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Forensic psychiatric evaluations of defendants: Italy and the Netherlands compared

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ABSTRACT

Background: Forensic psychiatric practices and provisions vary considerably across jurisdictions. The diversity provides the possibility to compare forensic psychiatric practices, as we will do in this paper regarding Italy and the Netherlands.

Aim: We aim to perform a theoretical analysis of legislations dealing with the forensic psychiatric evaluation of defendants, including legal insanity and the management of mentally ill offenders deemed insane. This research is carried out not only to identify similarities and differences regarding the assessment of mentally ill offenders in Italy and the Netherlands, but, in addition, to identify strengths and weaknesses of the legislation and procedures used for the evaluation of the mentally ill offenders in the two countries.

Results: Italy and the Netherlands share some basic characteristics of their criminal law systems. Yet, forensic psychiatric practices differ significantly, even if we consider only evaluations of defendants. A strong point of Italy concerns its test for legal insanity which defines the legal norm and enables a straightforward communication between the experts and the judges on this crucial matter. A strong point of the Netherlands concerns more standardized practices including guidelines and the use of risk assessment tools, which enable better comparisons and scientific research in this area.

Conclusions: We argue that there appears to be room for improvement on both sides with regards to the evaluation of mentally ill offenders. More generally, a transnational approach to these issues, as applied in this paper, could help to advance forensic psychiatric services in different legal systems.

1. Introduction

Forensic psychiatric practices and provisions vary considerably across jurisdictions (Salize & Dreßing, 2005; Simon & Ahn-Redding, 2006). The diversity provides the possibility to compare forensic psychiatric practices, as we will do in this paper regarding Italy and the Netherlands. We aim to perform an analysis of legislations dealing with the forensic psychiatric evaluation of defendants, including legal insanity and the management of mentally ill offenders deemed insane. This research is carried out not only to identify similarities and differences regarding the assessment of mentally ill offenders in Italy and the Netherlands, but, in addition, to identify strengths and weaknesses of the legislation and procedures used for the evaluation of the mentally ill offenders in the two countries. Based on our analysis, at least in

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principle, improvements could be made, for instance, regarding the definition of a common standard for mental health care among European countries, especially for patients who are admitted for legal reasons, which is still lacking (WHO, 2008).[1]

Why would a comparison between Italy and the Netherlands be of interest? Italy and the Netherlands both have a *civil law* system and in both countries *legal insanity* is a ground for exculpation (not all legal systems incorporate legal insanity).[2] In addition, in both countries, management of mentally ill offenders is articulated in the framework of *criminal law*, rather than in mental health law – which is different from, for instance, the UK (Freeman & Pathare, 2005). Finally, in both countries, the ultimate decision about insanity is up to *professional judges*, which is different from, for example, jury systems in the United States (Neubauer & Fradella, 2014). Based on these profound similarities, a comparison between forensic practices in Italy and the Netherlands is, in principle, feasible and can be instructive.

In this paper, we will focus on the assessment of legal insanity, but we will also address the procedure of risk assessment. Both types of assessment constitute central components of forensic psychiatric evaluations of defendants, at least in Italy (Traverso & Traverso, 2010) and the Netherlands (Koenraadt, Mooij, & Van Mulbregt, 2007). Both types are related to the mental state of the defendant, but they refer to different moments in time: while insanity refers to the mental state at the time of the crime, social dangerousness concerns the risk of future recidivism (Traverso & Traverso, 2010; Meynen, 2016a). The structure of the paper is as follows: we will start with comparing some general characteristics of behavioral evaluations of defendants in both countries, such as the number of defendants evaluated by behavioral experts annually (Section 2). Next, we will compare legal insanity (Section 3) and risk assessment procedures (Section 4). In Section 5 we will discuss our findings and formulate, in our view, some strengths and weaknesses of the procedures used for the evaluation of the mentally ill offenders in the two countries, with regards to legal insanity and social dangerousness.

