the mental health system actually prevented to find concrete and positive possibilities of coercive treatments in the community. Thus, before a strict refusal to undergo treatment, many psychiatric teams have often felt that the only real alternative was between compulsory clinical admission and to let the patient drop out from the mental health services.

2) Lack of training of community care teams

Another crucial point is that of training of community care providers. Community care teams, including psychiatrists, are often expected to be responsible for the care of people with serious mental health problems after only a brief induction period, with many of these staff having been trained in wards. This is unrealistic, and leads to severe staff pressures. In the last two decades Italy has been a huge laboratory on mental health, where (because of the radical change in care) new techniques of cure and care have been invented and tested. Universities however failed to

participate at this psychiatric lab (save few remarkable exceptions). Most psychiatric institutes in the universities remained unrelated with community care. “Two crucial elements of the practical field remained completely out of academic psychiatry: a) coercive treatments in the community of psychotic patients; b) promotion of mental health in the community, preventing that discomfort gets disturbance and that disturbance gets disease. [...] The long period of ‘handicraft’ psychiatric work and reflection is finished. New times require a systematic evaluation on effectiveness of new treatments. This kind of work requires universities and cannot be substituted by research carried out in mental health services by psychiatric workers by definition without methodology, techniques and time to implement significant scientific research”[42].

One task of the next future will be therefore to involve universities in the new psychiatric system. Psychiatrist have a full medical training behind them but their skills have to be embedded in a social model of care, requiring teaching of disciplines which address the impact that other individuals, groups and society at large can make on the human being, such as anthropology, sociology, and social psychology. This implies a shift away from the present biomedical discipline, which is strongly associated with hard-core medicine, towards a more pragmatic and humanistic profession. As stated by Prof. P.L. Scapicchio, president of the Italian Psychiatric Association: “For their practice, psychiatrists should be trained in the skills they require at the place where they need them, i.e. the community. Essential is a good understanding of the fundamental principles of community care: client-centred assessments, continuity of care and co-ordination of services. Skills training should concentrate on the tasks required of the psychiatrist working with a multidisciplinary team. An area of training currently ignored is team and personnel management. Often, it is assumed that the psychiatrist represents the team and thus is taking on some leadership role within the group. This can easily lead to tensions about individual responsibility and, unless dealt with in a constructive manner, can constrain the team’s functioning.”[43]

2. Inventory of relevant mental health law, regulations and case law/jurisprudence in Italy

2.1. Mental Health Laws and consent to treatment

The art.32 of the Italian Constitution affirms: "*No one can be treated against his own will unless it is differently provided by law. In any case Law cannot break limits imposed by the respect of human dignity*". It means that - except certain cases strictly ruled by law - each Italian citizen has the right

to refuse medical treatments. This principle has been more recently confirmed by the law n. 833 of 1978 which rules the whole Health Care System in Italy (art. 33 and 34).

By Italian law consent is indispensable to consider a treatment legitimate. Lacking a special law on medical treatments to base medical treatment, jurisprudence usually refers to the Penal Code, art 50, which states: *"It is not punishable who injures or endangers a person's right, with the consent of the person who can freely consent"*. This article gives juridical basis to medical cares and cures, even if it is to note that by the Italian law one's own body is not a property always fully available (art.5 of the Civil Code and art.579 and 580 of the Penal Code).

In 1992 the Italian Bioethical Committee published a report on "Information & Consent and Medical Acting" where it is stated that consent legitimates and founds medical acts and it is a mean to establish the therapeutic alliance and to humanise medicine.

According to the Italian Medical Deontological Code there are three different kinds of consent: *a) presumed - b) implicit - c) explicit:*

a. If the patient is not aware or cannot understand and runs a serious risk to die, consent to treatment can be **presumed.** In these cases consent is always presumed even if the patient expressed his refuse in the past by speaking, writing or acting (e.g.: relative's evidence, living will, attempt of suicide) since the law assumes that one's will differs with time.

b. If cares do not imply particular risks for the patient, consent can be considered **implicit**. It is supposed that the same fact that an *informed patient* has asked for being cured means that he consents to treatments. It is noteworthy that according to all authors the notion of implicit consent to be accepted requires a clear demonstration that the patient was fully informed.

c. If cares imply special risks, or a permanent reduction of physical integrity, consent can never be considered implicit but it must be formally requested and **explicitly** given, usually by writing. The Code however remains vague in defining which cares imply special risks and what the word "risk" means in this context.

