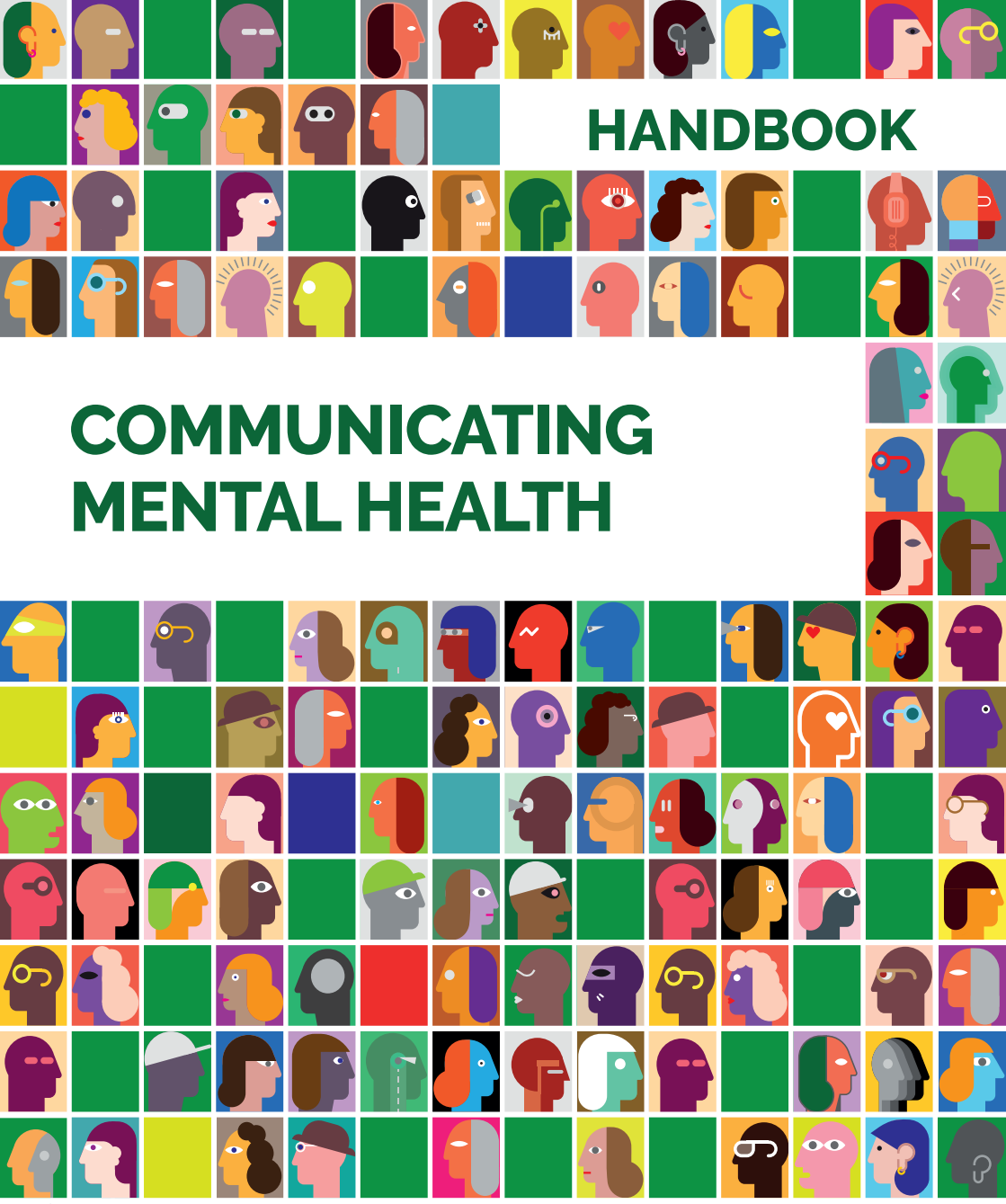


HANDBOOK

COMMUNICATING MENTAL HEALTH

ORDINE DEI GIORNALISTI
CONSIGLIO NAZIONALE

Rai Per la Sostenibilità ESG

SISTEMA SANITARIO REGIONALE
ASL ROMA 2
REGIONE LAZIO

The handbook *"Communicating Mental Health"* was conceived by **Rai for Sustainability ESG** within the framework of the **RO.MENS Festival**, promoted by the **Mental HealthDepartment of ASL Roma 2** in collaboration with the **Department of Social and Health Services of Roma Capitale**.

Its aim is to **improve how journalists report on mental health**, contributing to the **reduction of stigma and prejudice**.

The project has been **endorsed and supported** by the **National Council of the Italian Order of Journalists** and is shared by **ASL Roma 2**.

HANDBOOK

COMMUNICATING MENTAL HEALTH

“Madness is a human condition — it can be everything and nothing. It dwells within us just as reason does. The problem is that a society, to call itself civil, must accept both reason and madness”.

Franco Basaglia 1924 – 1980

ORDINE DEI GIORNALISTI
CONSIGLIO NAZIONALE

Rai Per la Sostenibilità ESG

SISTEMA SANITARIO REGIONALE

ASL ROMA 2

REGIONE LAZIO

Edited by

For the Italian Order of Journalists, ***Renato D'Argenio***, ***Lorenzo Sani***

For Rai for Sustainability – ESG, ***Rossella Antonini***, ***Daniela de Robert***, ***Marina Marino***

For the Mental Health Department of ASL Roma 2, ***Emanuele Caroppo***, ***Massimo Cozza***

Graphic design: Zonamista di ***Nico*** and ***Nino Pellacani***

The portrait of Franco Basaglia is by ***Giuseppe Palumbo***.
Taken from Costellazione Basaglia by Di Vittorio and Palumbo (Action 30 graphic essays)

Translation by ***Gabriella Vaughn***, ***Jennifer Williams***

Table of Contents

Media and Mental Health: An Alliance to Counter Stigma and Prejudice 11

Mental Health: A Foundation of Well-Being and a Universal Right 13

Toward Respectful Communication 21

Mental Health Glossary 35

Mental Health and Justice 47

Communicating Mental Health is the English-language edition of a text conceived in reference to the Italian context — the first country to abolish asylums and to carry out a profound cultural, administrative, and social reform of mental health care.

This journey, still ongoing, requires the contribution of every institution and every resource in order to be completed. In in the process of overcoming stigma and discrimination it is crucial to involve journalists.

It is why this text is addressed to communicators in the first place but to all those who, through their behaviours and language, can take part in changing the vision from exclusion to inclusion.

Media and Mental Health: An Alliance to counter stigma and prejudice.

In today's society, the media plays a key role in shaping public opinion and influencing social attitudes. This influence can be a powerful force for good, especially in helping to overcome prejudice and stigma in the complex field of mental health. **Television, print media, social media, radio, and blogs can all contribute to promoting the rights and dignity of individuals with mental health conditions, dispelling persistent myths and prejudices that fuel social exclusion and make it harder for people to seek help.**

However, despite progress in raising awareness of this sensitive issue, **stigma and prejudice remain deeply ingrained** and continue to represent often insurmountable barriers. Fear of being judged, blamed, or discriminated against frequently prevents individuals from seeking the support they need, thereby perpetuating silence and isolation.

In this context, a **strategic alliance between mental health professionals and media workers** is essential for advancing knowledge and fostering a truly inclusive culture.

We firmly believe that better communication can help people with mental health challenges feel less isolated, more understood, better supported, and more respected. **We believe** in the media's potential to build a more empathetic and informed society—one in which the complex topic of mental disorders is addressed with dignity and respect for those who experience it.

The goal of this guide is to support efforts against stigma through balanced and informed storytelling, and by addressing mental health disorders in a responsible, unbiased, and respectful manner.

Mental Health: a foundation of well-being and a universal right

The World Health Organization (WHO) defines mental health as "an integral part of health and well-being," and defines health itself as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

Focusing on the WHO's biopsychosocial framework, mental health—like other aspects of health—can be shaped by a wide range of social, economic, relational, and cultural factors. Addressing these requires global strategies for mental health promotion, prevention, treatment, and recovery. In this people-centered process, language plays a fundamental role.

According to the WHO, **well-being** is a condition in which every individual realizes their own potential, copes with the normal stresses of life, works productively, and contributes to their community. This perspective moves beyond a purely clinical view to place the person at the center-affirming that even with a mental health condition, one can achieve a high level of well-being and lead a fulfilling life. Conversely, the absence of a diagnosed mental disorder does not automatically equate to optimal mental health.

Mental health, therefore, is not only an individual goal but also a fundamental human right and a public good that concerns everyone.

A DYNAMIC AND INTERCONNECTED CONCEPT

Mental health encompasses a broad continuum, ranging from optimal well-being to severe mental disorders, and includes states of moderate or temporary psychological distress. This continuum is influenced by biological, social, economic, and environmental factors, which can be addressed through strategies that promote mental health, prevent distress, and provide appropriate treatment.

Scientific evidence shows that many mental and physical health conditions have their roots in early life experiences. Positive or adverse childhood experiences accumulate over time, shaping health and social outcomes into adulthood and old age.