2. General aspects

2.1. The Netherlands

In the Netherlands (population 17 million),[3] approximately four to five thousand reports about defendants are made by forensic psychiatrists or psychologists every year (Netherlands Institute of Forensic Psychiatry and Psychology, 2016; Meynen, 2016b). The evaluation, in the standard case, is ordered by the court or the prosecution and may be performed on an outpatient basis or in a clinical setting (Van Der Leij, Jackson, Malsch, & Nijboer, 2001). The majority of the assessments are performed by psychologists, rather than psychiatrists, and sometimes by a couple of a psychiatrist and a psychologist.[4] In about only 5% of cases, defendants are evaluated by during clinical observation, usually at the Pieter Baan Centre, located in Almere (Meynen, 2016b). This is a forensic facility under the supervision of the Dutch Ministry of Justice where defendants are placed under the observation of a multidisciplinary team of behavioral professionals and experts (psychiatrists, psychologists, sociotherapists) (Van Der Leij et al., 2001). Clinical assessment may be ordered, for example, when a defendant is uncooperative with an outpatient court-ordered evaluation (Meynen, 2016b). For the court, the purpose of the forensic psychiatric assessment is providing information to the court on "the person and personality" of the defendant "with regard to the offence he has been charged with" (Van Marle, 2008). This evaluation is crucial, because the Dutch penal code provides exculpation on the ground of insanity (Meynen, 2016a). The behavioral experts performing evaluations are asked to answer a standard format of questions, posed by the prosecution or the judge.[5] Dutch legislation does not provide codification for this set of questions; it has been originally proposed by psychiatrist Van Panhuis and since then it has been used with few modifications (Meynen, 2016b). The Netherlands Psychiatric Association (NVvP) has published official guidelines for the behavioral experts called upon to perform forensic evaluations in criminal cases (Nederlandse Vereniging voor Psychiatrie, 2012). Since 2010, there is a nationwide register for court experts, including behavioral experts, the Netherlands Register of Court Experts (NRGD). Other experts (not listed in the register) may be consulted, but then the judge has to decide about that. The Netherlands Institute of Forensic Psychiatry and Psychology (NIFP) has developed a training course (part theory and part practice) for both psychologists and psychiatrists. The NIFP also plays a central role in assigning behavioral experts to specific cases, and in feedback on the initial version of the behavioral reports. After the round of feedback, the expert can draft the final version. The NIFP can also be consulted, for instance, for legal advice.

2.2. Italy

In Italy (a population of 60,5 million)[6] the situation is different in several respects. There is no national register collecting information about the forensic behavioral evaluations performed every year. No data about the number of defendants evaluated are available, nor about which kind of specialists are involved in writing forensic reports are available (e.g., psychiatrists, psychologists or medico legal specialists). Still, over the past few years Italian forensic experts have registered a considerable increase of the requests of behavioral evaluations (Catanesi & Martino, 2006).[7] The evaluation of defendants may be requested by court or public prosecutor and also by the defense counsel

[1] In this respect, it is important to mention the COST Action on Long-Term Forensic Psychiatric Care which is focused on laying the foundation for comparative evaluation and research on effective treatments, in order to develop the ´best practice´ in long-term forensic psychiatry in Europe: https://www.researchgate.net/project/COST-Action-IS1302-Towards-an-EU-Research-Framework-on-Forensic-Psychiatric-Care.

[2] (Simon & Ahn-Redding, 2006)(Gerben Meynen, 2016a)(Gerben Meynen, 2016b).

[3] Centraal Bureau voor de Statistiek (CBS). Data up-to-date as of August 2017. https://opendata.cbs.nl/statline/#/CBS/en/dataset/37943eng/table

[4] According to the 2012/2013 Yearly Report of the Netherlands Institute of Forensic Psychiatry and Psychology (NIFP), run by the Ministry of Justice and Security, the total number of evaluations among adult defendants in criminal cases during that period of time has been 4526. Evaluations carried out by psychologists: 46.55%; evaluations carried out by psychiatrists: 18.12%; double reports (usually both psychiatrist and psychologist): 29.81% (Gerben Meynen, 2016b).

[5] The questions usually are as follows, including a "zero" question about cooperation (shortened version): 0. Is the defendant cooperative? If not, what are your opinions with regard to this lack of cooperation? 1. Is the defendant at the moment suffering from a mental disorder or defect? (Please specify a diagnosis.) 2. Was the defendant suffering from a disorder or defect at the time of the act? 3. Did the disorder or defect affect the defendant's behavioral choices? 4. If so, (a) How did the disorder or defect affect the defendant's behavior? (b) Does this lead to the advice to consider the defendant's responsibility to be diminished or absent? (c) If the advice is to consider the defendant's responsibility to be diminished, specify this on behavioral grounds? 5. a What is the risk of recidivism (due to psychopathology)? b. Which are protective factors? c. Which contextual, situational and other factors should be taken into account? d. Can something be said about mutual influence of these factors? 6. a. Which recommendations can be made for interventions in order to reduce the risk of recidivism? b. Within which legal framework could this be realized?

[6] Istituto Nazionale di Statistica (ISTAT). Data up-to-date as of April 2017. http://dati.istat.it/Index.aspx?DataSetCode=DCIS_POPRES1

[7] To the best of our knowledge more recent data are not available, however this statement appears to be sustained by our experience in the field. The evaluations are often requested for most of the defendants charged in particularly with violent or unusual crimes (Carrieri & Catanesi, 2001).

(Peloso, D'Alema, & Fioritti, 2014).