Consent - both implicit and explicit - to be valid requires some pre-conditions (art 40 and 41 of the Italian Medical Deontological Code):

1. Medical Information: the patient should be fully informed about his own illness and any possible treatments and about the reason why his doctor suggests one treatment rather than another (*Italian Medical Deontological Code*);

2. Personalised Information: information should be given according to the cultural, intellectual and emotional conditions of the patient (*Italian Medical Deontological Code*);

3. Full Information: a piece of information can be considered valid, only if it is complete. Even if the patient does not ask for full information, information is not valid if medical doctors do not give a full picture of the patient's medical situation (*Italian Medical Deontological Code*);

4. Information and comprehension: informing is not still sufficient, comprehension is necessary. It is up to medical doctors to verify if their patients have correctly understood the information given. It is worthwhile mentioning that according to the Medical Deontological Code exists also a patient's duty to ask for and to get information.

5. Competence: to give his consent the patient should be competent, at least in part. The Italian law draws a distinction between "full incompetence" and "partial incompetence". Person under age of 14 years old, elderly people suffering from dementia and severe chronically mental disturbed people - the latter only according to a Court decision - are not entitled to give their consent to medical cares. Consent is therefore presumed or, when an explicit consent is required, it should be asked to a legal guardian appointed by the Court. The guardian can be a patient's relative or a special magistrate. Person under 18 but above 14, and less severe mental disturbed people are considered by law "partially incompetent". It means that they are requested to give their consent to treatment but, in case of controversies, their will must be seconded by a magistrate.

According to the Italian law treatments and clinical admission need patient's free and informed consent. There are only five cases in which one can be treated without or, even against, his consent:

1. Emergency: when a person runs an immediate risk to die and there is no time to explain him/her the situation or he/she is not able to understand, he/she can be treated even if he/she refuses treatment (R.D. 19/10/30 n. 1390). Consent is presumed and if any refuse occurs it is supposed to be the result of mental confusion or of a lack of information and/or understanding. It is also worth noting that by law the treatment must be:

i. proportioned to the risk;
ii. absolutely unavoidable from a medical point of view.

2. Compulsory Vaccinations (L. 1/3/ 1963 n.292);

3. Sexual Transmitted Diseases (except AIDS), **Tuberculosis and Leprosy** (l.26/7/1956 n. 897);

4. Drug Addiction: according to the law n.126, 26/06/1990 addicted persons can be obliged to undergo to treatment. It is however to note that the referendum of April 1993 has abolished any sanction against addicted people refusing to undergo treatment and the law is now ineffective.

5. Mental Diseases (art. 33, L. 13/5/78, n.180): in principle no psychiatric treatments can be carried out without an explicit consent. Compulsory hospitalisation is an exception and is possible only under strict rules:

a) First step: compulsory hospitalisation must be proposed by a medical doctor and confirmed by a psychiatrist belonging to the Regional Health Authorities. The proposal signed by the two doctors must be supported by a clinical report. This report should clearly show that compulsory hospitalisation is not avoidable. Three main conditions are to be fulfilled to justify a compulsory hospitalisation:
ii. The patient should refuse to be cured after any attempt to negotiate with him the treatment;
ii. No other solution should be available (domestic treatments, hostels, board-and-care homes, self-help communities);
iii. Mental troubles should be as severe as they require an immediate intervention. Although the law does not define "mental illness" or "mental disorders", severe in this context means:

1. risks for the patient's life;
2. risks for the patient's main interests;

It is worth noting that - in absence of these risks - it is controversy if the mere evidence that the patient's mental health will deteriorate if he does not receive treatment may constitute *per se* a sufficient reason to treat anyone compulsory. Risks for others (e.g., patient’s aggressive behaviours) are not formally considered by the law. Of course one can argue that an aggressive behaviour can provoke serious legal consequences to the patient

and, in this sense, it should be prevented by a compulsory treatment. At any rate it is to be emphasised that only when the patient's interest clearly overcomes patient's autonomy, and the patient is judged not to be able to understand it, one can propose a compulsory treatment.

b) Second step: proposal and clinical report have to be submitted to the City Major;

c) Third step: after evaluating proposal and clinical report, the Major can or cannot dispose a week of compulsory hospitalisation. In case of hospitalisation the Major must advice within 48 hours a magistrate;

d) Fourth step: the magistrate should confirm the proposed treatment within other 48 hours. The magistrate can also adopt any urgent measure to save patient's economic interests.

Compulsory hospitalisation/treatments can be stopped at any of these steps and, at any rate, they can be prolonged only for short periods (usually just an extra week). Any extra-period of compulsory hospitalisation must be re-negotiated with the magistrate specifying length of period and reasons. No long-term hospitalisation are provided by law. During any moment of this procedure patients can have a recourse to the Court against the hospitalisation.

