RASSEGNA ITALIANA DI CRIMINOLOGIA ANNO XVII N.1 2023
Società Italiana di Criminologia
Articoli di ricerca

Differences between Migrant and Italian National Patients in an Italian Forensic Unit: A Retrospective Study

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OPEN ACCESS

Double blind peer review

How to cite this article: Rossetto I. et al. (2023). Differences between Migrant and Italian National Patients in an Italian Forensic Unit: A Retrospective Study. *Rassegna Italiana di Criminologia*, XVII, 1, 39-49
https://doi.org/10.7347/RIC-012023-p39

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Received: 11.02.2023
Accepted: 11.03.2023
Published: 31.03.2023

Pensa MultiMedia
ISSN 1121-1717 (print)
ISSN 2240-8053 (on line)
doi10.7347/RIC-012023-p39

Abstract
With the increase in migrants entering Italy and being admitted to forensic inpatient facilities in recent years, it is important to identify differences in this population that could inform improvements in assessment and treatment. This descriptive study attempted to identify clinical, criminological, and legal characteristics of a migrant forensic inpatient population (males, n= 134, females, n=50) as well as differences in these parameters in comparison with Italian national inpatients. Among other findings, the male migrant inpatients were diagnosed with psychotic disorders more frequently and personality disorders less frequently in comparison with the Italian inpatients. Differences also emerged regarding the method of discharge of the two groups. It is opinion of the authors that the analysis of such data can provide useful indications regarding the methods of assessment and treatment of foreign patients with the aim of ensuring a course of care of sufficient quality for this special patient population.

Keywords: migrants, forensic inpatient, forensic facilities, diagnostic assessment, psychiatric treatment.

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Differences between Migrant and Italian National Patients in an Italian Forensic Unit: A Retrospective Study

Introduction

Migrants in prisons and in secure forensic residential units

In progressively multicultural societies, the portion of foreign national prisoners has grown at a disproportionately high rate over the past few years (Neumann, 2020). This is a sub-group of people who are, or have been subject to criminal proceedings, and are deprived of freedom in a country in which they are neither citizens nor residents (Till, 2019).

Some authors explained that foreign nationals accounted for more than 20% of all European prisoners (Val Kalmthout, 2013). In Italy, foreigners accounted for 8.7% of the general population (ISTAT, 2019) and 32.73% of the overall prison population in 2019 (Ministry of Justice, 2019), while the percentage was 36.72% in 2010. The situation of the psychiatric patients deemed not guilty by reason of insanity in Italy has been tortuous, due to the total closure of high security forensic psychiatric hospitals (*Ospedali Psichiatrici Giudiziari - OPGs*) and the conversion into a residential model of care based on secure residential units in the community (*Residenze per l'Esecuzione delle Misure di Sicurezza = Residences for Execution of Security Measures - REMSs*) (Carabellese, 2016).

In April 2008 the Italian government issued its first decree that established a program for progressive downsizing and closure of the six federal forensic psychiatric hospitals, transferring responsibilities and resources to the National Health System. In 2012, a new law (Law 9/2012) established that new residential facilities (REMSs) had to be developed to better meet the needs of providing intensive and high-quality mental healthcare under proper secure conditions to socially dangerous individuals with mental disorders. These small-scale facilities (no more than 20 individuals, up to 4 patients per bedroom) were intended to replace admissions to forensic psychiatric hospitals.

The REMSs were conceived as regional-based, according to the Italian territorial psychiatric management policy, and none were purposed to become high-security (Kennedy, 2002). As initial implementation of these laws had been unsatisfactory, in May 2014 Law 81/2014 set deadlines and operational procedures that mandated regional authorities to strictly follow the process of transformation (Barbui, 2015).

When the process of deinstitutionalization of forensic patients began, 30 REMSs were currently active, with a total of 604 forensic beds which was far fewer than the number of patients who were hospitalized in OPGs in late 2008 (n=1639) (Ministry of Justice, 2019). In a recent study of the population of 29 out of 30 REMS (n=650 males and n=80 females) treated in a one-year study period, Catanesi et al. (Catanesi, 2019) found that 83.1% of the socially dangerous psychiatric patients were Italian and 16.9% were migrants (2.7% from E.U. and 14.2% from non E.U. countries). Thus, compared to their share of the general population, foreign nationals were clearly overrepresented in both prison and forensic facilities (Neumann, 2020). To our knowledge, no previous Italian study addressed the clinical, criminological and legal characteristics of migrant patients treated nowadays in REMS and previously in OPGs. For this reason, the main objectives of this research are:

- to identify the possible specificities of this population;
- to find any differences between migrant and Italian national patients.