The Procedural Penal Code (Codice di Procedura Penale, CPP) regulates the participation to a trial of every kind of expert (not only the behavioral ones). In this respect, Art. 220 CPP states as follows: "The expert evaluation is allowed when it is necessary to carry out investigation or evaluations, requiring specific technical, scientific or artistic skills" (our translation). According with CPP, penal procedures of mentally ill offenders' management consist of four stages: inquiry, pretrial, trial and placement (Peloso et al., 2014). During the inquiry, the prosecutor collects evidence in order to determine whether a crime has been committed. At this stage, a psychiatric expert may be appointed: in case of petty crimes committed by defendant deemed mentally ill by the expert, the prosecutor usually does not process the offender, diverting him or her to the ordinary community care, according with expert's suggestions about care and treatment (Peloso et al., 2014).

At the pretrial stage, a judge establishes whether a court of law must be set up and which provisional measures must be imposed to the defendant. In addition, in this phase, behavioral experts may be called upon to answer questions regarding current mental state and social dangerousness of the defendant. The experts are also required to give recommendations about provisional placement. Based on the experts' evaluations, the judge can order a provisional placement in prison, in a forensic facility or in an ordinary psychiatric facility, balancing public safety and defendant's need of care. Generally, if a person committed a petty crime and is deemed mentally ill, the judge drops the prosecution. For serious crimes or in case of danger for the public safety, a trial is disposed (Peloso et al., 2014). At this point, in accordance with art. 70 CPP, an evaluation to assess competency to stand trial may also be requested (Farinoni, Martelli, & Merzagora Betsos, 2004). During the trial, behavioral experts are asked to give their opinion about offender's mental state at the time of the crime in order to enable the court to decide about criminal liability and, if required, social dangerousness (Peloso et al., 2014).

The second section of the already mentioned Art. 220 CPP clarifies that: "with the exception of what is provided for by law with regard to the execution of a punishment or a measure, expert evaluations assessing customary or professionality in crime commissions, and more in general mental features not related to psychopathology, are not allowed". This implies that psychological or criminological expertise, with regards to defendant's psychological or behavioral general aspects not directly related to psychopathology, is allowed only after a decision about insanity has been made; during the period preceding this decision, only medical evaluations are admitted (Traverso, Ciappi, & Ferracuti, 2000).

In Italy, any registered medical doctor, without need for certification of specific training or experience in the forensic field may be appointed as an expert,[8] which is different from the Netherlands. Each tribunal possesses a register of local experts by specialty, but it has been stated that it is used uncommonly and appointments may follow the general rule of personal acquaintance (Peloso et al., 2014) or randomness (Bertolino, 2006; Catanesi & Martino, 2006). There is no national register of court experts, as there is in the Netherlands. Moreover, no national statistics are available regarding the number of forensic behavioral evaluations performed per year, nor to the type of professionals involved for each examination (e. g. psychologist, psychiatrist, legal medicine specialists or criminologists). In fact, we have reason to believe that the forensic practices differ considerably in the various regions. For instance, some authors state that legal medicine specialists and criminologists, often with little or no clinical psychiatric experience, are frequently appointed as expert witnesses, even in case of insanity evaluations (Peloso et al., 2014)[9] and that clinical psychiatrists usually play a small role in court evaluations (Fioritti & Melega, 2000). However, according to our own experience, many courts appoint almost always psychiatrists to perform behavioral assessments. As far as guidelines are concerned, we are not aware of any publications in this area by the Society for Forensic Psychiatry or the Criminological Society. In writing their reports, court appointed experts do not have to consider any standard format of questions (Catanesi & Martino, 2006).[10] There is also no national forensic psychiatric or psychological institute like the Dutch NIFP.

According to Italian Criminal Law, criminal liability is considered present until proven otherwise (Bertolino, 2006). The expert may be called upon to answer questions regarding the mental state of the defendant at the moment of crime (infirmity), but also at the moment of trial (competency to stand trial) and the risk of recidivism (social dangerousness) (Traverso & Traverso, 2010), consistent with the criminal procedures mentioned above. The final decision about these matters is up to the judge (Bertolino, 2012).[11] In Italy, there are no clinical observation facilities such as the Dutch Pieter Baan Centre. The evaluations may be carried out on an outpatient basis or wherever the defendant is under provisional security measure (e. g. prison, general hospital, house) (Ariatti & Ingravallo, 2010).

3. A closer look: legal insanity

3.1. The Netherlands

In the Netherlands, a defendant may be acquitted due to legal insanity,[12] although no criterion for determining legal insanity has been defined (Meynen, 2016a). In practice, this means that forensic professionals use different concepts in their reports, ranging from a 'lack of control' to a 'loss of free will' (Radovic, Meynen, & Bennet, 2015)(Bijlsma, 2016). It has been argued that in such a context, behavioral experts in fact "develop their own arguments about a defendant's insanity, in which they use criteria they consider relevant in criminal responsibility, rather than evaluating a defendant in light of the criteria of a legal standard". (Meynen, 2016a). This is particularly remarkable if we consider that in many cases, the psychiatric argumentation is accepted by the court which eventually delivers a final judgment about legal insanity (Van Der Leij et al., 2001)(Meynen, 2016b).