The Italian Law does not draw clear distinction between Care and Cure. Actually out-patients compulsory treatments are neither planned nor ruled by the law n.180 which rules psychiatric health cares in Italy. According to the law n. 833/78, which established the regional organisation of the Italian Health Care System, out-patient compulsory treatment should be in principle possible (art. 33) following however the same legal rules of in-patients compulsory treatments. The article 33 of the law 833/78 states: "compulsory medical controls and treatments are provided by the City Major under justified medical proposal [...] and implemented by public community based health services and, *when hospitalisation is needed*, in public hospitals or in private clinics which have an agreement with the Region". This article seems therefore to state that compulsory hospitalisation is carried out when one thinks unavoidable not only treatments but residential treatments in hospital. One can consequently deduce that out-patients compulsory treatments are provided by law (however needless to say that the matter is not clear at all and can be highly controversial).

2.1.1. Coercion and competence

Only a competent patient can be coerced. In fact only that one who is competent by law can be legally coerced to do something that he would prefer not to do, while that one who has been declared incompetent has lost (at least in part) the legal right to express a valid consent/dissent. Actually the core of the notion of "coercion" is essentially the tension between the power to refuse and the power to oblige. If one of these two poles disappears, then the same idea of coercion becomes senseless. It is therefore important to describe legal mechanism of declaration of competence/incompetence.

Competence is indispensable by Italian law in order:

1. *To have the capacity to act* (as a legal word to act means to accomplish those manifestation of his own will which are able to modify his own juridical status);
2. *To have the capacity to make one's will;*
3. *To have the capacity to donate;*

Competence is also a pre-condition to be punishable.

Assessment/evaluation of competence is required when a person has accomplished or has to accomplish one or more of the aforementioned actions and anyone raises the issue of his capability to act, to make his will or to donate. Assessment/evaluation of competence is also required when a supposed mentally disturbed person is accused.

From the point of view of the Civil Law mental disturbances can justify two different and permanent juridical situations (art 414 and 415 of the Civil Code):

1. *Interdizione (*Interdiction): Interdiction occurs when a person, suffering from a chronic mental illness, is declared by a Court incapable to provide for his own interests. An interdicted person is considered fully incompetent. Criteria to declare a person interdicted are therefore two:

   i. Chronic Mental Illness;
   ii. Incapability to provide for his own interests.

Interdiction cannot be declared unless both two criteria are met.

2. *Inabilitazione* (Incapacity): incapacity means that the person cannot freely dispose of his own money and goods but he is still partially competent. A declaration of incapacity can be pronounced in four different situations:

   a) for those who chronically mentally disturbed but in a less severe way than those who are declared interdicted;

   b) for those who show not to understand the value of money with their extravagant manner;

c) for those who are substance abusers and as consequence of this habit cause to themselves and/or to their family severe economical damages;

d) for those who are born deaf or blind and have not been trained enough to deal with economical matters.

From the point of view of the Criminal Law, mental illness can be graded according to two main criteria: 1) Capacity to understand - 2) Capacity to will (art88 and 89 of the Criminal Code). If the subject is judged totally incapable to understand and to will (*vizio totale di mente*) he is not chargeable and if he is convicted he is entrusted to a criminal mental hospital; if the subject is judged partially incapable to understand and to will (*vizio parziale di mente*) he is chargeable but the sentence is mitigated.

One or more psychiatrists are appointed by the Court, by the defendant and/or by other parties to the case. These psychiatrists independently draw up their reports on the basis of:

1. Subject's mental status, which includes:
    a) Evaluation of his capacity to understand and to will;
    b) Psychiatric Diagnosis
2. Environmental factors;
3. Sociological and behavioural factors.

Psychiatrists can use pathographies, diagnostic manuals, psychological classifications or whatever they prefer to draw up their report.

The judgement of competence/incompetence is always pronounced by a Court of Law having discussed psychiatrist reports. Judge decides according to his free evaluation (*peritus peritorum*).

A legal guardian is appointed by the Court in case of judgement of interdiction or incapacity. This guardian can be a patient's relative or, more often, a special magistrate.

Relatives are patient's substitutes only in case of children till the age of 14. Relatives are not entitled to be automatically patient's guardians unless appointed by a Court. The current practice to ask relatives for having consent to treatment is not at all legal founded. No other forms of substitutes are provided by law. Living will of the patient is without any legal value. It can be considered just a mere suggestion for doctors and legal guardians.

To conclude this paragraph, it is worth noting that the civil judgement of interdiction and/or incapacity are now very rarely delivered because of the complex procedure they require and their substantial (if not theoretical) irrevocability. It has been said that: “These two decrees are usually

considered dangerous by psychiatric workers and patient's relatives. The former fear the restrictive aspects of the legislation, in particular those aspects which ratify a sort of civil death. The latter are scared by the consequences that such a decrees can produce in familiar relationships which are already disturbed"[44]

2.1.2. Law n 180, 1978

(See enclosures)

We have already diffusely spoken of the law 180/78. An English translation of the law can be read in the enclosures.