It is the opinion of the authors that knowing these differences is also essential to inform treatments practice and local policy, as well as making the necessary improvements in the evaluation and treatment of this population.

Mental Health in migrants

The relationship between diagnostic distribution of mental disorders in migrants is multifactorial. Any measured differential from that of native or national citizens can be authentic, artifactual and/or spurious. Theories to explain actual discrepancies include the selection of migrants, differences between receiving and originating countries, and stresses and circumstances of the three phases of migration. The selective migration hypothesis postulates that those individuals who decide to migrate and have the coping skills to do so successfully are mentally healthier individuals. This would explain the reported lower rates of disorders of mood, anxiety, and substance use in migrant population compared with native counterparts, as observed in the United States for example (Shekunov, 2017). However, two observations are disfavoring this theory. The first is that in the United States, with current and historical high rates of immigration, the rates of psychosis among migrants are increased. The second is the finding of lower rates of psychiatric disorders in Asian countries (Shekunov, 2017). The selection migration theory is, however, not disproven if valid for specific subpopulations and disorders. For example, one would expect legal migrants selected by the host country based

upon merit of immigrants and specific, specialized service needs of the receiving country to have fewer mental disorders including psychotic disorders.

Differential rates of mental disorders of migrants to the United States are also a function of sex, age, length of time since migration, lifetime prevalence rates. Migrant Mexican Americans (Escobar, 2000) as well as non-Hispanic whites have been shown to have significantly lower risks of mood, anxiety and substance use disorders than their counterparts who were born in the United States (Grant, 2004). Similarly Asian Americans have lower risk of mental disorders than U.S. born Asian Americans (Breslau, 2006). Contrary to the selection hypothesis as stated are the elevated rates of psychosis in migrants from the Caribbean and United Kingdom (Williams, 2007). Whether these results can be duplicated among the recent massive surge of undocumented and unregistered (avoided all authorities) migrants is doubtful.

The survey by Williams et al. (Williams, 2007) suggests that race/ethnicity, sex, and generation after immigration are factors that can affect the risk of mental disorders. Caribbean black men had higher risks for 12-month rates of psychiatric disorders compared with African American men, whereas Caribbean women had lower odds 12-month and lifetime psychiatric disorders compared with African American women. Third generation Caribbean blacks had substantially elevated rates of psychiatric disorders compared with first generation Caribbean Blacks. The authors postulate that the increased rate of psychiatric disorders with successive generations may reflect downward social mobility and increased social stress of being Black in the United States (Williams, 2007). However, the association with rising rates of mental disorders after migration, appears not to be limited to Black migrants. Breslau and Chang found that while the risks of mental disorder were lowest for Asian Americans who migrated as adults and the risks of first onset was lowest in the years before migration compared to U.S. born, with longer residence in the United States after arrival, the rates 5 of mental disorders rose to those of their U.S. born counterparts (Breslau, 2006). Thus, the increased rates of mental illness may be associated with minority or migrant status in general. Or, on the other hand, the increase in rates of mental disorders may reflect acculturation, and "assimilation" to the elevated rates of mental disorders already present among native born U.S. residents in general (Breslau, 2006).

The third theoretical explanation of discrepancies in mental disorders among migrants are the different stress or risk factors as well as protective factors associated with the three phases of migration. In the pre-migration phase, stressors such as war, tyrannical government, crime, socioeconomic hardships may drive the motivation to migrate. Conversely, protective factors such as resourcefulness, means, welcoming connections and supports in the receiving country may be enabling and contribute to the desire to migrate.

The migration itself, the second phase, can be extraordinarily challenging, with diminished living conditions, and even exposure to violence and victimization, human trafficking, as well as disruptions in supportive relationships from the country of origin. Entering the new country, the migrant can experience cultural shock, language barriers, and difficulties navigating unfamiliar social systems. Increased rates of grief and bereavement, post-traumatic stress disorder, depression and somatic complaints can result from the migration process itself (Shekunov, 2017).

Finally, the resettlement process ushers in changes and challenges that are more lasting. These can be favorable and offer hope and opportunity, access to more and better services, improved standard of living, educational opportunities for children, relief from stressors that led to migration.

Linguistic and cultural differences, disappointment and diminished expectations, negative biases, inadequate housing and availability of services, all can contribute to stress that increases the risk of mental disorders (Shekunov, 2017).

Patterns of emigration and immigration of a country can shift substantially over time. Turning our attention to Italy, the history of emigration began with the country's unification and between 1929 and 1975 about one in four Italians emigrated (Del Boca, 2003). Beginning in the 1970's Italy became a country of immigration. In the 1980s and 1990s the proportion of immigrants from outside the European Union increased, coming mainly from Asia and Africa, yet immigrants from Albania, Rumania, and Yugoslavia also increased (Del Boca, 2003).

