Law and Incapacitation: Empirical Insights into Mental Health Compulsory Treatments

Il diritto che genera incapacità: evidenze empiriche sui Trattamenti Sanitari Obbligatori (TSO) per salute mentale

Carolina Di Luciano[1], Michele Miravalle[2]

Abstract

Compulsory Health Treatment (TSO) for mental illness constitutes the primary form of "coercive care" in Italy, as recently reaffirmed by the Constitutional Court (judgment no. 22/2022). Drawing on the work of the Observatory on TSOs in the City of Turin, this study analyzes over 1,000 case files relating to TSO procedures carried out between 2017 and 2023, including validation orders issued by both the mayor and the guardianship judge. In addition, semi-structured interviews were conducted with healthcare professionals and local police officers involved in the procedures. The findings reveal a high degree of standardization within the administrative-judicial process which, despite being formally grounded in robust legal safeguards, operates in practice as a form of routinized justice characterized by medical dominance over other institutional actors. The analysis further suggests that the TSO is increasingly embedded in a paradigm marked by a renewed emphasis on practices of social control and can be interpreted as a *dispositif of incapacitation.*

Keywords: psychiatric care, coercive treatments, routine justice, medical dominance, mental health

Sommario

Il Trattamento Sanitario Obbligatorio (TSO) per malattia mentale rappresenta il principale caso di "cura coattiva" in Italia, come recentemente ribadito dalla Corte Costituzionale (sentenza n. 22/2022). Nell'ambito delle attività dell'Osservatorio sui TSO della Città di Torino, sono stati analizzati oltre 1000 fascicoli relativi ai TSO eseguiti nel territorio cittadino nel periodo 2017-2023, contenenti i provvedimenti emessi dal sindaco e dal giudice tutelare. Inoltre, sono state condotte interviste con operatori sanitari e di

1 Dipartimento di Giurisprudenza, Università di Torino. carolina.diluciano@unito.it.
2 Dipartimento di Giurisprudenza, Università di Torino. michele.miravalle@unito.it.

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Polizia Locale coinvolti nelle procedure. Dallo studio emerge la standardizzazione della procedura amministrativo-giurisdizionale che, pur strutturata su un iter fortemente garantista, si configura oggi come un tipico esempio di giustizia routinaria e di dominio del sapere/potere medico rispetto agli altri attori coinvolti nella procedura. L'analisi conferma come il TSO si inserisca sempre più nel paradigma di un ritorno a pratiche di controllo sociale e può essere considerato un *dispositivo di incapacitazione.*

Parole chiave: assistenza psichiatrica; trattamenti coattivi; giustizia routinaria; dominanza medica; salute mentale

1. The Compulsory Health Treatment (TSO) "in action", the case-study of Turin[3]

Mental health compulsory medical interventions constitute the core focus of this study. They are a highly contentious subject within the both domains of medicine and law. These measures pertain to scenarios wherein an individual is hospitalized and/or subjected to treatment against their will. Compulsory interventions are generally justified on the basis of two fundamental conditions: first, the protection of the health or life of the individual concerned; and second, the protection of others. As further explained below, Italian legislation provides that the principal legal mechanism for imposing medical treatment without informed consent is the procedure known as *Trattamento Sanitario Obbligatorio* (TSO) procedure.

The objective of the present research is to empirically ascertain how such procedure is interpreted by the local professional cultures of the various actors involved.

In designing this empirical research, we have decided to explore a specific case study, the city of Turin. The analyses and reflections presented in this article are therefore specific to this particular field of research, and it would be incorrect to extend or generalise them. Instead, this methodology could be replicated in other contexts in the future. This metropolis, located in northern Italy, is home to over a million inhabitants and exemplifies the distinctive features of large European urban agglomerations in the post-industrial era. Indeed, Turin was recognised as one of the world capitals of the automotive industry in the twentieth century, subsequently it has faced radical urban and socio-economic transformations in recent decades. In the contemporary era, the city of Turin is an economic entity that is predom-

3 The research has been jointly conducted by both authors. Michele Miravalle has written paragraphs 1, 2 and 3, Carolina Di Luciano has written paragraphs 4, 5, 6 and 7. Conclusions have been edited by both authors.

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inantly reliant upon the tertiary sector and the provision of services, with tourism being a recent addition to the economic landscape.