As far as the subject of the present research is concerned there are some points which should be emphasised:

1) The law was a transitional law. It can not rule the whole psychiatric matter in a specific way. The mere fact that compulsory treatments of out-patients are not even mentioned is therefore quite obvious.
2) It is anyway clear that the law is based on the concept that psychiatric hospitalisation is almost always useless if not anti-therapeutic.
3) The main sociological objective of the law is to put mental disturbed patients in the same position of any kind of medical patients. Actually the Italian Parliament did not intend to pass a bill specifically devoted to mental care. They were obliged to promulgate the law to avoid that a popular referendum promoted by the Italian Radical Party on the psychiatric legislation was held.

At any rate many authors have argued that a thoroughly analysis of the law can show that the law supports a radical point of view according to which mental disturbances are just the result of social pressures. In accordance with these scholars[45] the philosophy of the law 180/78 tends to deny the true existence of mental diseases in a line of criticism that regards psychiatric disease as a myth.

2.1.3. Law n 833, 1978

(See enclosures)

What has been told about the law 180/78 is also true for the law 833/78 (large English abstract of it can be read in the enclosures too).

We should only emphasise that the law 833/78 is the law which establishes the Italian National Health Service in which psychiatric system is included. The law 833/78 is obviously another outline law which can give just general lines to regional laws.

We have already analysed the crucial art. 33 where some scholars have believed to find justification to compulsory treatment of outpatients. Going back to this article we should still interpreter according to which rules the law would allow it: "In my opinion compulsory treatment of out-patients are possible when the same

conditions requested for compulsory clinical admission occur and when it is feasible to apply the same measures without hospitalising the patient, at home, in the day hospital or wherever he stays. Such a situation could occur for instance when a patient discharged by the psychiatric unit of a general hospital should take his medication. In this case the mental department should get in touch with the patient, try any measure to persuade the patient to take medication but in case of failure should carry out a compulsory treatment in the community. Likewise one should do in the case of chronic mentally ill patients, interdicted by law, who need to keep on being treated. In both cases the mental service has not a legal duty to provide for these patients (they are not actually already in charge of the service) but there is at least a deontological duty to interfere"[46].

2.1.4. DPR 7/ 4/ 78: "Tutela della Salute Mentale 1994 - 1996"

(See enclosures)

According to the target-project "Tutela della salute mentale 1994-96"(see a copy enclosed together with a few graphics showing the future organisation of the Italian Mental Health service) the key institution in the mental health system becomes the Mental Health Centre (MHC). We will therefore try to describe in which way the MHC is expected to change - or to improve - the current practice regarding coercive treatment.

The core concept of the MHC is that of "case management". The MHC should deal with case management, i.e. should ensure that "clients" (both suffers and their families) receive flexible and appropriate packages of care, which are firmly based on a comprehensive assessment of need. The MHC is expected to maintain long-term continuity, during transitions between one level of treatment to another, and to monitor the quality of the services provided. This co-ordinating function has become a necessity since mental hospitals have been closed and the danger of fragmentation of care has been therefore greater, as the experience of the last 18 years shows. The new target-project "Tutela della salute mentale 1994-96" intends to bridge this gap. Of course case management is not exclusively designed to deal with psychosis (and actually the MHC should deal with any kind of mental disturbances in the community) but the nature of psychotic disorders makes sufferers particularly vulnerable to falling into service "gaps" (failure in comprehensives) and "cracks" (failures in continuity).

This is quite important in relation with the patient's refusal of treatment and the need of coercion. The majority of patients with psychotic disorders have a chronic though episodic course of illness, spanning many years of life changes. Thus individuals' need vary over time, both because of illness process and because of ordinary life events. Relapses often entail a loss of insight, mounting apathy and social withdrawal. All these features make contact with professional services erratic and hard to sustain over time. From one hand the MHC staff should be adapted to tackle this problems and consequently to prevent the need of coercive treatments, particularly if they have known patients for some years, during period of both good and poor health, and are familiar with their strength as well as their disabilities. From another hand the MHC staff could minimise coercion when it needed using their knowledge of patients' need and habits and manipulating the patient's social network.

2.2. Is there any case law/jurisprudence with regard to coercive community treatment?

While in Italy there is a wide jurisprudence regarding compulsory clinical admission, there are no case law concerning compulsory treatments in the community[47]. The first few cases of compulsory treatment of outpatients occurred in the early 80'. In the district of Trieste the Major gave a positive answer to requests; in the district of Rome he refused to authorise them. Anyway in both cases it was matter of administrative measures without involving the magistrate and/or a Court of Justice. During the last decade a few authorisations have been erratically given: however one should emphasise that very few requests have been submitted in the same period.