Until a few years ago, a peculiarity of the legal insanity in the Netherland was the five-grade scale of responsibility (van Marle, 2000). The scale consisted of the following grades: responsibility, somewhat diminished responsibility, diminished responsibility, severely

[8] Optional master's degrees may be followed by different types of professionals (medical doctors, coroners, psychiatrist, psychologists) to extend their knowledge in the specific field of forensic psychiatry (Ramelli et al., 2010).

[9] It has been argued that this "paradox" arises from Lombroso's influence: the 'father' of the Italian criminal anthropology made efforts to separate forensic psychiatry from general psychiatry and to set this subject in the academic frame of criminology and legal medicine. This diversion has been maintained so far (Fioritti & Melega, 2000).

[10] Notably, in the Italian regions of Veneto and Lazio, the regional Council approved a standard format of questions for the court-appointed behavioral experts (Regione Veneto, Bollettino Ufficiale n°3, 2018, https://bur.regione.veneto.it/BurvServices/pubblica/DettaglioDgr.aspx?id=359066;
Deliberazione Regione Lazio n° 642 del 10/10/2017, Regione Lazio, Bollettino ufficiale n°84, supplement 1). However, the use of the format is not mandatory.

[11] The judge is considered *peritus peritorum* (expert among experts). When a judge disagrees with the report of a court-appointed behavioral expert, the judge can decide otherwise. However, the judge must provide the reasons of such a decision (Ciccone & Ferracuti, 1995).

[12] The Dutch penal code, article 39, states: "A person who commits an offence for which he cannot be held responsible due to a mental defect or mental disease is not criminally liable." (Radovic et al., 2015)(Kooijmans & Meynen, 2017).

diminished responsibility, and legal insanity.[13] These grades of responsibility were not mentioned by the Dutch Penal code, but had evolved in practice.[14] There has been a debate concerning the number of grades, since in 2012 the Dutch Guidelines for Psychiatrists replaced the five-point scale of criminal responsibility with a three-point one.[15] Recently, the NIFP has adopted the three point scale (since 2016, see: Meynen, 2016a).

3.2. Italy

The Italian Penal Code (*Codice Penale)*, art. 88, states: "the person who, at the time of a crime, was, due to an infirmity, in a state of mind excluding the capacity to intend (*intendere)* or will *(volere)* is not criminally accountable".[16] In Italy, criminal accountability is stated in a dichotomous way: present or not. However, in a way a similarity with the Dutch system exists: in Italy the infirmity may be complete, with a full lack of criminal accountability, or partial. In the latter case the defendant is still criminally accountable, but the punishment is reduced. In section 89, we read: "the person who, at the time of a crime, was, due to an infirmity, in a state of mind greatly affecting, but not excluding, the capacity to intend or will, is criminally accountable but the punishment is reduced". The exact translation – and meaning – of the Italian standard deserves some attention. The words we use differ from some other translations of the Italian Penal Code in a way we will spell out and substantiate in the following lines. For instance, Bottalico and Santosuosso (2016) wrote about art. 88 of the Italian Penal Code as follows:

"Article 88 provides that offenders who, at the time of committing a crime, because of mental illness, are not able to comprehend the unlawful nature of their act, or to act in accordance with that comprehension, shall not be criminally accountable.".

This translation suggests that the Italian Penal Code standard for infirmity is similar to the Model Penal Code (MPC) standard for insanity developed by the American Law Institute, which reads: "a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law." This MPC standard is widely used in the US, although after the Hinckley trial, it became less popular (Simon & Ahn-Redding, 2006). In our view, although 'infirmity' is not identical to 'mental disease or defect' – at least not as a concept – it can be an adequate translation in this context. The Italian code does not provide a definition of infirmity (Collica, 2007), so infirmity could be considered as any condition determining a mental state affecting (or completely undermining) the appreciation capacity or the decisional capacity at the moment of the crime. The condition is therefore broader than the nosographic definition of mental illness (Traverso & Traverso, 2010). Since the sentence of the Corte di Cassazione 9163/2005 (also known as "Raso judgment") personality disorders and psychiatric alterations (different from the official nosographic categories of psychiatry) have been considered as infirmities relevant in order to assess criminal responsibility.[17] Meanwhile, on our interpretation, *intendere* (intend) cannot be considered identical to "comprehend the unlawful nature of the act" (translation by Bottalico and Santosuosso, see: Bottalico & Santosuosso, 2016); such a translation would be too specific. In addition, *volere* (will) is somewhat different from "acting in accordance to the comprehension" (translation by Bottalico and Santosuosso, see: Bottalico & Santosuosso, 2016); in our view art. 88 refers to the volitional capacity more generally.[18]