Fazel et al (Fazel, 2016) conducted a historical cohort study of all 6,520 psychiatric patients discharged from forensic psychiatric hospitals between 1973 and 2009 in Sweden of which 89.2% was made up of men and 24.7% of migrants. The study did not differentiate the results based on the sex of the patients but reported that 17.1% of patients made substance use as the primary diagnosis and 22.4% as the secondary diagnosis.

In a UK study, Mikton and Grounds (Mikton, 2007) searched for disparities in the diagnosing of personality disorders by forensic psychiatrists working with different ethnic groups. They found that personality disorders were significantly underrepresented in foreign national patients receiving treatment at high-security hospitals. According to the authors, this could be due to cross cultural clinical judgment or ethnically insensitive diagnostic testing.

The overrepresentation of migrants, in the US and UK, among those who are diagnosed with psychosis, may be partly due to preconceptions or, at least, to methodological approximations (Merzagora, 2018). In cross-cultural examination, the concept of "equivalence" can be defined as a behavior, concept or measurement procedure that shares common meanings and relevance for culturally

different groups. As a consequence of using identical interpretations for different cultural groups, members of minorities would more often be diagnosed as psychotic or demented. These differences could be explained by the fact that doctors are less likely to request information about signs and symptoms of disease in non-Caucasian patients. For this reason the diagnostic disparities could be reduced by use of structured interviews. In forensic psychiatric facilities the situation is even more serious, as here the incidence of non-Caucasian individuals compared to Caucasians is higher than in the general population (83.1% of the socially dangerous psychiatric patients were Italian and 16.9% were migrants – 2.7% from E.U. and 14.2% from non E.U. countries, while – as before mentioned – in the general Italian population foreigners accounted for 8.7%) considering that they are more often deemed socially dangerous (Catanesi, 2019). Some authors (Linhorst, 1998) reduced that differences to the socio-economic status: low – status implies vulnerability to mental disorders, and components of minorities often belong to a lower status. According to the ECA (Epidemiological Catchment Area) survey data in US, once corrections by sex, age and socioeconomic status are made, no statistically significant differences were found between Caucasian and non-Caucasian individuals regarding the diagnosis of antisocial personality disorder, affective disorders and drug addiction (Fernando, 1998).

In Europe, a Swedish survey on migrants and refugees showed that although non-Caucasian individuals are generally more frequently diagnosed with mental diseases, Caucasian individuals are more frequently adjudicated "insane" and thereby avoid imprisonment (Warren, 1994; Weisman, 1997). In addition, account should be taken of the fact that the experience of migration is a specific problem in migrants. It has been described as an "acculturation stress", an amount of annoyances such as perceived discrimination, intercultural connection stress, schooling lack, intercultural friction (Rudmin, 2003); discrimination and racist views may exacerbate this state of tension with indirect communication (Carter, 2007).

A meta-analysis that investigated the potential relationship between migration and mental disorders found a higher incidence of psychotic disorders in migrants (Coluccia, 2015). Migrant status can be a powerful pathogenic factor, even regardless of previous traumas, for the amount of social disadvantage such as underemployment, housing difficulties, language barriers, lack of social networks, discrimination, intercultural conflict, nostalgia (Finch, 2003; Tartakovsky, 2007) that can result from it.

A recent multi-national meta-analysis attempted to evaluate factors that contribute to diverse rates of affective (APD) and non-affective (NAPD) psychotic disorders (PD) in migrants (Selten, 2020). European host countries were strongly represented (Europe n=37, Israel 3, Canada 2, Australia 1). Consistent with previous studies, the lifetime risk for psychosis in non-European migrants was elevated over that for Europeans (3-6% versus 1-2%). The risk to European countries was greatest among migrants originating from developing countries and/or with black skin (skin color having been estimated based upon the countries of origin, e.g., Sub-Saharan Africa). Migrants to Israel or Canada did not show increased rates of psychotic disorders. In Israel this was postulated to be due to migration predominantly of Jews from countries wherein Jews were in the minority, resulting in their status changing from exclusion to inclusion.