As far as coercive community treatments are concerned no true case law and/ or jurisprudence is currently available. In the past some cases of charge of "Failure to perform official duties" (art 328 Criminal Code), brought to psychiatrists who let their patients drop out from the mental health service, raised some concern[48]. It was also said that psychiatrists could be chargeable for civil and criminal consequences of any act committed by the mentally ill discharged or non-treated. In 1990 the art 16 of the law 86/90 modified in a more restrictive way the art 328 of the Criminal Code and allowed a closer interpretation of it. Now to be chargeable of "Failure to perform official duties" it is needed a *specific denial* to fulfil the duty, this denial must be *undue* and should concern a duty that must be performed without *any delay*. According to most authors this new interpretation should exclude any possibility to charge a psychiatrist for failure to assist when the patient refuses the treatment. In fact the psychiatrist can legitimately decide that there are no sufficient conditions to treat a patient against his own will. Of course he could be wrong but this is not a crime unless one can prove that he did not decide according to "science and conscience"[49].

As a consequence there is no legal duty (even if there is obviously no legal interdiction) to persuade or to force a patient who refuses to be treated and for whom one cannot find sufficient grounds for a legal compulsory treatment. Coercive treatments end up therefore to place themselves amongst those behaviours ethically, but not legally, remarkable.

2.3. What are the legal procedures/ safeguards against abuse?

Compulsory treatments

There are two principal safeguards regarding compulsory treatments (both of *in* and *out* patients): a) procedures to control decisions; 2) procedures to evaluate the quality of assessment about the alleged patient's incompetence to consent/dissent.

The main instruments to control decisions about compulsory treatments are:

1. **Procedure:** The four steps procedure to accomplish to achieve a compulsory treatments is *per se* a guarantee;
2. **Publicity:** Information on compulsory treatments is public and not only the patient or his relatives but anyone who likes can have a recourse to the Court against the treatment;
3. **Communication:** The patient must have always the right to communicate with anyone he likes;
4. **Period of treatment**: Compulsory treatment is allowed for only 7 days. Doctors can prolong this period (usually no more than an extra week) only asking the legal guardian and presenting a written report which strongly justifies the request. The request must be repeated for each extra-week. This practically exclude the possibility of long-term compulsory treatments.

There are three main instruments to safeguard quality of assessment of patient's competence/incompetence:

1. **Principle of publicity:** the assessment is public and anyone can have a recourse;
2. **Principle of cross-examination:** patients or other parties in case can always oppose their expert reports;
3. **Principle of "the third":** the Court of Justice or the magistrate appointed takes always its free decision as the third independent party.

Coercive treatments

As formerly explained it is quite difficult to find in the Italian legislation civil and/or criminal rules which can be interpreted in relation to coercive treatments. The lack of jurisprudence and case law regarding this specific aspect gets more difficult to describe possible measures to prevent abuses.

At any rate it seems reasonable that the same measures that can be taken to prevent abuses of compulsory treatments can be legitimately taken also in case of abuse of coercive treatments.

- Legal consequences in the case of misuse of coercive/compulsory treatments:

a: Civil law: Psychiatrists are obliged to indemnify the patient for the prejudice caused by compulsory/coercive treatments if the patient can prove that these has been result of malpractice or that his case was not one included in those provided by law.

b: Criminal law: In case of misuse of compulsory treatments psychiatrists can be charged with 1. Private violence (art. 610 Criminal Code); 2. Forgery of an official document (art. 481 Criminal Code).

c: Professional law: In case of misuse professional law provides for a suspension from the licence to practise medicine.

- Role of Ethical Review boards in this context:

No role of ethical review boards is provided either by law or in current practice and no case have been submitted during the last decade to the Ethical Committee of the Italian Psychiatric Association.

3. Description of the debate

Is there debate in your country with regard to coercive community treatment?

During the last 15 years the debate on the psychiatric system in Italy has been focused on the effectiveness of the law 180/78 and the way to implement it. That has almost prevented any other public debate either among "lay" people or professional. Till few years ago the ideological quarrel between *pro* and *against* law paralysed any possibility to deepen the understanding of single, specific, issues as coercive treatments. To give an idea of what kind of politic commitment was involved in the debate it is sufficient to read what Dr Vincenzo Pastore, national secretary of the movement *Psichiatria Democratica* (Democratic Psychiatry), still wrote in 1992: "The analysis of what happened after enacting law 180/78 needs to be made in the context of new political and social conditions. Soon after 1978, a shift of the political axis occurred in Italy, as in the whole Western world: a burdensome process of industrial re-organisation was implemented; trade unions underwent serious withdrawals; the welfare system suffered grave attacks. That drive towards change which characterised society of the former decade ended. In that context the law 180 was, from its beginning, criticised. These critics, started by the same Ministry of Health, produced a sort of 'place in the default' of the law, justifying immobility and lack of technical and political commitment towards its implementation. Right-wing bloc, soon born to promote a general counter-reform, located in the Psychiatric Reform the main element of contradiction and break of interests, and concentrated its attacks against it"[50].