In many legal systems, in line with the Model Penal Code, the insanity test has two components: a cognitive and volitional component (Meynen, 2016a). The cognitive or epistemic component has to do with knowledge and it can be phrased and understood in different ways: knowing, understanding, or appreciating (that the act is wrong or criminal). The first is merely knowledge that something exists or has specific characteristics (e.g., homicide is a crime and it is prohibited by the law). The second, understanding, is the subsequent step: being actually aware of something and what is connected to this notion in practice (e.g., homicide is a crime, it is prohibited by the law and it has legal and social consequences). The third, appreciating, refers yet to a deeper form of understanding (e.g., homicide is a crime, it is prohibited by the law, it has legal and social consequences and is related to certain values).[19] The Italian legal insanity test as such contains both an epistemic component (*intendere*)[20] and a volitional one (*volere)*. Whereas in other legal standards control of the act is sometimes mentioned (Simon & Ahn-Redding, 2006), in Italy volition itself is articulated.

[13] Van Marle explained the 5 grades as follows: "Undiminished responsibility means that the person concerned had complete access to his or her free will at the time of the crime with which he or she is charged and could therefore have chosen not to do it. Irresponsibility means that the person concerned had no free will at all with which to choose at the time of the crime with which he or she is charged. Important here is determining the moment when aspects of the disorder become manifest in the situation ('the scene of the crime') that will eventually lead to the perpetration. […] A behavioral, three-way division takes place in order to justify the polymorphousness of psychopathology and its influence on behavior, where slightly diminished and severely diminished responsibility can be found on either side of diminished responsibility. Severely diminished responsibility entails a further reduction of free will as a result of a severe psychiatric illness or a situation-determined exacerbation in the mental clinical image. […] Slightly diminished responsibility means that there are a number of prominent characteristics that make the perpetrator more susceptible to committing crime, such as impulsiveness and anxiety. However, free will is only slightly limited in this case because the motives for the crime are the usual ones that can also be expected in the average person." See: (Hjalmar Van Marle, 2008).

[14] A diminished degree of responsibility is not restricted to specific diseases and disorders and may be assessed in case of personality disorders (Koenraadt, 2011).

[15] In the Dutch guidelines we read as follows: "there is no evidence for any scale whatsoever, neither for a five-point scale nor for a three-point scale." (see for the translation: Radovic et al., 2015).

[16] The original Italian phrasing is: "Non è imputabile chi, nel momento in cui ha commesso il fatto, era, per infermità, in tale stato di mente da escludere la capacità di intendere o di volere" (Italian Penal Code, Art. 88).

This article has been written in 1930, during the fascist years and it is a legacy of the so called "Rocco Penal Code", after the name of the then chancellor (Zappa & Romano, 1999). The acquittance on grounds of insanity, however, precedes the creation of the Kingdom of Italy and is already established in the local penal codes, such as the ones running in the Kingdom of the two Sicilies (1819), in the States of Parma, Piacenza and Guastalla (1820), in the Kingdom of Sardinia (1839) and in the Gran Duchy of Tuscany (1853) (Zappa & Romano, 1999). In 1889 the Kingdom of Italy approved the first penal code, known as the Zanardelli Code; here the art.46 stated: "The person who, at the time of the fact, was in such a state of infirmity to lose the awareness or the freedom of their own actions, is not accountable" (Zappa & Romano, 1999).

[17] Notably, the sentence of the Corte di Cassazione 9163/2005 itself states as a necessary condition: the presence of a recognizable causal relationship between the personality disorder and the crime the defendant is charged with. In particular, it must be argued how and to what extent the disorder affected the capacity to intend and will at the moment of crime (see also: Merzagora, 2005; Sardella & De Matteis, 2005).

[18] Our translation comes closer to the one given by Ferracuti and P. Roma (2008): "Article 88 of the Penal Code states: A person who committed a criminal act is not considered responsible if at the time of the commission of the criminal act he was incapable of understanding the significance of his act or control his conduct, by reason of insanity" (Ferracuti & Roma, 2008).

[19] As Mancini writes, the system of beliefs and values is not evaluated on a moral basis, but in a phenomenological and hermeneutical perspective, where every human experience is linked to the individual life-world (Mancini et al., 2014).

[20] From Latin *in-tendere*, to move (figuratively) toward something.