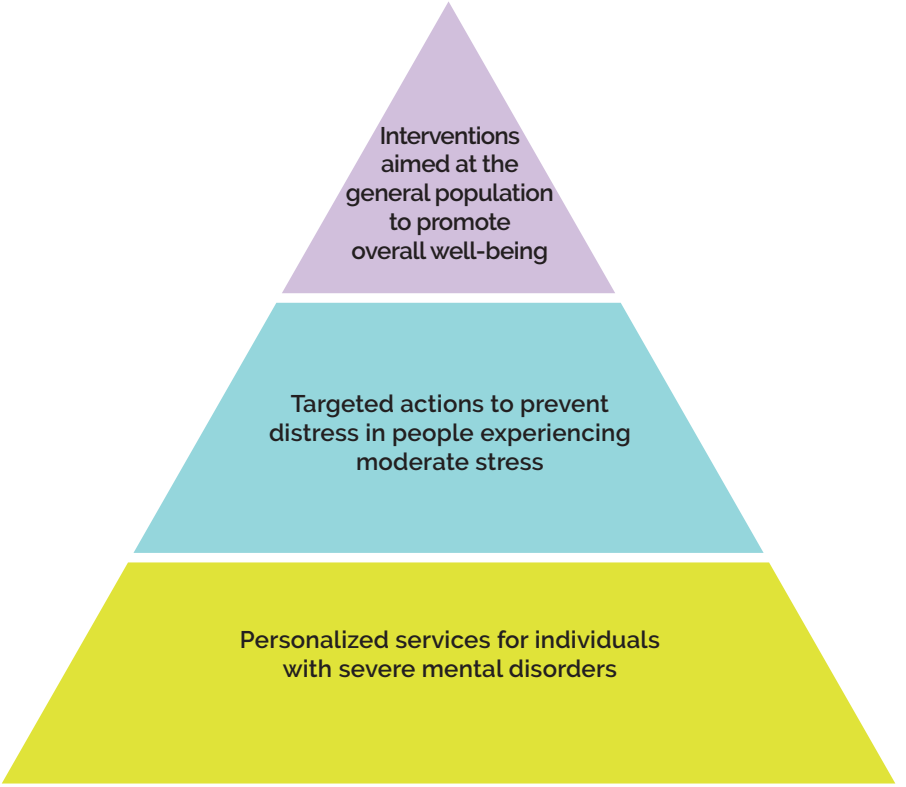
INEQUALITIES AND RISK FACTORS

Mental health is closely tied to social, economic, and environmental contexts. Risk factors such as poverty, discrimination, and job insecurity are often linked to social inequalities. In more unequal societies, exposure to such risks increases, raising the likelihood of developing mental health conditions. Therefore, social and economic policies that promote equity and well-being are crucial.

Mental health is inherently connected to psychosocial well-being—a concept that integrates psychological dimensions (emotions, thoughts, behaviors) with social aspects (interpersonal relationships, community life, values, and roles). A good level of psychosocial well-being is essential for achieving mental health, and vice versa. This is why the term "mental health and psychosocial well-being" is increasingly used as a unified concept.

AN INTEGRATED APPROACH: THE PYRAMID OF WELL-BEING

Mental health interventions are often conceptualized as a pyramid of intensity levels, emphasizing the importance of **acting at all stages**—from prevention to treatment. However, a significant gap persists between the demand for and supply of mental health services. In low- and middle-income countries, this treatment gap reaches approximately 80%, while in Italy it stands at 57% for individuals with severe mental disorders. The COVID-19 pandemic has further worsened the situation, increasing the incidence of depression and anxiety, particularly among women and young people.



MENTAL HEALTH IN LATER LIFE: A LIFE-COURSE PERSPECTIVE

Addressing mental health in older adults requires adopting a life-course approach. Grief, loss of identity, social isolation, and loneliness are common risk factors among the elderly. However, many of these vulnerabilities originate from early life experiences and accumulate over time. Therefore, it is essential to aim for:

- A safe and nurturing childhood
- An inclusive and supported adolescence
- An adult life with opportunities for growth, stable relationships, and access to adequate services.

THE CRUCIAL ROLE OF PREVENTION POLICIES

A broad, multidisciplinary approach to mental health is not just an individual goal—it is a **collective responsibility**. Global and local action is needed to reduce risk factors linked to social inequalities, ensure access to services, and promote sustainable well-being. Mental health is not merely a health objective—it is the foundation of a dignified and fulfilling life and a prerequisite for building a better future for all.

What Is a Mental Disorder? It's a **condition that significantly alters a person's thinking, emotional regulation, or behavior due to psychological, biological, or developmental dysfunctions.** This results in **personal distress** and impaired social functioning.

It is important to note that deviating from social norms alone is not sufficient to define a mental disorder. These conditions go beyond simple disagreement with societal values.

WHY IT IS IMPORTANT TO DEFINE MENTAL DISORDERS

- **Clinically**, definitions help distinguish between normal variation and pathology, supporting effective diagnosis and treatment.
- **Legally and socially**, they influence decisions such as criminal responsibility or access to healthcare benefits.
- **Therapeutically**, a clear diagnosis enables the development of appropriate care pathways.

Mental disorder and psychological distress are not the same

MENTAL DISORDER	PSYCHOLOGICAL DISTRESS
Severe and long-lasting if untreated, involving deep alterations in thought and behavior	Milder and often temporary
Significantly impairs daily life and causes marked suffering	Arises from stressful events (e.g., relationship issues, bereavement, job difficulties)
Has complex causes: biological, psychological, and environmental	Does not profoundly affect adaptability and can resolve with appropriate support

HOW TO DISTINGUISH BETWEEN NORMALITY AND PATHOLOGY

Normality does not represent an absolute condition but rather a statistical concept, indicating the most frequent behaviors, emotions, and thoughts within a given population. Similarly, mental disorders can be described statistically through the presence of similar symptoms in multiple individuals, as classified in diagnostic manuals based on expert consensus.

Importantly, in mental health there aren't scientifically validated biological markers that can definitively certify the presence or absence of a psychopathological condition. However, four key factors can help identify a mental disorder:

Cultural Comprehensibility – Is the behavior incongruent with the values and norms of the cultural context?

- **Adaptation** – Is the individual able to live and cope with the demands of everyday life?
- **Distress and Impairment** – Does the condition cause significant suffering or impair functioning?
- **Mental Status** – Are there persistent alterations in thought or behavior, with clear symptomatic manifestations?

Critiques of the Mental Disorder Concept. The anti-psychiatry movement—including thinkers like Michel Foucault, Franco Basaglia, and Ronald Laing—criticized psychiatry for labeling deviance as "illness." According to this perspective:

- Diagnoses often serve as tools for controlling those who deviate from social norms;
- Psychiatric institutions have historically marginalized and excluded the "different."

Even today, the concept of mental disorder remains complex and contested. Nevertheless, it is essential for ensuring effective clinical support and fostering a respectful approach to human diversity.

Mental Health in Numbers. The World Health Organization (WHO) estimates that **one in eight people** worldwide is affected by a mental disorder. However, arriving at a precise global figure is extremely difficult due to major uncertainties. On one hand, **social stigma leads many individuals to conceal their suffering**, and data collection systems—especially in low-

and middle-income countries—are often incomplete. In these regions, the treatment gap can exceed 85%. On the other hand, prevalence may be **overestimated** in certain areas due to inconsistent diagnostic criteria or the use of non-comparable methodologies across studies. Nonetheless, regardless of the exact number, what truly matters is maintaining high awareness of mental health, as millions of individuals are affected even within a single country. In Italy, the 2023 Mental Health Report from the Ministry of Health recorded 854,040 adult users receiving care from public mental health services. Adding an estimated 6,000 unregistered users from the Abruzzo region brings the total to over 860,000 adults. When considering minors—estimated to make up approximately 15% of the population—the number of people receiving care from public mental health services approaches one million.

This is still an underestimate, as it excludes:

- individuals treated by general practitioners or pediatricians,
- those receiving private care,
- and people with mental disorders who are not receiving treatment due to economic barriers or stigma.

It is therefore essential to **center care around the individual**, ensuring that anyone experiencing psychological difficulty feels safe **to ask for help without fear of discrimination**. Equally important is the availability of **adequate services** capable of responding effectively to support needs and the implementation of comprehensive prevention strategies.

These must include:

- **Primary prevention** to reduce risk factors,
- **Secondary and tertiary prevention** to provide timely interventions and long-term support for those affected by mental disorders.

LAW 180: A TURNING POINT

Law no. 180 of May 13, 1978, Assessments and voluntary or compulsory healthcare treatments, commonly known as Law 180 or the Basaglia Law, marked a radical shift in Italian psychiatric care.

The law mandated the **closure of psychiatric hospitals**, established a new community-based psychiatric healthcare system, and regulated **compulsory healthcare treatments**. Italy thus became the first country in the world to abolish psychiatric asylums.