This introductory statement is essential to explain why those themes that we are about to discuss have been somehow peripheral in the Italian debate. However, now that ideological disputes appear to be partly overcome, they promise to be at last faced.

We have extrapolated from the current debate two topics more related to the issue of coercive treatments: a) *Coercive treatments of patients not involved in the community care system*; b) *Coercive treatments and psychotherapy.*

a) Coercive treatment of patients not involved in the community care system:

The first topic to be discussed is the responsibility of community-based psychiatric teams for those patients who refuse treatment without having been previously in charge of the mental health service. This point has been highly debated mainly with regard to homeless population. Recent studies have shown that among this population there is a high rate of serious mental disturbances

(from 25% to 90% according to different studies)[51] and of former psychiatric in patients discharged by hospitals. It is however worth noting that no systematic study has been carried out in Italy to evaluate the rate of former psychiatric in-patients in this population.

Homeless people have been of crucial importance in the first period of the Italian psychiatric reform. While the public opinion accused the law 180 to increase this population, psychiatric units in general hospitals were soon paralysed by the presence of these patients. Actually in the bigger cities, like Rome, Milan, Turin, Neaples, compulsory clinical admission of homeless mentally disturbed patients overwhelmed the possibility of residential care. This led psychiatrists to abandon this population to his own destiny. Homeless were not taken in charge by either social services, since "*they are mentally disturbed*", or mental health services, since "*their problems have a social origin*". To get things more complex, these patients very often refused any attempt to help them because of the development of an "institutional anorexia", as it was well named by a group of Italian scholars[52].

In this first period the debate on homeless was essentially used to criticise the law 180. No one in fact did anything concrete for those people (except some non-profit catholic associations) and no one seemed to perceive the ethical relevance of this social phenomenon. During the last four, five, years the attention towards homeless people, new forms of poverty and social marginality has been increasing. Thanks to the end of ideological disputes, the same no-profit associations (e.g., the "*Comunità di Capo d'Arco*", the "*Gruppo Abele*") concerned with assistance became to develop an analysis of this phenomenon, involving sociologists, psychologists, psychiatrists, economists and philosophers. Following their example several scholars got the more and the more interested in understanding trends of social exclusion. It is important to emphasise that in big cities this kind of population is now rapidly increasing because of the presence of migrants, above all from Eastern Europe.

Meanwhile, becoming less ideological, the psychiatric debate focused on a more ethical issue: have psychiatric services the moral duty (or the right) to treat homeless, drop outs and all other people at the societal margins? Prof. M.Cuzzolaro, a psychiatrist involved in this debate, who teaches in the University of Rome "La Sapienza", states: "It is difficult to say which non-coercive interventions are more useful with mentally ill beggars. Is there any case in which coercive treatments are justified both by intentions and results? The relationships between mental illness and process of social deviation are complex, mutual, with continual feed-backs. We cannot avoid considering them. [...] Difficult problems of practical psychiatric ethics start. Among those we should consider the risk that the visible 'scandal' of homeless mentally ill, its 'obscenity', makes only swing the pendulum again: from indifference to new process of institutionalisation"[53]. On the other hand one of the most relevant expert in the field of psychiatric ethics, Prof. S.Gindro, argues:

" We should distinguish between moral right, that is which one can do, and moral obligation, that is which one must do. The problem of coercive treatments should be faced from these two different points of view. Thus, speaking of rights, we have the moral right to force another human being who refuses to be cured only if he is involved in the social network. If he demands supports, home, assistance, we have the right to force him to respect the social contract, that is to accept to be cured. In this case the blackmail is fully ethically justified. However when anyone refuses all benefits linked to the social contract, i.e. he drops out of the society, it is arguable that we have the same right. Of course one could state that we have the duty to do it in order to respect his dignity and according to the concept of human solidarity: but he refuses our solidarity and clearly shows to have a different view of what dignity is. Can our claim to preserve human dignity ever mean to overcome the boundaries of the right of self-determination?"[54].

b) Coercive treatments and psychotherapy

The topic of coercive psychotherapy has not been debated in relation to psychiatric patients but to substance abusers. Apart from the more trivial interpretation of this issue, no one can deny that the artificial attainment of mental states, via chemical or suggested psychological actions, which ablate the mental functions always raises the question whether the therapist has the right to interfere with the patient's will. This is both a scientific and a philosophical problem: is there a moral duty to prevent *self-menticide* even with coercion?