3.3. Implications of considering a defendant insane

The lack, or reduction, of criminal responsibility on the ground of insanity has legal and practical consequences. Italy and the Netherlands share the same legal distinction between punishment and measure. In Italy punishment comes after a sentence establishing criminal liability and may result in imprisonment; in case of full infirmity, punishment - and hence imprisonment - is not possible but a measure can be given (Vecchione, Ferracuti, & Nicolò, 2012). A measure may be combined with punishment - and therefore prison detention - with observational or therapeutic aim, in case of partial infirmity (Fioritti, 2005; Peloso et al., 2014). Moreover, measures may be custodial (admission to a forensic psychiatric facility) or not custodial (e.g., probation) (Vecchione et al., 2012). In the Netherlands a judge can impose imprisonment (for serious offences) if the defendant is not considered legally insane. If the defendant's responsibility is considered to be diminished and if the defendant poses a serious threat to the safety and security of other people ('social threat'), the prison sentence can be combined with a hospital order (e.g., *TBS with compulsory nursing*): an involuntary admission to a forensic psychiatric facility. In those cases, the execution of TBS follows the prison sentence. If a defendant is deemed (completely) insane, however, punishment is impossible (Edworthy, Sampson, & Völlm, 2016; Koenraadt, 2011), but TBS is still possible (see below). The imposition of a measure is, in both systems, based, in part, on the evaluation of the risk of recidivism or social dangerousness (Meynen, 2016b; Peloso et al., 2014). We will explore this issue in the following section.

4. Risk of recidivism

4.1. The Netherlands

In the Netherlands, two measures can be applied to offenders deemed legally insane. According to the Dutch Criminal Code (CC, art. 37) one option is the admission to a psychiatric hospital for the duration of one year if the defendant is a danger to himself or to others or to the general safety of people or properties. However, under specific circumstances,[21] a judge may impose a more severe measure, known as hospital order (*terbeschikkingstelling*; *TBS*; art. 37a CC).[22]

TBS is the most severe safety measure in the Dutch criminal justice system, in particular because in most cases, it is imposed for an indeterminate period of time. A person sentenced with a TBS-order must stay in the forensic psychiatric system as long as the recidivism risk remains too high for release into society.[23] Annualy or bi-annualy, the court, consisting of three judges, may repeat the assessment and decide about release from TBS, considering, among other factors, the reports by professionals from the facility where the person is interned. Every six years, independent behavioral experts assess the patient, and give advice to the court (Drost, 2006)(Meynen, 2016b).

The Dutch forensic mental health system is considered a pioneer in the use of violence risk assessment tools, their introduction dating back to the late '90s. Before that, risk assessment was performed by means of unstructured clinical judgments (De Ruiter, 2016). The Dutch guidelines for psychiatrists consider the use of structured tools, in principle, as a requirement for a state of the art risk evaluation in forensic practice (Nederlandse Vereniging voor Psychiatrie, 2012). Instruments commonly used are: HCR-20, PCL-R and HKT-30[24] (De Ruiter, 2016).

In order to prepare the patient for a reintegration into society, an elaborate system of steps to (temporarily) leave the hospital has been created. Ideally, the pathway of a person under the TBS order should go from supervised to unsupervised leave, ending up in a "transmural" phase, in which the patient lives outside the hospital, but still under strict clinical supervision (De Ruiter, 2016). During these stages patients are assisted in finding a job and being reintegrated into society; yet, if the leave is not successful – for instance in terms of social dangerousness – the person is readmitted to the hospital. The structured risk assessment is performed before any liberty extension, and in any case at least every 6 months. Usually, a TBS order ends via conditional discharge, under the supervision of the probation service. Since the '90s, the duration of the TBS order has increased from 4.2 to 8.4 years in 2008, whereas the conditional phase may last up to 9 years (De Ruiter, 2016). In 1999, long-stay units were introduced, aimed to host TBS patients considered permanently dangerous (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2012).[25] In these facilities, the focus is on quality of life rather than intense mental treatment (Oosterhuis, 2014).

The Dutch system of criminal sanctions not only incorporates measures but also penalties in order to protect society against the dangerousness of the offender. Imprisonment contributes to this protection, at least during the term of the prison sentences. In addition, the judge can impose conditional prison sentences. Conditions which can be imposed, are – among others – the hospitalization of the offender in a health care institution, and the obligation of the offender to follow a therapeutic program on an outpatient basis: art. 14c CC.

4.2. Italy

In Italy, since 1978, the year of the *radical reform* of psychiatry (Babini, 2014), the concept of "dangerousness to self and to others" related to mental illness has been abolished in the framework of the civil psychiatry (Traverso & Traverso, 2017). The therapeutic model of care took over the traditional custodial attitude of psychiatry and civil psychiatric hospitals have been closed, replaced by a community-based system of care (Cimino, 2014). However, "social dangerousness" persisted as a legal issue in the criminal context[26] and it remained as a requirement to be admitted to a forensic facility (Traverso & Traverso, 2017).[27] The evaluation of social dangerousness is usually performed by forensic experts appointed at the trial stage, alongside the assessment of infirmity (Traverso and Traverso, 2010); unstructured clinical judgment is the most common means of report (Castelletti, Rivellini, &

[21] The court can impose a TBS order if all of the following conditions are met:
-the defendant must suffer from a mental disorder, with a diminished or absent criminal liability for the crime he or she is convicted of;
-the law provides for the alleged crime a prison sentence of at least four years, or the crime is included in the list of offences ending up in a lesser sentence;
-there is a risk for the safety of people or goods. (art. 37a CC. See: Corine De Ruiter & Hildebrand, 2007).