Another fundamental principle of Law 180 is the **centrality of the person**. The closure of asylums restored dignity to individuals with mental disorders, recognizing them as full citizens with civil rights, and symbolically ending custodial and repressive approaches. It introduced a new model of care grounded in **individual responsibility**, **therapeutic alliance**, **and comprehensive psychosocial support**.

This led to a model of care based on genuine encounter **between patient and therapist**, where hospitality, attentive listening, and empathy lay the foundation for active collaboration and therapeutic engagement, considering biological, psychological, and social dimensions.

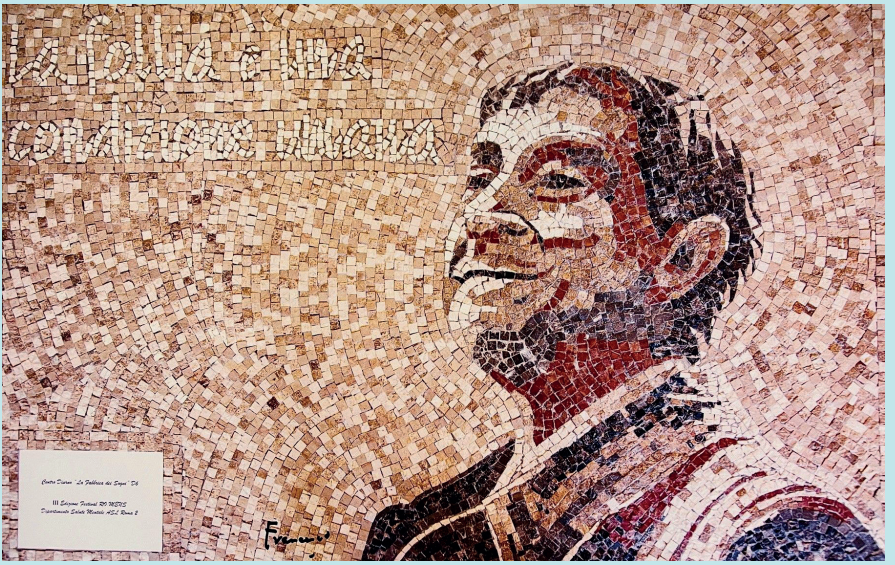
FRANCO BASAGLIA (1924-1980)
WHEN DEMOCRACY ENTERED THE ASYLUM

Franco Basaglia, born in Venice on March 11, 1924, was a psychiatrist and neurologist who spearheaded the cultural and political movement that culminated in **Law 180**. His work in the 1960s and 1970s brought an end to the institutional internment of individuals with mental disorders, and to the "**culture of control over madness**."

In the psychiatric hospitals of **Gorizia** and **Trieste**, Basaglia introduced an approach based on equality between patients and healthcare workers. He promoted open, **non-hierarchical institutions**, eliminated physical restraints, discontinued the use of electroshock therapy, and abolished closed wards. No longer were individuals to be seen as inmates to be confined, but as people living with mental disorders.

In 1968, he published *The Institution Denied*, and in 1973, he founded the **Democratic Psychiatry** movement.

"To truly address 'illness', we must encounter it outside of institutions—not only outside the psychiatric institution, but also outside all institutions whose function is to label, classify, and freeze individuals into fixed roles. But does such an 'outside' truly exist, from which we might act before institutions destroy us?" (Basaglia, *The Problem of Management*, 1968).



The portrait of Franco Basaglia in the RO.MENS mosaic donated to Pope Francis: an artwork by users of La Fabbrica dei Sogni Day Center (DSM ASL Roma 2)

Toward respectful communication

The word **stigma** originally referred to a physical brand burned into the skin of slaves, criminals, and traitors to mark them as socially undesirable. Over time, the term came to represent **a condition of shame and disgrace**.

In 1963, sociologist **Erving Goffman** provided a systematic, scientific analysis of stigma, describing it as a deeply discrediting attribute that marks and devalues an individual—sometimes permanently. Stigma can be associated with physical deformities, character traits, or group memberships (e.g., cultural or ethnic identity).

In the mental health context, stigma refers to the process by which people with mental disorders are subjected to **social discrimination and prejudice**. More than in any other area of healthcare, stigma in mental health is not only a source of discrimination but also contributes to **ongoing psychological suffering** and the persistence of mental disorders. For this reason, eliminating stigma is a key objective of all major international strategies, from the WHO's World Mental Health Report to the Global Mental Health Summit.

The primary goal of mental health communication is to challenge stigma, prejudice, and stereotypes associated with mental disorders—none of which are scientifically justified.

HOW STIGMA IS CONSTRUCTED: STEREOTYPES, PREJUDICE AND DISCRIMINATION

Mental disorders are often surrounded by negative stereotypes that fuel fear and mistrust, reinforcing prejudices. For example, saying "a person with schizophrenia" is fundamentally different from saying "a schizophrenic," which reduces the individual to their diagnosis.

Such stereotypes and prejudices often lead to discriminatory behavior, such as: "People with mental illness should be locked up because they are dangerous," or "We can't hire someone with a mental illness—they're unreliable."

Mental health reporting demands attention, sensitivity, and respect.

Ethical journalism must avoid sensationalism, stigmatization, and distortion of reality. Instead, it should promote an accurate and respectful understanding of people with mental disorders.

SENSATIONALISM
STIGMATIZATION
DISTORTION OF FACTS

In addition to informing about mental disorders, mental health education—grounded in respect for dignity and fundamental rights—can promote preventive behavior and wellbeing. Accurate and accessible information helps people understand how to care for their psychological health and encourages them to seek help without fear of judgment.

THE FIVE MOST WIDESPREAD PREJUDICES

Incurability – Mental disorders are often wrongly perceived as untreatable or barely manageable. This misconception is compounded by the false belief that people with mental disorders cannot make autonomous decisions or are intellectually impaired. In reality, viewing individuals as people with specific symptoms enables a clinical approach and appropriate care.

Dangerousness – This concept, rooted in 1930s penal code definitions, portrays individuals as violent and a threat to themselves or others. In fact, there is no scientific evidence linking mental disorder per se to violence. People with mental disorders are more likely to be victims rather than perpetrators of violence.

Incomprehensibility – People often view the thoughts and behaviors of those with a mental disorder as meaningless. Yet, with active and non-judgmental listening, even the most unusual expressions can be understood within the unique life story and context of the person.

Unproductivity – The myth that people with mental disorders cannot work or contribute to society is outdated. With appropriate training and support, many individuals have successfully entered the workforce. Employment itself is a powerful tool for recovery and reintegration.

Irresponsibility – There is a common belief that individuals with mental disorders are incapable of understanding or controlling their actions. While some mental disorders may reduce cognitive or emotional capacity, complete irresponsibility is rare. There exists a wide spectrum of functional abilities.

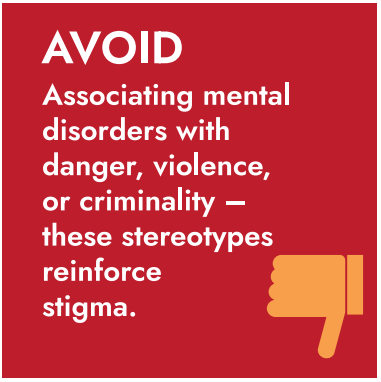
Education and **awareness-raising** are vital processes that support science-based understanding of mental health.

- **Education** aims to provide accurate information, resources, and clarity.
- **Awareness** seeks to increase public understanding and positively influence societal attitudes.

To educate and raise awareness means to **make mental health knowledge accessible**, including: causes of mental disorders, symptoms, available treatments, and when and how to seek help. The starting point for many prejudices is the failure to recognize mental suffering, often linked to the false assumption of permanent disability. Yet with proper care, many people can partially or fully regain social and cognitive functioning.

Fighting stigma requires involving individuals with lived experience and their families in care and psychosocial recovery.

The media can be powerful allies in dismantling stereotypes, which is why it's important to use caution when reporting on mental health issues—and **avoid misusing psychiatric terms** in unrelated contexts such as sports or politics, where such misuse remains common.



EXAMPLES OF HEADLINES THAT FUEL STIGMA

- Tragedy of madness: kills his son with a knife
- Goes crazy during Christmas dinner, attacks family members: arrested
- Kills partner in a fit of madness
- Night of madness: three dead
- Loses his mind and kidnaps a two-year-old
- Naples, night of madness at juvenile prison: inmates set cell on fire and assault officers
- He had the face of a lunatic: he injured me and then came back

THE ROLE OF RESPONSIBLE JOURNALISM

The temptation to exaggerate or dramatize news to attract public attention is ever-present, especially with the rise of digital media. Sensationalism distorts information by using inappropriate terms and misleading concepts to make stories more appealing.

Avoid alarmist tones, shock effects, and language that traps individuals in stereotypes. Words like "madness," "*lunatic*," or "*maniac*" reinforce stigma. Avoid imagery associated with custodial representations of mental disorders—such as straitjackets, restraint beds, and other dehumanizing portrayals.

Instead, provide balanced, fact-based information, verifying any mental health diagnoses, and respecting individuals' privacy and confidentiality.