Another group of problems related to psychotherapies is that of suggestion. Excluding a few clear cases of sexual and/or economic exploitation of patients (which involved even well known psychoanalysts of the Italian Freudian Society causing serious concerns in the public opinion), the debate focused on the right to interfere with the patient's system of values and choices (and it can be considered a sort of "moral" coercion). Faced with concrete situations, the psychotherapist is confronted with myriad of ethical dilemmas, each of which he must try to solve: this might be the reason why this debate has been periodically raised.

Coercive psychotherapies have been also discussed with regards to family therapy. Has the psychiatric staff the right to coerce (blackmailing, bribing) a member of the patient's family to undergo a family therapy? The actual issue seems to be how to establish boundaries between a "soft" pressure (that all authors think to be ethical) and a real coercion[55]. In the authoritative book *The Italian Treatise of Psychiatry* one can read: "From a systemic point of view , we should not consider individuals but systems. As a consequence the therapeutic goal will not be that to normalise a disturbed behaviour but that to give new rules to the whole system. From this perspective, the issue of consent is puzzling: who is entitled to consent or to dissent since it is not matter of a single patient? And in case when one element of the system does not accept to take part to the therapy is legitimate to go ahead with other family members, knowing that the treatment will produce effects also in the one who refused to participate? Is it a case of coercive treatment?

There is no doubt, in our opinion, that, independently from any perspective and any psychotherapeutic approach, consent is and remains individual. That means that if one thinks that all family members should participate to one or more sessions, consent will have to be required to any participant and any participant will have to be informed that the therapy can influence each other family member. In relation to the possibility that the therapy can have effects on a family member who refuses to undergo the treatment, it seems to us that since we should not consider a single patient but a disturbed system, any treatment requested by at least one member of this system is fully legitimate"[56].

3.2. Inventory of guidelines, reports and proposals with regard to outpatient coercion at the governmental level and/or the level of professional organisations and patient-organisations

Governmental organisations/institutions/ agencies

Apart from political disputes pro and against the psychiatric reform, neither governmental organisation nor institutions and agencies have been particularly involved in the general debate on the mental health system producing guidelines, reports and proposal for change. It holds true also for the specific issue of coercive treatments.

Many proposal of change of the law 180 have been submitted since 1981 (about 20). About each Italian political party has submitted at least two or three different proposals. No single proposal was really debated and one can probably suspect that it was essentially matter of demagogic operations. Actually only in 1993 the Ministry of Health set up a specific committee devoted to the implementation of the law. This committee, together with the special Task Force of the Italian Association of Psychiatry, produced in 1994 the target-project "Tutela della Salute Mentale 1994-96".

3.2.1. Professional Organisations

Even professional organisations were fully involved in ideological disputes and failed to deal with practical matter as coercive treatments in the community.

- Psichiatria Democratica (Democratic Psychiatry)

The movement of "Psichiatria Democratica" gathered the pro-law 180 psychiatrists. This movement has not produced either statements or guidelines concerning out-patients coercive treatments. This lack appears to be really odd in a movement that made the promotion of patient's autonomy one of its crucial goals. Analysing possible reasons of it, there are two possible explanations. The first one was the need to defend the law which ended up to stiffen the movement on ideological positions. The second, and deeper, reason

was, in our opinion, the well rooted bias that, in the last analysis, the mental illness was a social construction. An important wing (if not in certain periods the majority) of the movement “Psichiatria Democratica” was actually convicted that mental illness can be defined as the imposition of a label, arguing that the medical definition, making reference to a biochemical mechanism, has not been adequately conceptualised, and that psychological definition has been rooted of a bourgeois “individual” paradigm. Mental illness is therefore a convenient labelling device which society uses as a form of social control. But if mental illness is originating within the functioning of society itself, there is no need of a theory of coercive treatments in the community, since community is a doctor in itself. Namely if we set up a “sane” community and put the patient in, that is already a treatment: any refusal to participate to the community life will not be an expression of free will but, on the contrary, it will be the result of an internalisation of the social control. Open the doors, get the patient free and he will not have any need to be coerced: this was actually the philosophy of most of the de-institutionalisation movement. Community care based mental health system was therefore established without clarifying the model of mental illness underlying. On one hand it was said that de-institutionalisation only meant rationalising medical care. On other hand it was supposed that mental illness was chiefly, if not only, a social construction.