The authors have explained such discrepancies on bias and poor understanding by Western psychiatrists of different cultural backgrounds of migrant patients. A study in the Netherlands showed a higher rate of diagnosing psychotic disorders and schizophrenia among Moroccan migrants compared with native Dutch patients. Upon administering a cultural sensitive diagnostic procedure, in contrast, the incidence of schizophrenia in Moroccans were no higher than that for ethnic Dutch patients (Zandi, 2010). They doubted this was a significant factor as no diagnostic bias was found in most studies. Using the World Health Organization (WHO) Life Chart and the Global Assessment of Function Disability (GAF-D) scale, considered cross-culturally valid and reliable, the "gold standard" in international research on psychosis, Morgan and colleagues followed up after 10 years White British (n=320), Black Caribbean (n=108) and Black African (n=45) cohorts in London and Nottingham, UK (Selten, 2020). Because the clinical course for Black Caribbeans and Black Africans with first episode psychotic disorder was not better than for White British patients and for Black Caribbean patients it was even worse, the authors conclude that the higher rate of psychosis in these migrant minorities was not due to an excess of acute, good prognosis disorders or, by extension, to misdiagnosis. Rather, their elevated rates of psychosis with poorer outcomes may have been related to these ethnic groups being socially disadvantaged and isolated (Morgan, 2017).

Moreover, Selten and colleagues found the highest rate of psychosis was found in migrants from Eastern European Countries. Lower rates of psychosis from other European countries were thought to be due to the availability of support services in the countries of origin. In terms of SES, downward socio-economic mobility was observed more during the prepsychotic period of native individuals, whereas migrants and their children had already belonged to a lower SES.

Such issues may be crucial also within the forensic field. In psychiatry, the clinical examination and the doctor-patient relationship is peculiar: a crucial role is played by the conversation between doctor and patient and communication (verbal and non-verbal) plays a fundamental role, also for diagnostic purposes. The interview is therefore the most important aspect of the doctor-patient relationship and communication usually comes from the

depth of the dialog (Agarwal, 2012). The crucial mediator is verbal language, so the interview in psychiatry is the hinge around which doctor and patient revolve. Firstly, language can be an obstacle: the linguistic problem affects human interaction, and communication may have the most significant impact on the individual's fate. The main objective of this study was to identify clinical, criminological and legal characteristics in migrant patients admitted to OPG and then to REMSs of Castiglione delle Stiviere, in Lombardy Region, over a period of ten years.

Methods

Sample and study settings

The study sample was comprised all migrant patients (men and women) who were admitted from January 2010 to December 2019 in forensic facilities of Castiglione delle Stiviere. The migrant sample was compared to a group of Italian men and women admitted at the same time. Since the Lombardy Region has decided not to activate individual territorial REMS but to maintain the structure of Castiglione delle Stiviere as a Multi-module system of REMS, it was not considered necessary to differentiate the samples according to the date of entry given that, even after the entry into force of Law 81/2014, the methods of admission, assessment and treatment of patients have remained the same.

The population of the REMS' catchment area is approximately 10 million of inhabitants, nearly 50% of whom are women. The authors examined retrospectively a database of electronic clinical records of all inpatients on March 31st, 2020. Data were anonymized. Since this study includes data concerning natural persons, the authors consulted the ethics committee of the ASST of Mantova, competent in the matter, which stated that their approval was not needed since the nature of the study is a retrospective analysis of medical records. All patients, in fact, sign upon entry their consent to the processing of personal data, also for reasons of study and research, obviously with all the guarantees of respect for privacy. Also in this case, indeed, the data have been extrapolated exclusively from medical records. Demographic, clinical and legal data are routinely collected upon admission and during inpatient care. Male and female populations were considered separately due to the contradictory results of studies on sex differences in the forensic and non-forensic psychiatric population (Alm, 2010; Wang, 2019). The samples of migrants were considered comparable to the samples of Italians on the basis of three parameters: 1) Legal status: all the patients considered (both migrants and Italians) belong to the same population because they were considered not guilty by reason of insanity by a Court and interned in the forensic facilities in Castiglione delle Stiviere; 2) Age; 3) Same admission period.

In order to examine the difference between the groups of nominal variables Chi-square test was used (p 0.05).

Data sources

All patients were given a clinical diagnosis at the time of their first discharge according to the Diagnostic and Statistical Manual of Mental Disorders IV Edition Text Revision (APA, 2000) through the administration of the Structured Clinical Interview (SCID). The following psychiatric diagnoses at first discharge were taken into consideration: schizophrenia spectrum disorders (SSD); mood disorders (MD); substance use disorders (SUD), personality disorders (PD); and learning disability (LD).

SUD was considered as a primary diagnosis or as a comorbidity because of the increased risk of mortality and because comorbid substance use and personality disorder increases the risk of violent offending (Fazel, 2016).