Distortion may be intentional or unconscious—but the consequences are the same. It is essential to remain vigilant and perform all necessary fact-checking to avoid misrepresentation.

Do not emphasize a person's mental disorder in stories where it is not relevant. For example, if someone with a psychiatric condition commits a crime, avoid attributing the action solely to the illness.

Report facts accurately without forcing interpretations.
Mental disorders are not synonymous with dangerousness.

Precision is always necessary—haste, vagueness, and superficiality are constant threats.

Avoid spreading misleading or inaccurate information about mental disorders, especially regarding causes and treatments

Always refer to **reliable medical sources** and give voice to **mental health experts** to ensure accurate public understanding.

Person-Centered. The fundamental principle is to put the person first—not their health condition, which may be only one of many characteristics.

Language should educate and inform, not judge. The perspective on disability has changed radically with the bio-psycho-social model endorsed by the World Health Organization (WHO) through the International Classification of Functioning, Disability and Health (ICF, 2001) and the UN Convention on the Rights of Persons with Disabilities (2006), ratified by Italy in 2009. Today, disability is understood as the result of a complex interaction between an individual's health condition and their personal and environmental circumstances.

Therefore, always **identify the person before the condition**. Use respectful, non-discriminatory language. Prefer expressions such as: "lives with a mental disorder" over "mentally ill" or "crazy", "a person with schizophrenia" rather than "a schizophrenic", "a person living with depression" instead of "a depressive"

It is essential to present reliable data and facts on mental health, referencing trusted sources such as the WHO, research institutions, and professional associations. Use simple and accessible language. Support communication with infographics, animated videos, or other visual formats to convey complex concepts.

Real-life stories have a powerful emotional impact. Sharing experiences from individuals who have lived with a mental disorder helps build empathy and strengthen the human connection at the core of all communication. Give voice to both challenges and **recovery stories**, showing that **recovery is possible**.

Encourage user engagement through interactive content such as questions, polls, and comment-based discussions. **Social media platforms** are particularly suited for this kind of dialogue. Consider live streams or webinars with experts, allowing users to ask questions and receive accurate information on mental health topics.

Create educational content that emphasizes the role of social support from family, friends, and the community. An inclusive and understanding environment significantly contributes to recovery. Highlight the potential for improvement and long-term wellbeing. Discuss coping strategies, relaxation techniques, and mindfulness practices that help individuals live well with a mental health condition and maintain quality of life. Challenge myths and stereotypes through science- and evidence-based content. For example, debunk the myth of the "dangerous mentally ill person" with accurate data and analysis. Consider adding "Myth vs. Fact" sections that tackle common misconceptions.

VIOLENCE: MORE OFTEN A VICTIM THAN A PERPETRATOR

Although studies show a slightly higher risk of violent outcomes in people with diagnosed psychiatric conditions, it is crucial to note that the **absolute rate of violent crimes over a 5–10 year period remains below 5% in individuals with mental disorders**, rising to 6–10% for those with personality disorders or schizophrenia spectrum disorders (*The Lancet Psychiatry, 2021*). Risk increases with co-occurring factors such as substance abuse, previous history of violence, being a victim of crime or abuse, or experiencing major life crises (e.g., divorce, job loss).

Most people with mental disorders are not dangerous. In fact, they are **ten times more likely to be victims of crime** compared to the general population (*Italian Ministry of Health*). Nonetheless, the public perception—often fueled by media and news reporting—continues to conflate mental disorder with dangerousness, contributing to discrimination and social exclusion.

WORD CHOICE MATTERS

Use non-stigmatizing language that respects the dignity of individuals: Describe the person, not just the diagnosis.

Use legally and scientifically accurate terms, avoid sensational or offensive labels.

Protect individuals who agree to speak publicly about their mental health, and never reduce them to their illness. Ensure their right to respond is upheld.

Consult with: Mental health professionals, Healthcare and social service providers, Legal and law enforcement representatives, Advocacy organizations

View individuals with mental disorders as potential stakeholders and interviewees, but remain aware they may not fully grasp the implications of media exposure.

Include detailed information about: Available services, Treatment options, and Psychosocial support;

Promote positive narratives, such as recovery journeys and successful treatment outcomes.

Avoid linking mental disorders with violence unless the connection is relevant and well-supported by evidence. Unwarranted associations foster fear, reinforce stigma, and harm both individuals and public understanding.

Avoid pitying tones, or automatic absolution of guilt based solely on a diagnosis. Likewise, don't attribute criminal acts to a psychiatric disorder unless such a link is established and relevant.

Avoid misusing psychiatric terms in unrelated contexts—for instance: "a schizophrenic political decision", "a massacre of madness"

Such expressions trivialize mental health and equate it with inconsistency or irrationality, further entrenching public prejudice.

Some terms may carry negative connotations that can be demeaning to people, such as "mentally ill" or "mental illness."

COMMON MENTAL HEALTH MYTHS VS. FACTS

MYTH	FACTS
Mental health problems are rare and won't affect me	One in four people experiences a mental health issue each year.
People with mental health conditions cannot be helped.	A great deal can be done to help individuals with mental health problems, starting with making contact and listening without judgment.
No one recovers from a mental disorder.	Mental health issues may recur over a lifetime, but many individuals live fulfilling lives, work, and maintain relationships.
Mental disorders are incurable.	Studies show one-third of people fully recover, another third manage moderate symptoms and live socially integrated lives, while the remaining third experience significant disability. The belief that recovery is impossible causes loss of hope, discouragement, and damaged relationships.
People with mental disorders cannot work.	Many people work even while managing symptoms. Historical and contemporary figures like Abraham Lincoln, John Nash, Vincent Van Gogh, Alda Merini, Dino Campana, David Helfgott, Antonio Ligabue, Leonardo DiCaprio, and Adam Levine are examples. Employment fosters self-esteem, social connection, and a sense of purpose.
Most people with mental disorders are violent and dangerous	Most are not violent. They are statistically ten times more likely to be victims of violence than perpetrators.
Seeking help at mental health centers means you're "crazy" or weak.	Reaching out to mental health professionals is a crucial first step toward recovery. Mental health centers support a wide range of conditions, from altered perceptions of reality to emotional challenges such as anxiety, panic, or depression.

TIPS FOR CONDUCTING INTERVIEWS:

WHAT TO DO

Address the person directly, not through their caregiver or family.

Remember you're speaking to someone who may be vulnerable and deserves protection from stigma or manipulation.

Make the person feel comfortable.

Maintain an empathetic and respectful attitude.

Let your body language and tone reflect genuine understanding and nonjudgmental openness.

WHAT NOT TO DO

Do not use informal or overly familiar speech just because the person has a mental health condition.

Avoid patronizing or infantilizing behaviour.

Do not speak with detachment, irony, or dismissiveness.

Never show fear or reduce the person to their illness.

Avoid dehumanizing language or representations.

WORDS THAT WOUND

(Use these)

WORDS THAT DISCRIMINATE

(Avoid these)

WORDS THAT WOUND

CRAZY, MAD, LUNATIC, OUT OF YOUR MIND, INSANE, FREAK OUT, DERANGED, PSYCHOTIC, UNHINGED, MENTAL BREAKDOWN, FEAR

WORDS THAT DISCRIMINATE

ASYLUM, DANGEROUS, VIOLENT, FEAR, SEGREGATION, RESTRAINT, CONFINEMENT, INMATE, ISOLATION, SOCIAL DANGEROUSNESS, OUTBURST

NEGATIVE STEREOTYPES

INCURABLE, SOCIALLY DANGEROUS, INCOMPREHENSIBLE, UNPRODUCTIVE, IRRESPONSIBLE

INCLUSIVE LANGUAGE PERSON FIRST, OR CHARACTERISTIC FIRST?

Person-first language refers to the practice of talking about someone with a disability, or a particular health condition, by placing the idea of the person before the disability — which is only mentioned at all when it's actually relevant to the context. This approach aligns with the standards set out in the International Classification of Functioning, Disability and Health (ICF, WHO, 2001), which frames disability in positive terms of "functioning," valuing the person over the deficit.

As a result, it's best to avoid using "disabled" as a noun and to say instead "a person with a disability" — an inclusive phrasing that puts the person at the centre. This is why there's a growing shift toward person-first language, in which information about disability or health conditions is treated as a secondary characteristic. The deficit shouldn't be hidden, but it shouldn't become a defining label either.

IDENTITY-FIRST LANGUAGE (CHARACTERISTIC FIRST)

When it comes to self-definition, communities have every right to determine how they wish to be described, and this doesn't conflict with the ICF's own recognition of the unquestionable right to self-determination. Although person-first language is the more commonly used convention, blind and deaf people, for instance, tend to prefer being described simply as "*blind*" or "*deaf*," rather than as "*visually impaired*" or "*hearing impaired*." Similarly, in the field of mental health — where person-first language is now widespread — the autistic community generally prefers to be described as "*autistic*," since many, particularly within autism activism, see neurodivergence as an integral part of their identity. They therefore prefer "*autistic*" over "*person with autism*" or "*autistic person*."