[22] TBS can be translated as 'detention at the government's pleasure' (See: Meynen, 2016b).

[23] It has been argued that the main aim of the TBS order is to protect society from the risk of criminal recidivism with serious consequences. The second aim is to care for the TBS-patients and provide treatment useful to prevent criminal recidivism in the long term and to enable rehabilitation (De Kogel, 2005).

[24] HKT-30 (Historische, Klinische, Toekomstige-30) is a structured risk assessment tool, developed in the Netherlands. (For further information see: C. De Ruiter, 2016).

[25] Criteria used for the admission to a long stay unit are: already executed TBS measure of at least six years; treatment provided in at least two different forensic psychiatric units; no observed reduction in dangerousness; no suitability for discharge in a less secure environment (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2012).

[26] Criminal Code, art. 203 defines the social dangerousness as a high likelihood of criminal recidivism, even in case of lack of criminal liability (our translation).

[27] However, it has been argued that the introduction of law 180 in 1978 created two unequal models of care: on one hand a pioneering civil psychiatry, abolishing the insane asylums and promoting the reintegration of mentally ill patients into society; on the other hand, forensic psychiatry with just a custodial aim (Fornari & Ferracuti, 1995).

Straticò, 2014). As happens with regard to infirmity evaluations, any medical doctor may perform this kind of assessment. Moreover, at this stage, with the only purpose of assisting the judge to define contents and terms of the potential execution phase, psychological and criminological examinations (with the optional use of structured diagnostic tools) are also allowed (Traverso et al., 2000).

If a defendant is deemed by the court legally not accountable due to complete infirmity and dangerous to society, different kinds of measures may be imposed, considering the therapeutic indications provided by the forensic expert. In case of partial infirmity, a measure may be combined with imprisonment. Available measure options range from community treatment orders with probation (not custodial measure), to the admission to a forensic facility (custodial measure).[28] The social dangerousness is furthermore assessed according to a timeframe defined by the court, usually before the end of a measure (Traverso and Traverso, 2010). If the risk of recidivism is deemed still high, the measure may be renewed (Traverso and Traverso, 2010). However, the total length of the custodial measure, meaning the involuntary admission to a forensic psychiatric facility, must *not be longer* than the length of the prison sentence provided for the crime the mentally ill offender is convicted of (which is a clear difference with the Netherlands).[29] This requirement has been introduced by the law 81/2014 in order to avoid the phenomenon known as "white life sentences", that was common in the former Italian forensic system (Commissione parlamentare di inchiesta, 2013).[30] At the same time, no limitations have been set with regard to the length of measures that are not custodial (e.g., probation) and that may be come after a custodial measure. Moreover, the law stated the closure of, the former forensic psychiatric hospitals (*Ospedali Psichiatrici Giudiziari, OPGs*)[31] in favor of a residential model of care, based on small- scale therapeutic facilities (20 beds maximum) (*Residenze per l'Esecuzione delle Misure di Sicurezza – REMS*) (Di Lorito et al., 2017). These facilities have been conceived to provide appropriate treatment, according to a scientific perspective, to the population of mentally ill offenders not eligible for community mental residential structures (Ferracuti et al., 2019). Nonetheless, the new law has raised considerable concern among Italian forensic experts and community psychiatrists. In addition, safety and cost-effectiveness of the reform have been questioned (Barbui & Saraceno, 2015; CriManSCri, 2015). Meanwhile, Di Lorito, Dening & Völlm (2017) reported regarding the REMS that their "findings evidenced some success in the long journey of reform of the forensic psychiatric sector in Italy in at least one of the specialist units." They state that "It is remarkable that patients who were once deemed to require high security are now accommodated in REMS, which only employ clinical personnel and where the only security measures are a fenced perimeter, CCTV and air-locked doors." According to some authors, however, community mental health services were unprepared to manage the risk of violent behavior among forensic patients (Candini et al., 2015). In addition, there is not much information about the population of mentally ill offenders in Italy with regard to epidemiological, clinical and criminal features of this sample (Candini et al., 2015; Castelletti et al., 2015).

5. Concluding observations

As mentioned in the introduction, the Italian and Dutch criminal law systems are both civil law systems sharing some further important characteristics such as the notion of 'legal insanity' and professional judges to whom the experts give their testimony. Such basic similarities make it possible to make an informative comparison between forensic psychiatric practices regarding the evaluation of defendants. In the previous sections, we have identified several important differences regarding forensic psychiatric evaluations of defendants. In view of the comparative analysis of the previous paragraphs, we will now highlight some of the differences.