In addition, neuropsychiatric factors and above all SUD are the most important risk factors for interpersonal violence in the general population (Fazel, 2018). Reoffending was described as readmission into a REMS for any kind of crime (violent and nonviolent) that resulted in a new verdict. Violent reoffending was defined as a crime that was a serious threat to the victim and that resulted in a new verdict. Crimes at first admission were classified as crimes against the person, which included: homicide and attempted homicide; aggravated and common assault, sexual offenses, assaulting an officer; kidnapping, threats and harassment; property crimes, which included: robbery, arson; and non-violent crimes such as burglary, traffic and drug offenses, extortion, and revocation of conditional discharge. The difference between crimes against the person and against property was considered because offenders convicted of drug and non-violent offenses have higher rates of reoffending compared to serious offenders (Coid, 2009). Also registered were the country of origin and the condition of homelessness.

Results

Male sample

Between 2010 and 2019, 134 male migrant patients were admitted in Castiglione delle Stiviere forensic facilities. 1 male patient died by suicide during his stay in the REMS. The number of men discharged over the course of 10 years was 102 (76%), none of whom were readmitted at the end of the period of data collection. They came from 44 different countries, the countries of greatest representation being Morocco (15%, n=20), Nigeria (10%, n=13), and Romania (11%, n=15). The countries of origin most frequently represented as well as the presence of homelessness are shown in Table 1.

		Men n %	Women n %
Country of origin	Albania	9 (7%)	2 (4%)
	Bosnia and Herzogovina	0 (0%)	4 (8%)
	Egypt	9 (7%)	2 (4%)
	Ghana	7 (5%)	0 (0%)
	Morocco	20 (15%)	3 (6%)
	Nigeria	13 (10%)	7 (14%)
	Romania	15 (11%)	3 (6%)
	Tunisia	6 (4%)	3 (6%)
	Other countries	53 (40%)	23 (46%)
	Ukraine	2 (1%)	3 (6%)
Homeless	Yes	55 (41%)	12 (24%)
	No	79 (59%)	38 (76%)

Table 1. Countries of origin and presence of homelessness of 134 foreigner men and 50 foreigner women admitted between January 2010 and 31stDecember 2019 in Castiglione delle Stiviere

The primary diagnoses most represented were the SSD in 73% and PD in 19% of cases. SUD as a primary diagnosis was found in 5% of cases and as a primary or secondary diagnosis in 18% of cases. The legal characteristics of the migrant inpatients are shown in Table 2. The most frequent types of index offenses were: Homicide and attempted homicide (14%), Aggravated and Common Assault (16%), Sexual offenses (10%), Assaulting an officer (15%), Threats and harassment (18%) and Non-violent crime only (16%). As for the Reason of discharge, first it should be noted that 23% of patients were still in REMSs at the time of data collection, 23% had been conditionally released and in 34% of cases had been unconditionally released by revocation (10%) or repatriation (24%). The most frequent discharge disposition was a psychiatric residential facility (27% of cases), others were repatriated (24%) after agreement with the authorities of the country of origin and the revocation of the security measure. Eventually 8% of cases (11 patients) managed to elope and had not yet been located at the time of data collection. The mean age at admission was 33.9 years; the median length of stay at the time of data collection was 20.7 months.

TYPE OF INDEX OFFENCE AT ADMISSION	**FM**	**IM**	***p***
Homicide and attempted homicide	19	20	
Aggravated and Common Assault	21	12	
Sexual offences	13	9	
Assaulting an officer	20	4	**0.006**
Kidnapping	3	1	
Threats and harassment	24	43	**0.01**
Robbery	11	11	
Terrorism	1	0	
Non-violent crime	22	24	
REASON OF DISCHARGE			
Conditional release	31	63	**0.0004**
Revocation	13	19	
Eloping	11	8	
Repatriation	31	0	
Transfer	15	20	
Death	1	4	
Still in REMS	32	20	

		FM	**IM**	***p***
Primary diagnosis at admission	Schizophrenia Spectrum Disorders	98	70	**0.04**
	Mood Disorders	1	4	
	Substance Use Disorders	7	12	
	Personality Disorders	26	40	**0,047**
	Learning Disability	2	8	
Substance Use Disorders	Yes	24	32	
	No	110	102	

Table 2. Legal and clinical characteristics of Foreigner (FM) and Italian Men (IM) admitted between January 2010 and 31st December 2019 in Castiglione delle Stiviere

Female sample

Between 2010 and 2019, 50 female migrant patients were admitted in the female forensic facilities of Castiglione delle Stiviere. 1 woman died (in a general hospital) from cancer during her stay in the REMS. The number of women discharged during the 10 years period was 47 (94%), none of whom were readmitted at the end of the period of data collection. They came from 26 different countries. Countries represented by two or more female migrants (2 to 4) were rather evenly distributed over

Albania, Bosnia and Herzegovina, Egypt, Morocco, Romania, Tunisia and Ukraine with the most (14%, n=7) from Nigeria. The countries of origin most frequently represented as well as the presence of homelessness and clinical characteristics of 50 migrant women are shown in Table 1.