As a general rule, then, it's always good practice to ask the person concerned which term they themselves prefer.

ITALIAN LEGAL GUIDELINES ON DISABILITY LANGUAGE – ITALY, 2024

On **June 30**, **2024**, Legislative Decree No. 62 of May 3, 2024, came into force in Italy. The decree defines the concept of disability, the basic assessment, reasonable accommodation, and the multidimensional evaluation for the development and implementation of a personalized, participatory individual life project.

The decree dedicates Article 4 to terminology: "*Terminology in the field of disability*". It officially bans the use of the term "*handicap*" in institutional communication, replacing it with "*condition of disability*". Similarly, expressions such as "*handicapped person*," "*person with a handicap*," "*person affected by disability*," "*the disabled*," and "*differently abled*" are to be replaced with the term "*person with a disability*."

Furthermore, phrases with connotations of severity, such as "*in a condition of severity*" or "*severe disability*," are to be replaced with "*requiring high or very high support*."

Instead of "*severely disabled person*," the correct terminology becomes "*person requiring intensive support*."

SUICIDE: BETWEEN STIGMA AND CAUTION

Suicide is not necessarily a direct consequence of a mental disorder, and it remains one of the hardest phenomena to predict, since it depends on a complex combination of factors — economic conditions, substance use, environment, acute stressful events and social context.

A 2017 study by Joseph Franklin and colleagues analysed 365 studies conducted over a fifty-year span, examining 3,428 risk factors for suicide. **The results showed that the predictive power of these factors is only marginally better than chance, underscoring just how difficult it is to anticipate such events.** *(https://www.apa.org/pubs/journals/releases/bul-bul0000084.pdf)*

It is essential, then, not to spread the idea that suicide depends solely on mental health problems, since this view not only reinforces stigma but also oversimplifies an extremely complex and painful phenomenon.

Given this multiplicity of factors, suicide prevention cannot be limited to treating mental disorders alone; it must also include social support strategies, educational programmes, stigma reduction, access to support services, and the restriction of lethal means.

News of a suicide always calls for particular care, especially when it involves someone well known. It is essential to handle these events with sensitivity, avoiding sensationalism and favouring messages that convey the possibility of overcoming moments of crisis.

Publicising support centres, dedicated helplines and available resources can make a real difference, helping to raise awareness that asking for help is possible.

Article 15 of the new Code of Ethics for journalists is devoted to precisely this question: how episodes of suicide should be handled in the media (Journalists' Code of Ethics)

The mental health glossary

ADHD – ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

A **chronic neurodevelopmental disorder**. It typically begins in childhood and affects a child's or adolescent's behavior and attention; however, it may also manifest in adulthood with different symptoms. The main features include inattention, hyperactivity, impulsivity, and difficulty in self-regulation.

Due to its widespread diagnosis, concerns have been raised about **overdiagnosis**—an excessive and sometimes unjustified tendency to label certain behaviors as ADHD. For instance, hyperactivity and impulsivity may fall within normal developmental variations. Some scientific studies suggest that the diagnosis can be influenced by cultural, socioeconomic, and educational factors. These studies also indicate a growing risk of overdiagnosis, leading to the misclassification of behavioral difficulties or poor academic performance that may instead be linked to learning challenges, emotional issues, or a lack of educational support.

ASO – COMPULSORY MEDICAL ASSESSMENT (ACCERTAMENTO SANITARIO OBBLIGATORIO)

ASO is a restriction of individual liberty applied when there is a reasonable suspicion that a person—who refuses healthcare contact—has a mental disorder requiring urgent therapeutic intervention. It aims to assess the person's mental condition for health-related reasons.

It is governed by Articles 33, 34, and 35 of Law No. 833 of December 23, 1978 (Establishment of the National Health Service).

It may be ordered when an individual shows clear signs of severe mental distress or refuses necessary care.

The order is issued by the mayor (as Health Authority) based on a physician's

documented request and is carried out by public health services.

AUTISM

A neurodevelopmental disorder characterized by difficulties in communication and social interaction, as well as repetitive behaviors or restricted interests. Autism is part of the Autism Spectrum Disorder (**ASD**), which manifests in widely varying forms. The term "**high-functioning autism**" is often used to describe individuals with average or above-average cognitive abilities and greater autonomy, though they still exhibit core features of the spectrum. Conversely, "**low-functioning autism**" refers to cases with significant cognitive, linguistic, and self-care challenges.

However, this binary classification is often criticized for oversimplifying the complexity and diversity of individuals' needs and capabilities. Current clinical and advocacy guidance increasingly favors describing individual support needs rather than applying "high-/low-functioning" labels, which are considered imprecise and potentially stigmatizing.

AUTISM SPECTRUM DISORDER (ASD)

ASD is a neurodevelopmental disorder marked by persistent difficulties in communication and social interaction, along with restricted, repetitive patterns of behavior, interests, or activities. Symptoms typically appear early in life, usually within the first few years, and vary significantly in intensity and presentation, constituting a spectrum of diverse conditions. Individuals with ASD may exhibit sensory sensitivities, atypical language patterns, and challenges with adapting to change. There is no single known cause of ASD, and effective support requires a personalized, developmental, and socially inclusive approach.

BDS – PERSONAL HEALTH BUDGET (BUDGET DI SALUTE)

An instrument that integrates financial resources and services into a personalized care plan combining health and social support. It aims to provide a holistic, individualized, and flexible approach to the care of individuals with vulnerabilities, such as disabilities, mental health conditions, or other long-term support needs.

CYBERBULLYING

A set of aggressive, harassing, and discriminatory behaviors carried out through digital communication tools and online platforms. Cyberbullying can have serious effects on victims, including anxiety, depression, low self-esteem, social isolation, and in extreme cases, suicidal ideation.

DD – DUAL DIAGNOSIS

In mental health, dual diagnosis refers to the co-occurrence of a *mental disorder and a substance use disorder in the same individual*. This means that a person may suffer from both a psychiatric condition, such as depression or schizophrenia, and substance-related issues involving alcohol, drugs, or medications.

Individuals with dual diagnosis often experience symptoms that interact and complicate treatment. The relationship between mental disorder and substance use can be bidirectional: some may use substances to "self-medicate" psychiatric symptoms, while in other cases, substance abuse can lead to or worsen an existing mental disorder.

Dual diagnosis represents a major challenge in mental health, but with an integrated, biopsychosocial approach, it is possible to support individuals in managing both conditions.

DSM-5-TR (TEXT REVISION, 2022)

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)*, published by the American Psychiatric Association (APA), is a key international resource for the diagnosis and classification of mental disorders. It provides a comprehensive and standardized framework for clinical diagnosis, communication, and research. It should be applied critically, always prioritizing the person over the illness—a principle especially vital in mental health, as emphasized by Franco Basaglia.

ED – EATING DISORDERS (ALSO KNOWN AS FED – FEEDING AND EATING DISORDERS)

A group of complex conditions marked by dysfunctional eating behaviors and an excessive concern with body weight and shape, often coupled with body image distortion and low self-esteem. These disorders require careful recognition and appropriate treatment. With timely intervention, recovery and a return to a healthy, fulfilling life are possible.

Eating disorders can negatively affect both physical and mental health. They typically arise during adolescence and are more prevalent among females. Incidence has been increasing in Western countries, especially among young people, and particularly after the COVID-19 pandemic.

The main types include: **Anorexia Nervosa** (AN), **Bulimia Nervosa** (BN) and **Binge Eating Disorder** (BED).

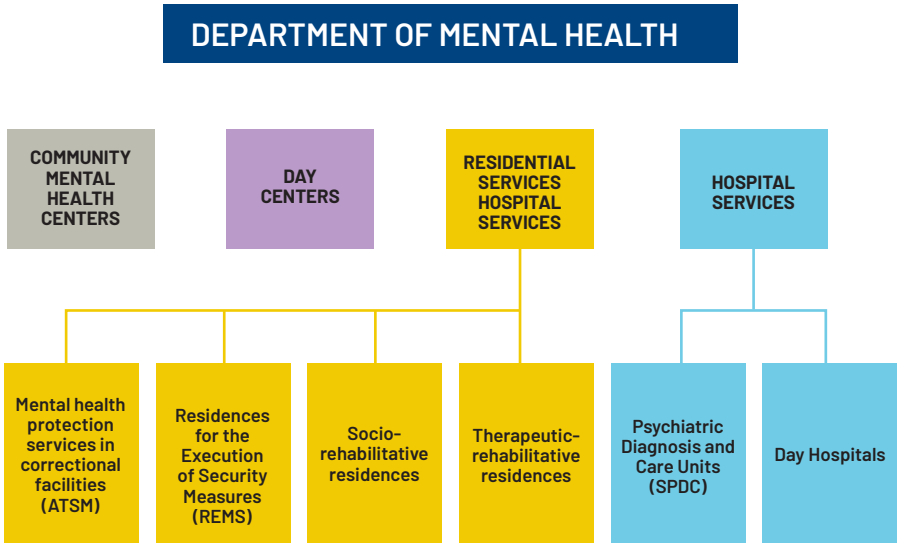
ELECTROCONVULSIVE THERAPY (ECT)

ECT is a physical treatment that involves the controlled induction of seizures through electrical stimulation applied via electrodes on the scalp. The procedure is performed under general anesthesia with muscle relaxation. It is rarely used in psychiatric practice and only for severe mental disorders (e.g., treatment-resistant major depression, severe mania, catatonia) when all other evidence-based treatments have failed. Its use is strictly regulated, such as by the Italian Ministry of Health Circular dated February 15, 1999

HIKIKOMORI

Originally identified within Japanese culture, hikikomori refers to a condition of **extreme voluntary social withdrawal**. Individuals with hikikomori retreat from social life for extended periods (ranging from months to years), remaining isolated in their homes and avoiding direct contact with the outside world.