In this scenario, the overall objective of the research was to comprehend the manner in which mental health protection aligns with the dual imperatives for *care* and *control*.

The city of Turin is an intriguing case study in this regard, due to a tragic event that occurred in 2015.

In Turin, on 5th August 2015, Andrea Soldi died as a consequence of a compulsory health treatment (TSO) that was conducted in an improper manner and with excessive force by the local police and healthcare professionals. Andrea, aged 45 at the time, had been living with a diagnosis of schizophrenia. He was a well-known patient by local healthcare professionals and the neighborhood community. His death occurred in a public square in broad daylight. This event has had a profound impact on the collective consciousness of Turin (Spicuglia 2021).

Consequently, the municipality, in collaboration with healthcare authorities and law-enforcement agencies, implemented specific training initiatives and a comprehensive overhaul of TSO procedures: a new collaborative protocol has been signed between healthcare professionals and law enforcement agencies concerning operational practices.

Andrea Soldi's tragic death could be considered as a collective trauma, frequently recalled during our research, especially in interviews and focus-groups. It surely remains firmly entrenched in the collective memory of health and police workers even ten years later. However, Andrea Soldi's name is never mentioned, and instead expressions such as "the serious incident" or simply the "incident" are used.

The most recent output of the activities carried out in Turin regarding the Compulsory Health Treatments is the Observatory on TSOs, formally established in 2022 by the City of Turin[4]. Thus far, the experience has been without parallel at the national level. The Observatory has been established with the objective of analysing TSO cases that have been carried out in Turin over the past decade. Among different qualitative and quantitative methods implemented by the Observatory, in this article we will mainly analyse semi-structured interviews and focus-groups conducted with personnel involved in administering these treatments[5]. This research activity in

4 The Observatory is composed of the University of Turin, the Municipality of Turin – in particular, the Ombudsman for the Rights of Persons Deprived of Liberty, the Welfare Department with the TSO delegation, and the Department of Security Policies and Local Police – as well as the Local Health Authority (*A.S.L. and A.O.U. Città della Salute e della Scienza*) and the Court of Turin.

5 Semi-structured interviews were conducted with psychiatrists, some working in the city's main SPDC (Mental Health Department of the hospital), others in two different CSMs (Community Mental Health Services), one interview with the Commander of the

particular has been undertaken by a team of sociologists and lawyers from the University of Turin between 2023 and 2025. This article presents some of the findings resulting from such empirical socio-legal analysis.

2. The assumptions to disprove: the Compulsory Health Treatments as emergency and extraordinary procedures

At the beginning of the research, a series of assumptions were formulated, primarily inspired by the in-depth analysis of the national legal framework, specifically with regard to the definition of Compulsory Health Treatments (TSOs). In accordance with the prevailing legal framework, we have assumed TSOs represent a set of *extraordinary* procedures that are undertaken in an *emergency* where there is an imminent threat to the patient's well-being or that of others. As will be demonstrated in the following pages, both of these assumptions – the *extraordinary* and the *emergency* related to an existing *danger* – have been disproved by the research results.

We define TSOs as *extraordinary* in light of the fact that they should be interpreted within the broader Italian psychiatric tradition. This tradition differs radically from that of other countries. Italian psychiatry is significantly influenced by the "revolutionary" vision proposed by the school of psychiatrist Franco Basaglia (Foot 2023), which is characterized by its dem-

Local Police responsible for TSO activities, and two focus groups with local police personnel, both from the territorial service and the special operational service assigned to this activity. The empirical insights have been also collected from official meetings of the Observatory (six sessions in total). The personnel selected for the interviews were chosen according to the following criteria. For healthcare personnel, two CSMs were identified, easily accessible for the field due to the inclusion of the director of the reference DSM within the working group. In any case, the centers were located in an area of the city where, according to the quantitative data collected, there was a high use of compulsory health treatments. Furthermore, although belonging to the same territorial unit (so called ROT), they are located in two different areas of the city: one more central and affluent, the other more peripheral and working-class. The chosen SPDC is located within the city's university hospital and also serves as a reference for admissions from outside the province and region. In selecting the interviewees, attention was paid to years of professional experience and gender. As for police personnel, members of the ROS (special operational service), trained to carry out TSOs, and members of the territorial service, with various years of professional experience, were interviewed. Again, the selection took into account different qualifications (officers, agents) and the gender of the interviewees.