The primary diagnoses most represented were the SSD in 56% and PD in 34% of cases. SUD as a primary diagnosis was found in none of cases and as a secondary diagnosis in 6% of cases.

Regarding the types of index offense, the most frequent were: Homicide and attempted homicide (26%), Aggravated and Common Assault (10%), Threats and harassment (12%) and Non-violent crime only (22%). Regarding the Reason of discharge, first it should be noted that 6% of patients were still in REMSs at the time of data collection, 36% had been conditionally released and in 14% of cases had been unconditionally released (by revocation 4% and repatriation 10%). The legal characteristics are shown in Table 3.

		FW.	IW	*p*
Primary diagnosis at admission	Schizophrenia Spectrum Disorders	28	31	
	Mood Disorders	1	5	
	Substance Use Disorder	0	1	
	Personality Disorders	17	11	
	Learning Disability	2	2	
Substance Use Disorders	Yes	3	2	
	No	47	48	
Type of index offence at admission	Homicide and attempted homicide	13	10	
	Aggravated and Common Assault	5	7	
	Sexual offences	1	0	
	Kidnapping	1	0	
	Assaulting an officer	3	1	
	Threats and harassment	6	18	**0.04**
	Robbery	10	2	**0.01**
	Arson	0	0	
	Non-violent crime only	11	12	
Reason of Discharge	Conditional Release	18	29	**0.02**
	Revocation	2	8	**0.04**
	Eloping	0	0	
	Repatriation	5	0	
	Transfer	3	11	**0.02**
	Death	1	0	
	Still in REMS	21		**0.04**

Table 3. Legal and clinical characteristics of Foreigner (FW) and Italian women (IW) admitted between January 2010 and 31st December 2019 in Castiglione delle Stiviere

The most frequent disposition was transfer to prison (30% of cases), then a psychiatric residential facility (26% of cases). Others were repatriated (10%) after agreement with the authorities of the country of origin and the revocation of the security measure. Finally, none of female patients managed to elope from REMS. The mean age at admission was 38.6 years, and the median length of stay at the time of data collection was 10 months.

Comparing migrant and non-migrant psychiatric patients

As far as we know this is the first study in Italy aimed at evaluating clinical and legal characteristics of one group of male and one group of female foreigner patients admitted to Italian forensic psychiatric facilities.

Regarding the countries of origin, there was no correspondence between the population of the migrant residents in Italy on January 1, 2020 (ISTAT, 2020) and the sample of psychiatric patients, both males and females, residing in the REMSs (and before in OPG) considered in this study. This can be explained by the fact that most of the migrant patients who were admitted in these REMSs, men more frequently than females, had reached Italy irregularly from North Africa. This is consistent with the finding that 41% of men and 24% of women of this sample were homeless (did not have a permanent residence) at the time of the index offense.

As for the primary diagnosis, in this sample, men had a higher number of SSD (98) compared to a group of male Italian patients (70) with statistically significant difference (p=0.04, see Table 2).

These findings are consistent with data from other European Countries, as we shall see later. The difference regarding the diagnosis of personality disorder, which is more frequent in the Italian sample, is also significant (p=0.047, see Table 3).

As far as women are concerned, the diagnosis of SSD appears to have a similar distribution in the two groups, while personality disorders are more frequent among foreign women, although without statistically significant differences.

As for Substance Use Disorders as primary or as secondary diagnosis, there are no significant differences between the two male and female samples (see Table 2 and 3).

Regarding the type of index offense, there is a significant difference between the two male groups concerning the crime Assaulting an officer, which is more frequent in the sample of (p=0.006) while the crime of Threats and harassment is significantly more represented in the Italian sample (p=0.01, see table 2). Non-violent crimes the percentages were quite similar in the two samples.

In the female sample, significant differences between the two groups emerge regarding the crime of Threats and harassment (p=0.04), more frequent in Italian women, and regarding the crime of Robbery, (p=0.01) more represented in the sample of migrants. As for non-violent crimes the percentages were similar.

As far as the reason of discharge is concerned, 76% of the male migrant sample were released from the REMSs at the conclusion of data collection. 23% of the male migrant sample were conditionally released while in the male Italian sample 47% were conditionally released, with statistically significant difference (p=0.0004, see Table2).