ITALIAN ORGANIZATION OF MENTAL HEALTH SERVICES



This is a standard organizational framework which may vary regionally, particularly with respect to the inclusion of child and adolescent mental health services and addiction treatment.

LONG-ACTING INJECTABLES (LAIS)

These are a class of medications designed to remain active in the body over extended periods following a single injection. LAIs are particularly useful for patients who struggle with daily medication adherence. In psychiatry, they are primarily long-acting antipsychotics, playing a vital role in the maintenance treatment of schizophrenia spectrum disorders.

MOOD DISORDERS

Mood disorders are mental health conditions marked by persistent or episodic mood changes that significantly impair daily functioning and well-being. Symptoms may include altered mood, energy levels, sleep patterns, and cognitive-emotional abilities. These disorders are treatable with psychotherapy, medication, and psychosocial interventions.

They are mainly categorized as:

- **Depressive disorders**, such as Major Depressive Disorder
- **Bipolar disorders**, characterized by alternating episodes of depression and mania or hypomania

Mania and **hypomania** are states of elevated mood, irritability, and increased activity or thought processes.

- **Mania** is more severe, often involving grandiosity, decreased need for sleep, excessive talking, impulsive or risky behavior, and typically requires hospitalization.
- **Hypomania** is a milder form that does not cause severe impairment but shares similar symptoms. Both occur in **bipolar disorder**, although hypomania may appear in other conditions as well.

NEURODIVERSITY AND NEURODIVERGENCE

Neurodiversity refers to the natural variation from one brain to another within the human species; put more simply, it highlights that every brain differs from every other. In this sense, we are all neurodiverse, even as we belong to the same species.

Within this neurodiversity, however, a majority of people share a certain number of characteristics with one another, following a broadly similar neurological development, and are therefore described, in statistical terms, as neurotypical. The remaining minority of the population shows a neurological development that differs, to varying degrees, from the statistical average, and is described as neurodivergent.

The concept of **neurodivergence** thus encompasses variations in brain functioning relative to the population average, understanding them as part of a natural diversity grounded in social, rather than clinical, inclusion. It can include conditions such as autism, ADHD (attention-deficit/hyperactivity disorder), dyslexia, dyspraxia and other cognitive differences — **regarded as differences rather than deficits**.

The concept of neurodivergence also encompasses care, understood as a means of helping people overcome the difficulties they may encounter. These variations are not viewed as pathologies, but as different ways of perceiving, thinking about and engaging with the world. The concept promotes the acceptance and appreciation of neurological diversity, challenging the idea that there is only one "normal" way of functioning. **Neurodivergence is an integral part of human biodiversity and contributes to a more inclusive understanding of mental health**.

NEUROPSYCHOMOTOR FUNCTIONING (NPM)

Neuropsychomotor functioning examines how the brain and nervous system regulate and coordinate bodily movement and mental activity, focusing on the interplay between motor, cognitive, and emotional functions during development. As such, it lies at the intersection of neurology, psychology, and motor sciences.

NO RESTRAINT

In mental health care, *No Restraint* refers to a therapeutic approach that **avoids the use of physical restraints** or coercive containment for individuals with mental or behavioral disorders. This method, which requires sufficient professional staffing, emphasizes non-invasive interventions such as dialogue, emotional regulation, and psychological support. The goal is to uphold individual dignity and autonomy, encouraging alternative strategies to prevent physical aggression or crisis escalation.

PERSONALITY DISORDER

Personality disorder is a psychopathological condition characterized by pervasive, rigid, and maladaptive patterns of thinking, feeling, and behaving that significantly impair personal, social, and occupational functioning. These patterns are stable over time and typically emerge during adolescence or early adulthood.

- **Character** refers to the acquired aspects of a person's behavior and attitudes, shaped by upbringing, environment, and life experiences. It represents the individual expression of moral values and modes of relating to others.

Personality denotes the stable and unique set of psychological traits, emotions, thoughts, and behaviors that define an individual and distinguish them from others. It is shaped by biological, psychological, and social factors, and results from the interaction between temperament (innate) and character (acquired).

PHYSICAL RESTRAINT

Contrary to common belief,

- physical restraint is **not explicitly regulated by law**. It is governed only by general legal provisions, particularly the "**state of necessity**" under Article 54 of the Italian Penal Code:

  "*A person is not punishable for an act committed out of necessity to save themselves or others from immediate danger of serious harm, not caused voluntarily and not otherwise avoidable, provided the act is proportionate to the danger*." Unjustified use of restraint is considered unlawful and may constitute a criminal offense.

- Restraint **is not a medical act**, as clarified by the National Bioethics Committee (CNB) in its April 23, 2015, document "*Restraint: Bioethical Issues*."

- Its use should be an **absolute last resort**, applied only after all de-escalation techniques have failed, and in safe conditions. It must be properly **justified, monitored, and documented**.

- The CNB advocates for the **elimination of restraint** as part of a care culture that respects the dignity and rights of all individuals, especially the most vulnerable. It also **criticizes the current overuse and normalization of restraint** as routine practice.

- In addition to **physical or mechanical restraint**, there are also **chemical** (pharmacological) and **environmental** forms (such as the use of locked rooms or spaces).

PHYSICAL RESTRAINT – THE MASTROGIOVANNI CASE

Francesco Mastrogiovanni was an elementary school teacher, affectionately called "the tallest teacher in the world" by his students due to his height of 1.94 meters. His tragic story began on July 31, 2009, when he was subjected to involuntary treatment (TSO) and taken to the "San Luca" Hospital in Vallo della Lucania, where he remained for 87 hours in the psychiatric ward (SPDC). For 83 of those hours, he was physically restrained—his hands and feet tied to the bed with plastic straps that caused deep wounds—until August 4, when medical staff discovered that he had died from pulmonary edema. His restraint was not recorded in his clinical chart.

His ordeal became public knowledge through the documentary "*87 Hours – The Last Days of Francesco Mastrogiovanni*" by Costanza Quattriglio, shown in the Italian Senate and aired on RAI 3. The film presents his prolonged suffering through footage from nine security cameras.

The case led to a lengthy judicial process. In the first trial, the healthcare professionals involved were convicted of manslaughter (later changed on appeal to death as a consequence of another crime), unlawful detention, and falsification of records. In 2018, Italy's Supreme Court upheld the convictions of six doctors and eleven nurses for unlawful detention. The doctors were also convicted of falsifying records. However, the charge of death as a consequence of another crime was dismissed due to the statute of limitations.

PHYSICAL RESTRAINT – THE LAVORGNA CASE

On November 7, 2024, the **European Court of Human Rights** (ECHR) **condemned Italy** for violating Article 3 of the European Convention on Human Rights (prohibition of torture and inhuman or degrading treatment) in the *Case of Lavorgna v. Italy* (application no. 8436/21), concerning the use of **mechanical restraint** in a psychiatric hospital.

Matteo Lavorgna was subjected to involuntary treatment on October 7, 2014, and hospitalized at Santa Maria delle Stelle Hospital in Melzo. The reasons for the TSO included psychomotor agitation, aggression towards others, and an overall diagnosis. The TSO was extended, and on October 14, two psychiatrists filed an urgent report stating that Lavorgna had assaulted his parents and a doctor, was unaware of his actions, and had to be constantly restrained. He was kept under pharmacological sedation until his transfer to another hospital on October 27, 2014.

The Court found that the Italian Government failed to justify the necessity of such prolonged restraint and did not demonstrate that it was a measure of "last resort" rather than a "precautionary" one.

PSYCHOSIS

Psychosis is a mental condition characterized by a loss of contact with reality. Individuals experiencing psychosis may have symptoms such as hallucinations (sensory perceptions without external stimuli) and delusions (false or irrational beliefs not shared by others).

Psychosis can occur in various disorders, including schizophrenia, bipolar disorder, and major depressive disorder, or be induced by substance abuse or underlying medical conditions. Treatment typically includes a combination of pharmacotherapy, psychotherapy, and psychosocial support.

PSYCHOTHERAPY

Psychotherapy is a clinical psychological and psychiatric treatment performed by licensed psychologists or physicians. It involves the treatment of various psychopathological disorders of different natures and severities through psychological techniques and therapeutic relationships.