With respect to legal insanity, we noted that while Italy has a clear test (referring to an epistemic as well as a control factor), in the Netherlands no standard for legal insanity has been formulated. This leaves open the question: under what terms is a defendant deemed legally accountable? The absence of a test has resulted in a practice in which forensic psychiatrists and psychologists, answering a set of preformed questions describe what *they themselves consider relevant with respect to the question of legal insanity* (Meynen, 2016a). On the other side, the judge, without a legal framework, may well have difficulty to establish whether the expert's report is relevant to the *legal question* concerning the defendant's sanity. The situation could also result a *conceptual ambiguity*, under which court and behavioral experts only apparently share the same language (Radovic et al., 2015). Note that in a vast majority of cases the experts' advice is followed. In such a scenario, there are grounds for concerns about legal certainty for defendants (Meynen & Kooijmans, 2015). In Italy, a standard has been formulated, and it encompasses two relevant elements: knowledge and control. At this point, in our view, Italy could be a valuable example for the Netherlands. Ideally the legislator would develop a criterion for legal insanity (Ligthart et al., 2018), similar to the Italian model comprising both an epistemic and a control element. The current legislative process of modernization of the entire Dutch Code of Criminal Procedure – including the modernization of provisions with regard to mentally ill defendants – provides a good opportunity to do so.

Unlike in Italy, in the Netherlands official guidelines for forensic evaluations have been formulated by the Netherlands Association for Psychiatry. Furthermore, the existence of an institution such as the Netherlands Institute of Forensic Psychiatry and Psychology, supervising training and practice of forensic behavioral experts, is valuable, also in combination with the clinical observation clinic (which is part of the NIFP). In principle, a nationwide register of experts (NRGD), including behavioral experts, may also be valuable. According to our opinion, the Italian state-of-art on forensic psychiatry is too heterogeneous. In theory, any registered medical doctor - not necessarily a psychiatrist - is allowed to perform forensic behavioral evaluations (Peloso et al., 2014). The preparatory attendance of a criminological training is non-statutory (Ramelli, Rossi, & Righi, 2010) and no institution supervises training and practice of forensic behavioral evaluations (Catanesi & Martino, 2006). In this perspective, Italy could at least draw inspiration from the Dutch model. The development of guidelines, for instance, in our view, may be very helpful to enhance the quality of forensic psychiatric assessments. In addition, a guideline can provide scientific, legal, and professional context to the central elements of forensic psychiatric practice.

One of the crucial elements of evaluations of defendants concerns evaluating risk of recidivism. In the Netherlands, the use of assessment tools has become more or less 'standard practice', even though there is a continuous debate about its exact value (and about the preferred

[28] The sentence 253/03 of the Italian Constitutional Court allowed the imposition of measures different from the admission to a forensic facility. In particular, it has made it possible to define for the mentally ill offender an appropriate therapeutic program in the frame of the civil psychiatry. Moreover, the recent Law 81/2014 states clearly that admissions to forensic facilities ought to be prescribed only in the event of lack of alternative therapeutic options in the community care system.

[29] See: Law 81/2014 and Sentenza Corte Costituzionale n°186 del 2015.

[30] Prior to the reform, a requirement for the offender's discharge was the lack of social dangerousness; however, this one was not evaluated on the basis of an individual risk assessment, but factoring in elements such as the lack of family and social conditions suitable for discharge (Commissione parlamentare di inchiesta, 2013). The latter ones are often not modifiable and this may explain the previous high number of admissions to forensic facilities lasting indeterminately.

[31] At the beginning, Law 09/2012 provided the closure of OPGs and the establishing of small-scale therapeutic units (Residenze per la Esecuzione della Misura di Sicurezza (REMS)). Law 81/2014 has been enacted in response to delays, in order to define a timetable and operational procedures to conclude this process (Hopkin, Messina, Thornicroft, & Ruggeri, 2018).

instruments). We feel that at this point, Italy might learn something from the Netherlands. Not because risk assessment tools are a 'golden standard' for risk assessment, but because they may well provide valuable, structured information. In fact, the use of such tools also has the effect of standardizing the evaluation, which may also provide the opportunity of comparisons over time, and, notably, it might better enable scientific research in this area. So, in our view, Italian forensic experts and clinical psychiatrists should implement on a wider scale the risk assessment tools, as proposed by other Italian authors (Castelletti et al., 2014).

In conclusion, Italy and the Netherlands share some basic characteristics of their criminal law systems. Yet, forensic psychiatric practices differ significantly, even if we consider only evaluations of defendants descriptively. However, we feel that a transnational approach to these issues, as applied in this paper, may improve the understanding of forensic psychiatric services in different legal systems. In our perspective, deepening the knowledge about legal procedures dealing with mentally ill offenders in each European country is not only a condition to find out common ground in order to improve the international scientific exchange (Nedopil et al., 2015), but it may contribute to reaching standardized practices that may ensure the same rights to mentally ill offenders all over Europe.

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