This difference can be partly explained due to the fact that 24% of the male migrant sample were repatriated (which suggests first the revocation of the security measure by the surveillance judge) while 8% eloped and never returned to the REMSs.

There is another factor that must be taken in account in the male population: the difficulty of taking care of these patients by the regional psychiatric services. In fact, 27% of them were released to a Psychiatric Residential Facility and only 3% of them were released directly to their home in Italy with the support of the regional psychiatric services.

As for the female sample, significant differences in the method of discharge are found with regard to Revocation and Conditional Release, both more frequent in the Italian sample (p=0.04 e p=0.02, see Table 3).

This difference might be partially explained by the

fact that 10% were repatriated (after the revocation of the security measure by the surveillance judge) and 30% were transferred to prison. It may be easier to take care of patients by the territorial psychiatric services. In fact, 26% of them were released to a Psychiatric Residential Facility and 14% of them were released directly to home with the support of the territorial psychiatric services.

Discussion

Interpretation

Migrant male and female psychiatric patients treated in REMSs represent a vulnerable group of psychiatric patients. Many of the males arrived in Italy illegally from North Africa. Before arriving in Italy, they stayed in foreign countries, facing very harsh living conditions for months, to obtain the means to undertake the journey, usually with makeshift means, to Europe. About 28% of the deaths recorded in 2018 and 2019 occurred during attempts to cross the Sahara Desert. Some of them reported being physically abused both during the journey and upon arrival by human traffickers, many of them having suffered abuse and threats with racist connotations and had no health assistance. About 31% of people surveyed by the Mixed Migration Centre (MMC) who witnessed or survived sexual violence in 2018 or 2019 experienced such assaults in more than one location during migration (UNCHR, 2020). Many of them had no documents at all. Although women also reported traumatic experiences related to emigration, the countries of origin and the ways in which they reached Italy were a little different than men. From a clinical point of view, more attention should be put into the evaluation of the traumatic aspects of migration experience. It is important to know if the onset of the mental disorder occurred prior or consecutive to the migratory experience, if the migration was a trigger and what has the migrant been experiencing in the host country (Agarwal, 2012).

In these REMSs the authors have found deficits in the diagnostic assessment due to the difficulty of using psycho diagnostic tools not influenced by the language barrier or having cultural mediators available for lengthy psychometric assessments.

Migrant men in the REMSs were more frequently diagnosed with a psychotic and less frequently with a personality disorder compared to Italian comparable samples.

In a recent German study, which investigated the disparities regarding the percentage of male foreign national patients who were treated in high-security hospitals compared to the psychiatric wards of prison hospitals (Neumann, 2020), foreign national and German nationals in a prison psychiatric ward showed no significant disparities in diagnosis; however, in high security hospitals, foreign nationals were more likely to have been diagnosed with schizophrenia/psychotic or neurotic/stress-related disorders and were less likely to have been diagnosed with personality disorders than German patients.

In the United States too, Perry at al. (2013) found that African Americans were far more likely to receive psychotic diagnosis and, as a consequence, were found not criminally responsible by court. According to the authors, higher levels of psychotic disorders in ethnic, migrant, or foreign national than in national offenders may partly be due to incomplete explorations and understandings of language barriers and cultural knowledge. As discussed above discrepancies in the rates of diagnosis of mental disorders and psychotic disorders in particular can be the result of multiple factors between migrant and native populations.

Similar results were found in other countries, although these findings are not consistent, depending upon, other factors, countries of origin. A critical question is whether this represents actual disproportion in these disorders among migrant forensic inpatients or is an artifact of the clinical assessments. Further inquiry into the supporting clinical evidence for these diagnoses as well as specific treatment and outcome could help to clarify the validity of the disorders. If diagnoses were insufficiently supported, examination for linguistic and cultural barriers to accurate diagnoses could clarify any diagnostic deficiencies. Assurance of quality translation and culturally sensitive interviews are recommended in any case. Structured interviews may further ensure a more standard diagnostic process, if accomplished with cross-cultural sensitivity.

These differences in diagnosis between migrants and Italian nationals were not found in women. These results are consistent with a UK study (Logan, 2009) upon a sample of women in a High

Security Hospital that did not consider patients' ethnicity.

Again, the question as to whether the sex differences in diagnoses represents actual differences in psychopathologies or whether differences related to sex in the diagnostic assessments occurred. There is also the question of whether a difference in threshold for admission to forensic inpatient facilities was related to sex. For example, would females more easily qualify for the insanity defense without having to have a psychotic disorder?