PTSD – POST-TRAUMATIC STRESS DISORDER

PTSD is a psychopathological condition that may occur after experiencing

or witnessing a traumatic and extremely stressful event. It can affect individuals of any age or background and can significantly impair quality of life.

PTSD may result from physical violence (e.g., rape or assault), serious accidents, natural disasters, or other events that evoke intense and prolonged fear. Unlike a temporary emotional reaction, PTSD is a clinical condition that can persist for months or years, interfering with daily functioning.

RAPTUS (IMPULSIVE OUTBURST)

The term raptus refers to an impulsive action often linked to emotional, social, economic, or relational difficulties. **It is not a medical term and is not recognized as a mental disorder in international psychiatric classifications** such as DSM-5 or ICD-11.

Rather than a sudden and inexplicable act, it often represents the culmination of a complex personal history and distressing circumstances. While not necessarily indicative of a mental disorder, it may co-occur with conditions such as personality disorders or schizophrenia spectrum disorders, particularly when substance abuse is involved.

The term is frequently used in sensationalist journalism, especially in the context of violent crimes, to imply a simplistic narrative—"a moment of madness." However, violence is a human condition, not necessarily a symptom of a mental disorder. One can be violent without having a mental disorder.

SELF-INJURY

A behavior in which an individual deliberately harms their own body without suicidal intent, often as a means of coping with emotional distress or intense turmoil. Common forms include **cutting**, burning, or hitting oneself.

Self-injury is frequently associated with psychological difficulties such as depression, anxiety, borderline personality disorder, and significant past trauma.

Although it may provide temporary relief, self-injury does not address the underlying issues and can result in long-term physical and emotional harm.

SLD – SPECIFIC LEARNING DISORDERS

A group of neurodevelopmental disorders characterized by significant difficulty in acquiring and using specific academic skills, such as reading,

writing, or math. These challenges occur despite normal overall intellectual functioning and are due to differences in the way the brain processes certain types of information.

SLDs require careful diagnosis and an individualized educational approach. With appropriate support and strategies, individuals can often achieve functional compensation and reach their full potential.

The main types of SLDs are: **Dyslexia** (reading difficulties), **Dysorthographia** (spelling difficulties; referred to in DSM-5 as impairment in written expression), **Dysgraphia** (writing difficulties), **Dyscalculia** (math difficulties).

SUPPORT ADMINISTRATION (AMMINISTRAZIONE DI SOSTEGNO)

It's a legal measure introduced in Italy in 2004 (Law No. 6, January 9, 2004) to protect individuals who, due to physical or mental conditions, are unable to adequately manage their own interests. It is intended as a less invasive alternative to **interdiction** or **incapacitation**, aiming to provide the necessary support without stripping the individual of legal capacity.

The appointment process may be initiated by the individual, family members, the Public Prosecutor, or social and health services. A support administrator can be a relative, a trusted person chosen by the beneficiary, a professional (e.g., lawyer, accountant), a volunteer, or a representative from an organization supporting vulnerable individuals.

The duties of the support administrator are defined by the guardianship judge and may include: **managing finances** (e.g., paying bills, handling bank accounts, overseeing investments), **personal care** (e.g., health decisions, daily assistance), and **legal representation** (e.g., signing contracts, applying for benefits).

The administrator is subject to periodic review by the guardianship judge, and the appointment can be temporary or permanent, depending on the beneficiary's needs.

SPDC – PSYCHIATRIC DIAGNOSIS AND CARE UNITS

SPDCs are specialized hospital units within General Hospitals, forming part of the Mental Health Department. They provide acute psychiatric care during crises or exacerbations of mental disorders under inpatient settings.

Hospitalization is typically voluntary (Voluntary Health Treatment, VHT), but under specific conditions, Involuntary Health Treatment (IHT or

TSO) may be enacted. The length of stay depends on the clinical severity and is generally limited to the time necessary to resolve the acute episode, averaging around 12 days.

SYNDROME

A syndrome is a set of signs and symptoms that occur together and characterize a particular clinical condition or disorder. In mental health, a syndrome may involve changes in behavior, mood, or cognitive function that do not necessarily match a definitive diagnosis but may prompt further diagnostic assessment or treatment. An example is the mixed anxiety-depressive disorder, which includes symptoms of both anxiety and depression.

TOTAL INSTITUTION

A concept developed by sociologist Erving Goffman, total institutions are social environments that isolate individuals from broader society, subjecting them to strict control and loss of autonomy. In mental health contexts, this term applies to settings such as psychiatric hospitals, prisons, or care homes, where residents are governed by rigid routines, rules, and authorities. Such environments can negatively impact mental well-being, fostering feelings of dehumanization and stigmatization.

TSO – INVOLUNTARY HEALTH TREATMENT

IHT (Trattamento Sanitario Obbligatorio) involves the **restriction of individual freedom** solely for health reasons, applied when necessary care is refused. Hospitalization occurs in **general** hospitals within Psychiatric Diagnosis and Care Units, part of the Mental Health Department.

According to Article 34 of Law No. 833 (December 23, 1978), IHT may only be implemented if:

- The individual exhibits psychiatric alterations requiring urgent therapeutic intervention.
- The necessary treatment is refused by the patient.
- No suitable and timely outpatient alternatives are available.

IHT **must be ordered by the mayor** (in their role as Health Authority), based on a physician's **proposal and validated by a public health (ASL) physician**.

The Mayor's decree must be issued within 48 hours of the validation and submitted to the Guardianship Judge, who must confirm or reject the measure within 48 hours of admission through a reasoned decree.

Mental health and justice

Until the enactment of Law 180 in 1978, mental disorders were primarily managed under a justice-based rather than health-based framework.

Still today, some institutions and aspects of mental health fall under the jurisdiction of the justice system, rather than the health system—for instance, issues like legal incapacity, security measures, or the concept of social dangerousness.

Below are key examples:

INCOMPETENCY AND PARTIAL INCAPACITY (INTERDICTION AND DISQUALIFICATION)

These are **legal protection measures** restricting an individual's civil and property rights when they are found incapable of self-care due to a mental disorder.

- **Interdiction**: Full legal incapacity; a guardian is appointed to act on behalf of the individual.
- **Disqualification**: Partial legal incapacity; the individual may carry out certain acts only with a curator's assistance.

These have largely been superseded in practice by the **Support Administration** (Amministrazione di Sostegno) introduced by Law No. 6/2004, a more flexible legal instrument that allows the Tutelary Judge to delegate only specific domains (e.g., personal care or asset management) while respecting the principle of self-determination.

INTERNMENT / INTERNED PERSON

Today, the terms internment and interned are considered outdated and stigmatizing, associated with practices of institutional segregation that failed to uphold human rights and dignity.

Nonetheless, these terms remain in use legally and refer to individuals with mental disorders subject to custodial security measures, such as placement in a **REMS**.

Modern alternatives include:

- **Psychiatric hospitalization**: With a therapeutic, rights-based approach.
- **Residential treatment**: Long-term care in non-custodial settings, often lasting up to three years.
- **Outpatient psychiatric care / community-based treatment**: Prioritizing care within the community and minimizing institutionalization.

This shift in terminology reflects the broader move toward **deinstitutionalization**, focusing on **community integration** and respect for individual autonomy and rights.

OPG, REMS, ATSM – MENTAL HEALTH AND JUSTICE INTERFACES

Law 180 of 1978, a piece of civil innovation for our country, remained incomplete for over thirty years where the forensic asylum system was concerned — a system founded on fears surrounding the "criminal madman". For those individuals whom the law recognised as guilty but not responsible for their actions, a double tier of total institutions was envisaged: prison on the one hand, and the asylum on the other.

For this reason, the closure **of the — forensic psychiatric hospitals (OPGs, Ospedali Psichiatrici Giudiziari)** and the end of segregation within the asylum institutions set up for the "criminally insane" carries considerable cultural weight.

Launched in 2011, the reform reached its conclusion with Law No. 81 of 30 May 2014 — converting into law, with amendments, Decree-Law No. 52 of 31 March 2014, containing urgent provisions for phasing out the OPGs. This law introduced significant developments, both culturally and legally, in the treatment of people with psychiatric disorders who have committed an offence and are deemed socially dangerous.

The law provides for the closure of the OPGs, yet it does not do away with

the **"double track" of security measures set out in the Criminal Code**, nor does it address the epistemological **ambiguity of the concept of "social dangerousness" — a notion of a legal rather than scientific nature, with no evidentiary basis.**

For individuals who have committed an offence, the double-track system provides for one of two paths: criminal responsibility and the imposition of a sentence, or lack of criminal responsibility and, where social dangerousness is established, the imposition of a security measure.

With the OPGs abolished, the law provides for the establishment **of Residences for the Execution of Security Measures (REMS, Residenze per l'Esecuzione delle Misure di Sicurezza)**, facilities within the National Health Service under the exclusive management of health authorities. REMS facilities fall, in fact, under the Mental Health Departments of the relevant local health authorities (ASLs). These are residential facilities with therapeutic-rehabilitative and socio-rehabilitative functions, intended for transitory and exceptional stays only. Indeed, admission to a REMS applies "only in cases where evidence shows it to be the sole measure suitable for ensuring adequate care and addressing the social dangerousness of the person found to be mentally ill or of diminished capacity" (Law 81/2014).