- Italian Association of Psychiatry

If the sin of “Psichiatria Democratica” was ideology, the sin of the official Italian Association of Psychiatry (IPA) was absence. Till few years ago the IPA swung between the denial of the problem and mild anti-law 180 positions. Eventually in 1992 the IPA signed an official statement with “Psichiatria Democratica” in which it was declared the need to implement the law 180 and to set up community care in all the country. Currently the IPA is full committed in promoting the target-project “Tutela della Salute Mentale 1994-96”. As far as coercive treatments in the community are concerned not yet the IPA has produced guidelines or reports. However its position is to encourage the shift from compulsory clinical admission to compulsory treatments in the community when compulsion is necessary. Prof. A.Balestrieri, chairman of the IPA Ethical Committee, states: “In my opinion, and according most psychiatrists, not more than 1% of compulsory treatments for psychiatric reasons really need compulsory clinical admission too”[57].

3.2.3Lay organisations (patient groups and family member groups)

- Patient groups

In Italy there are several self-help communities, patient organisations (e.g.: the so-called "Court for the Patient Rights" *Tribunale per i Diritti dei Malati*) and paraprofessional organisations which claim to protect patient interests. However very few of these organisations are devoted to psychiatric patients. It has been said that a peculiarity of the Italian psychiatric reform was the absence of patient associations and it is undoubtedly true. Dr Renato Piccione, of “Psichiatria Democratica”, recently wrote that among future tasks of Italian psychiatry there should be that of promoting patient associations and groups[58]. Obviously there are no patient group statements or guidelines regarding coercive treatments in the community.

- Family associations:

The substantial role of families in providing care in the community and the burden that this role often places on their physical and mental well-being must be recognised. We should also consider the crucial role of families in psychotic patients: it is well known that for these patients one of the major source of stress, significantly increasing a vulnerability to relapse, is living in a family where members are highly critical, or intrusively overconcerned. To increase the family compliance to mental illness is therefore crucial.

The lack of support to families has been the major complaint made by public opinion in the first period of the law 180. Since community care services were not implemented, in most Italian regions the families of the mentally ill had to shoulder a greater burden than in the past. Already in 1979 a first family association (DIAPSIGRA), strongly against the law 180, was set up in Rome and several other associations were born subsequently. In the late 80s' a shift however happened from anti-law 180 positions to more moderate opinions. Currently the UNASAM, the federation of family associations which gathers more than 100 associations of 15 Italian Regions, has abandoned abolishing positions and supports the need to implement the Psychiatric Reform. Family associations have often emphasise the need to study methods of coercion and persuasion of patients in the community able to give a substantial help to the families. At any rate no official statement concerning this specific issue is available.

3.3. Proposal for change

The challenge over the past two decades has been to develop systems providing comprehensive care efficiently, particularly for people with severe and persistent mental illness. This challenge has been partly lost for the very reason of the regional organisation of the primary care in Italy. In fact the regional differences in Italy are enormous and that was not considered by the law. In addition few districts correctly evaluated the importance of mental health care in primary care. Mental health services have not been a priority also because of the misunderstanding that the shift from hospital based to community based system would have reduced costs.

The new target-project promises to solve certain difficulties, defining more clearly - and strictly - tasks, methods and organisation of mental health care services in the community. This promises also to improve methods of management of mental diseases in the community, including coercive treatments. After about 20 years Italian society (both lay and professional people) seems to have understood that community care is not just psychiatry moved from institutions to the community, but a paradigm shift requiring different attitude, skills and organisation as compared with standard hospital care. During the last two decades it has been clearly shown that community care benefit patients if the mental health system is adequately funded and the staff involved are committed. The potential of community care can only be fulfilled if everyone involved possesses the necessary skills and remains motivated. This holds true above all for psychiatrists. The psychiatrist can no longer be the captain on the ship, giving orders to his officers and crew from the bridge. Patients are non longer confined to wards, looked after by nursing staff and presented at weekly wards rounds. Instead they are seen in their own territory by any member of the multidisciplinary team (the psychiatrist being one of them) who will have to consider a range of interventions there and then. The question whether or not mental illness is a disease entity can be faced now without ideological committments. Constant support has to be offered against the multitude of social problems which should be recognised to be at the root of so much of the suffering whatever theorethical perspective one can adopt. This involves a shift from the medical model to a psychosocial model of care, with a different set of values, interventions, staff roles and ethical problems.

In conclusion three points should be emphasised with regard to the present research:

1. The need to improve negotiation skills of psychiatric teams in the community and therefore to promote debate among psychiatric workers, families and patients on this issue, now possible thanks to the end of the past ideological disputes;

2. The need to define the legal boundaries between compulsion and coercion, and to give clear rules for compulsory treatments of out-patients;

3. The need to give ethical guidelines on negotiated treatments, particularly in relation to:

a) homeless patients;

b) patients still involved in the social networks;

c) the use of rewards;

d) the use of blackmails;

e) moral right v/s moral duty to coerce patients who refuse treatments.

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