With regard to Substance Use Disorders as a primary or secondary diagnosis, a similar percentage of cases was recorded both in the migrant male sample and in the female one, compared to the samples of Italian patients divided by sex discharged from REMS. In the migrant male sample, in fact, the percentage of cases (18%) was similar to a sample of Italian patients (24%). As for females, the percentage of the foreign sample and that of the sample of Italian female patients is the same (6%).

These results, however, do not find consistency in the Logan & Blackburn sample (Logan, 2009), where the percentage of SUD among women with a history of violence and mental disorder was much higher (60%). This

difference, however, can be explained by the fact that in Logan & Blackburn's sample, of the 95 women who eventually completed the research evaluation, 47 were in a high security prison and the remaining 48 were in a high security hospital, thus constituting a not-homogeneous sample of prisoners and patients different from the sample of this study.

Fazel et al. (2016) reported that 17.1% of patients had substance use as the primary diagnosis and 22.4% as the secondary diagnosis, which is in line with the male sample of the present study.

Regarding the type of index offense is quite predictable that in the migrant sample the Aggravated and Common Assault, Assaulting an officers and Robbery are more significantly represented. In fact, these are crimes more frequently connected to the condition of clandestinity and homelessness. Just think of all the occasions in which foreigners are stopped to check documents or are caught stealing to get food or basic necessities. Crimes that probably, more effective integration policies could help reduce. Vice versa the crimes of threats and harassment, which often occur in the family environment, are more significantly present in the Italian sample also due to, obviously, the lower possibility of having a family in homeless subjects. The percentages of Nonviolent crimes were quite similar in the two samples (16% and 24% respectively).

Fazel et al. (2016) had results similar to the Italian male sample regarding the type of most common index offense, with Threats and harassment (49%), Homicide and attempted homicide (12.1%) and nonviolent crime (20.4%) but had higher results for Aggravated and common assault (35.3%).

Limitations

This study has some important limitations. First, the data were collected retrospectively from an historical cohort. Second, the sample sizes were relatively small, as the subjects came from a relatively small female and male REMS populations. Moreover, we were unable to assess other clinical factors such as secondary diagnosis, personality traits, different classes of illegal substance use, social support, adherence with medication, readmission in psychiatric wards, which are of significant importance for offenders with mental illness (Grann, 2008). We were also unable to assess anamnestic factors, including traumatic aspects.

Recommendations

Regardless the strength of linguistic and ethnicity differences as a factor affecting assessment and treatment of migrant inpatients, attention to such issues constitutes best practices in supporting respect for the individual and optimizing the quality of treatment. Other authors have proposed measures that warrant consideration. In the face of linguistic impediments, communication can be improved with the used of trained interpreters. "Cultural brokers" can assist in improving mutual understanding (Kirmayer, 2011). Providers who assess mental health and diagnosis must consistently address stressors associated with premigration, migration (including trauma, relational losses and disruptions, and mistreatment) as well as those attending the challenges of resettlement and gaining access to needed services (Kirmayer, 2011).

McLaughlin and de Mamani (McLaughlin, 2022) recently proposed multiple specific measures to address specific cultural barriers. For example, because of the possibility that some ethnic groups can receive less reliable diagnoses which could contribute to suboptimal or poor care and contribute to mistrust of the health system, the authors recommend the following three approaches: 1) Ask diagnostically relevant questions in a "neutral" way; 2) Using the patient's own terms, create a shared language, and 3) Acknowledge prior difficulties with the mental health system (McLaughlin, 2022). The other measures recommended by these and other authors warrant consideration. At the same time, it is important not to assume diagnostic discrepancies are completely or predominantly the result of ethno-linguistic challenges, diagnostic discrepancies can be actual and multifactorial, justifying the treatment provided and/or indicating other measures such as active social work involvement to support access to needed community services. Finding that the increase in psychosis in migrants and their children is real, not spurious or artifactual, Selten and colleagues [28] identify the most imperative challenge is to investigate the mechanisms in order to inform effective preventive and mitigative strategies.

Conclusion

Like other western countries, Italy has experienced substantial increase in the number of migrants entering the country in recent years. Consequently, the percentage of migrants admitted to forensic inpatient facilities has also increased. Consistent with findings in other countries, this descriptive study found that male migrant inpatients were more frequently diagnosed with a psychotic disorder and less frequently with a personality disorder. In contrast this diagnostic disparity with other Italian study populations was not found in female migrant inpatients. Neither were such disparities found regarding substance use disorders between male and female migrant inpatients. Future research should help to clarify whether discrepancies are accurate reflection of population differences or artifacts of imperfect assessments. In either case culturally sensitive methods of assessment are strongly recommended.

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