The quantitative data presented come from a long-lasting analysis of all the files of TSOs carried out in the city of Turin between 2017 and 2023. These files are stored in a specific public office of the City of Turin. Every file has been read, anonymized giving an alphanumerical code to each case and then a series of relevant data regarding both the patients and the procedures have been extracted and finally compared.

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ocratic approach. This tradition will reach its zenith with the "great reform" of closing civil asylums with l. 180/1978.

Indeed, between 1968 and 1990, Italy established the most notable example of deinstitutionalization, adopting a community-based and non-segregating approach to individuals with mental disorders (*ex multiis,* Saraceno 2024).

In the contemporary era, Italy stands as a rare example of a nation where psychiatric asylums are not only illegal but have also been permanently closed. The regulatory choice made in 1978 endures, despite much criticism and several attempts to revise it. As a consequence, every involuntary treatment of psychiatric patients is prohibited by law. Also, hospitalization can only take place on a voluntary basis and are confined to public hospitals, within designated wards known as Psychiatric Diagnostic and Treatment Services (the so called, SPDCs).

In accordance with such a reforming spirit, all forms of segregation and degradation of the mentally ill have been formally abolished, thereby recognising the full agency and autonomy of the mentally ill person in the choice of treatment.

Consequently, since 1978, all forms of involuntary or forced hospitalization have been deemed unlawful, with one exception: precisely Compulsory Health Treatment, the subject of this research. In all legal systems, forms of coercive treatment that can "overcome" the refusal to treatment deemed urgent and not deferrable are provided (Hachtel et al. 2019). However, in Italy, these forms of treatment take on a peculiar meaning.

The legal provision known as Law 833/1978, which was enacted in the period following the passing of Law 180/1978, does not impose any restrictions on the practice of compulsory health treatment. This legislative act acknowledges the nature of compulsory health treatment as an exceptional measure, a standpoint that assumes particular significance when evaluated from the perspective of socio-legal studies. The legislative body conceptualised the TSO procedure as a means to ensure consistency with the principle of emancipating and not segregating psychiatric patients.

The primary feature that renders TSOs *extraordinary* is their capacity to incorporate distinct groups of actors, each reporting to disparate lexical registers, modes of operation and hierarchies. Consequently, a complex procedure is envisaged, albeit with contingent and expeditious time frames, involving healthcare practitioners, administrative authorities, law-enforcement agencies and, lastly, the judicial authority.

In the field of healthcare, there are distinct roles and responsibilities that individuals assume in relation to the administration of compulsory health treatment. At the core of this process is the function of the healthcare professionals, whose duty it is to "*propose*" such treatment. These professionals

are tasked with the evaluation of the existence of the requirements of the norm.

Subsequently, the administrative authority, such as the mayor and his delegates, plays a crucial role in authorising the compulsory treatment. Then, the judicial authority, as the jurisdictional operator, is entrusted with the responsibility of validating the entire procedure. A fourth group, the police operators, are responsible for the material execution of the treatment or involuntary assessment, including through the use of force. At the normative level, law enforcement agencies, most commonly municipal police forces, are seldom designated as the primary actors in the procedural process. However, when considering the factual level, these agencies assume a significantly relevant role, as delineated by the recommendations established and endorsed in 2009 by the State-Regions Conference (Passerini, Arreghini 2019).

Each of these operators is thus obliged to fulfil a specific role, which, in a complicated system of checks and balances, depends on and is conditioned by that of the others.

From a socio-legal standpoint, it is evident that the objective of this intricate procedure is to establish TSO as a measure that transcends mere health concerns. So, TSO is justified by health conditions, but it is not solely a health practice. It is possible to interpret the legislature's intention as being to limit the power of the medical and psychiatric professions within the context of a procedure that can be regarded as a form of deprivation of personal liberty and a restriction on an individual's rights.

As will be demonstrated in the following analysis, this legislative intent is not reflected in the observations made during the course of the research. The reason for this is the dominance of healthcare practitioners in every phase of the procedures, which renders the other actors' roles almost irrelevant.

The definition of TSOs as an *emergency* measure to prevent possible danger has been our second assumption. In other words, the manifest purpose of involuntary treatment seems to "sacrifice" the need for the patient to provide informed consent, on the grounds that this would endanger the patient themselves and others.