To avoid the risk of a so-called "**white life sentence**", the law establishes that neither detention-based security measures — whether provisional or definitive — nor stays in REMS facilities may exceed the length of the custodial sentence provided for the offence committed.

Alongside this, prisons have introduced **"Mental Health Protection Units" (ATSM — Articolazioni per la Tutela della Salute Mentale)**, intended for detainees who develop a mental illness while in custody. These units are not present in every region.

In the years following the closure of the OPGs, a waiting list built up of several hundred people awaiting admission to a REMS. For some of them, the courts ordered temporary supervised release in residential psychiatric facilities; in other cases, they were admitted — clinically inappropriately — to hospital psychiatric services; and in some instances, for security reasons, they remained in prison despite not being criminally responsible. Italy has, in fact, been condemned by the European Court of Human Rights over this situation (*see Sy v. Italy*, judgment of 24 January 2022; *Pintus v. Italy*, judgment of 1 May 2024), and the Constitutional Court has already weighed in with Ruling No. 22/2022, calling for the "urgent need for a comprehensive systemic reform," while affirming the constitutional legitimacy of the OPGs' closure.

PSYCHIATRIC DISORDER DEVELOPED DURING IMPRISONMENT

Following Law No. 81/2014, which definitively closed the Judicial Psychiatric Hospitals (OPG), prisoners who develop a psychiatric disorder are not transferred to REMS (Residences for the Execution of Security Measures) but can be treated within the prison system in specialized sections called ATSM (Mental Health Protection Units).

Constitutional Court ruling No. 99/2019 affirmed the equal dignity of physical and mental health, introducing the possibility of "humanitarian" or "exceptional" home detention, even for prisoners with more than four years of remaining sentence.

This is authorized by the Supervisory Judge, provided public safety is not at risk, and must be accompanied by care obligations under the local Mental Health Department (ASL) and social reintegration pathways.

SECURITY MEASURES

Security measures are **special legal provisions** under Italy's Criminal Code, applicable to individuals deemed socially **dangerous**.

Italian penal law follows a **dual-track system**:

- **Penalties**:
  Traditional sanctions based on proven guilt, proportionate to the crime, and aimed at rehabilitation.
- **Security measures**:
  Based on the individual's social dangerousness, not guilt. Regulated by Articles 199–240bis of the Criminal Code, they are non-penal administrative measures. Before 2014, these had indeterminate durations, continuing until dangerousness was deemed to have ceased—leading to cases of de facto life sentences ("white life sentences").

Security measures can be:

- **Custodial**: Agricultural colonies, workhouses, REMS. Affected individuals are still legally termed **interned**.
- **Non-custodial**: Supervised liberty, residency bans, no-contact orders, deportation of non-citizens.

They may be imposed Immediately, e.g., no-contact or residency bans, or in addition to a sentence, e.g. agricultural colonies, workhouses or deportation of non-citizens. In the case of REMS, internment is provided for individuals who have committed a crime but are **recognized as not accountable but socially dangerous**. REMS admission may occur after sentence completion in semi-insanity cases.

Security measures are ordered by the judge in the same ruling that determines guilt or non-imputability. Their implementation and revocation are overseen by the supervisory judge.

SOCIAL DANGEROUSNESS

Social dangerousness is a **legal concept**, used to assess whether an individual poses a potential threat to public safety or others.

It is not a psychiatric diagnosis, but mental health assessments may contribute when behaviors linked to risk are associated with psychiatric disorders.

This concept plays a central role in criminal law, particularly in determining eligibility for security measures in cases of legal insanity.

TOTAL/PARTIAL INCAPACITY TO UNDERSTAND AND TO WILL / LEGAL INSANITY

This refers to a mental condition where a person, due to psychiatric illness:

- **Cannot understand** the nature or unlawfulness of their actions (incapacity to understand),
- **Cannot act consciously** or exercise free will (incapacity to will).

This condition may arise from severe psychiatric illnesses such as psychosis or neurological disorders and has significant implications for **criminal responsibility**.

The term "**mental insanity" (vizio di mente)** is a legal term indicating a mental state that impairs judgment and volition due to a psychiatric disorder.

WORLD MENTAL HEALTH DAY

World Mental Health Day is celebrated annually on October 10 to raise global awareness and mobilize support for mental health.

First observed in 1992, it is promoted by the World Federation for Mental Health and supported by the World Health Organization (WHO).

Stigma is an attribute that produces deep discredit: in our minds, we downgrade the person from whole to tainted. Stigma is a rupture between virtual social identity and actual social identity.

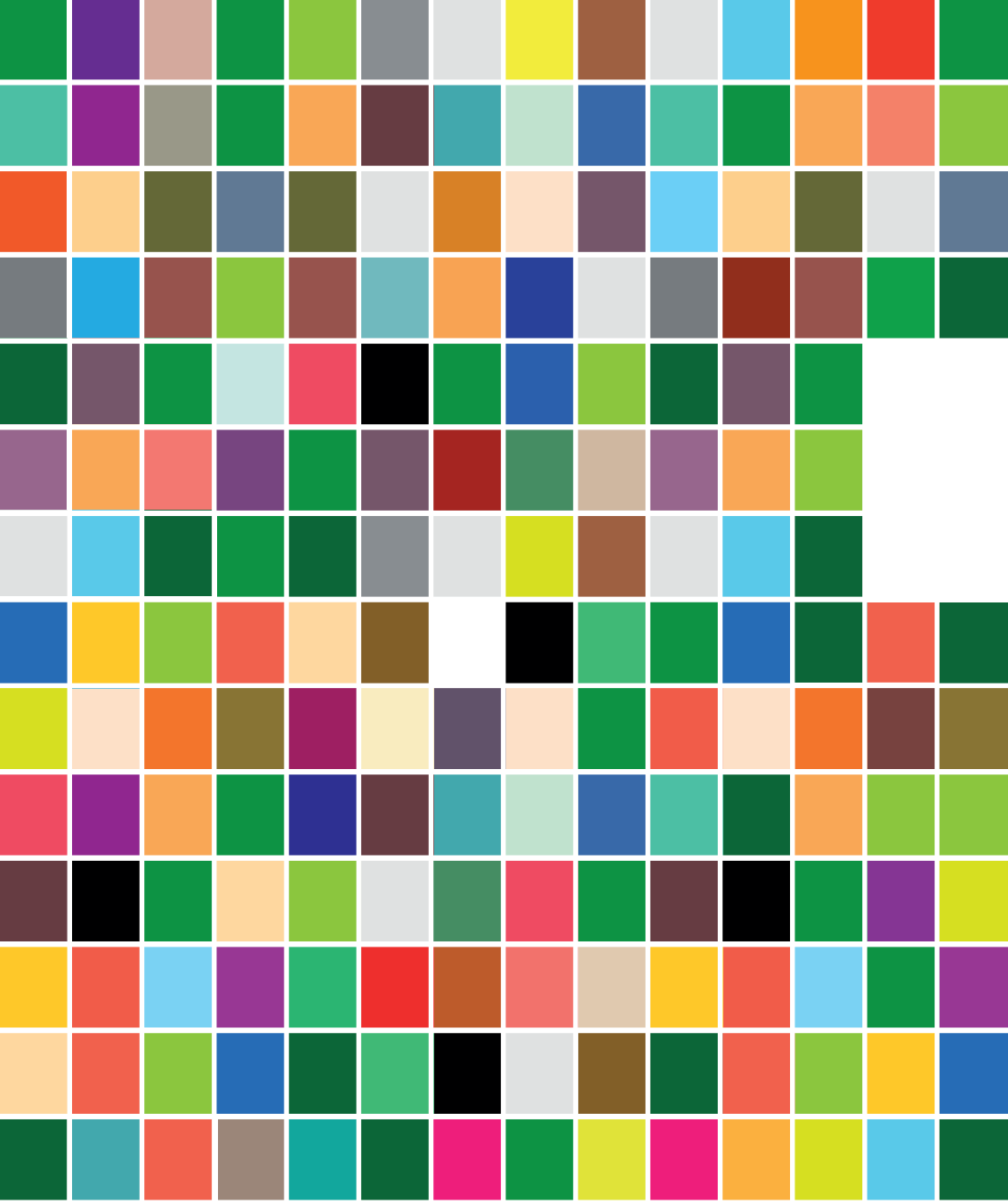
Erving Goffman 1922-1982

Perhaps today's main goal is not to discover what we are, but rather to refuse what we are. We must imagine and build what we might become.

Michel Foucault 1926-1984

Things can be done differently, because there is another way of approaching "the issue," even without coercion.

Franco Basaglia 1924-1980



ORDINE DEI GIORNALISTI
CONSIGLIO NAZIONALE

Rai Per la Sostenibilità ESG

SISTEMA SANITARIO REGIONALE
ASL ROMA 2
REGIONE LAZIO