However, an analysis of the empirical material collected reveals that practitioners tend to distinguish between *"emergency"* and *"urgency"*, even at the lexical level. This is one of the most interesting data that emerges from the research. It is evident that both terms share a common characteristic, namely that of being non-deferrable. However, there is a divergence in the level of predictability. Emergency situations are inherently unpredictable, whereas urgency is a more predictable phenomenon. In accordance with the prevailing interpretation in the local context, TSOs in Turin are classified as urgent procedures, i.e. they are not subject to deferral but are predictable.

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While superficially reducible to issues of lexis and semantics, this phenomenon exerts a profound influence on the practices and the legal nature of the type of interventions that health care and police concretely carry out. Indeed, as will be demonstrated in the following discussion, all interventions classified as emergency are legally interpreted as those carried out within the limits of the *state of necessity*. In such cases, the TSO procedure is never initiated.

3. The Compulsory Health Treatments as a contemporary example of dispositif of incapacitation

Therefore, if, considering the "law in action" perspective, TSOs are not merely extraordinary and urgent medical procedures, how should they be interpreted from a socio-legal perspective?

The sociological definition that bests frames TSOs as observed during the research is that of a *"dispositif of incapacitation"*.

We therefore explicitly refer to Foucault's concept of "dispositive" (or "apparatus", as Agamben would translate it). In Foucault's interpretation the dispositive is the

> Heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions–in short, the said as much as the unsaid (Larroche 2019, p. 83).

If we also recall the concept of incapacitation, we would define a dispositive of incapacitation as the articulated ensemble of practices, knowledges, norms, and institutions through which a society actively excludes certain individuals from full participation in social, political, and economic life, legitimizing such exclusion through diagnostic, moral, or legal categories. Unlike mere material exclusion, incapacitation operates on a discursive and performative level: it does not simply remove, but actively constructs certain subjectivities as "incapable"—unreliable, irrational, or non-autonomous—thus legitimizing protective, segregative, or neutralizing measures. As such, the dispositive of incapacitation functions as a mechanism of power that acts through the social production of minority or incompetence. It often unfolds within biopolitical regimes and manifests in institutional contexts such as psychiatry, juvenile justice, welfare systems, and the governance of disability and poverty.

Foucault and post-Foucauldian authors such as Judith Butler, Nikolas Rose and, above all, Robert Castel base their reflections on incapacitation

devices, bearing in mind what George Canguilhem wrote in his revolutionary work *The Normal and the Pathological* (1966).

Canguilhem strongly criticizes the neutrality of medical knowledge and in particular of psychiatry, saying that concepts such as "normality" and "pathology" are neither subjective nor scientific, but normative, i.e., the result of evaluations and interpretations.

In order to draw the line between what is normal and what is pathological, medicine also needs incapacitation devices.

Traditionally, incapacitation devices have been reserved for "dangerous classes", as defined by Louis Chevalier in his *Classes laborieuses, classes dangereuses* (1958). An individual and his social group became dangerous depending on economic, social and historical factors and the definition is a constantly evolving assessment.

Robert Castel (1991), however, points out that incapacitating devices in contemporary society affect not only "dangerous" individuals, but also those who merely pose a "risk".

Therefore, Robert Castel defines the concept of "risk" distinctly from the concept of "dangerousness", which had previously characterized the treatment of marginalized or vulnerable social categories. In his analysis, risk does not refer to an immediate and tangible threat stemming from an individual's intentions or actions (as was the case with dangerousness), but is understood as a predictive and probabilistic condition.

This shift is not merely semantic; it entails a structural transformation in the logic of intervention. "Dangerousness" presupposes a subject endowed with a certain psychological or moral coherence, who can be analyzed and, if necessary, corrected or neutralized. "Risk", by contrast, refers to a set of impersonal variables, to a predictive profile situated on a probabilistic continuum. The subject is no longer judged based on what they are, but on what they might potentially become under certain conditions.

For Castel, risk represents a potential harm that may arise from a set of interconnected factors, but it is not directly attributable to a specific behavior. In other words, the individual is no longer judged based on their individual characteristics (such as deviance or pathology), but classified according to their position relative to certain statistical or probabilistic criteria. Risk is therefore linked to an anticipatory assessment of the conditions that could lead to a problematic event, such as illness, poverty, or criminality.

In this new logic, the subject is no longer seen as someone "who must be reformed", but as a "potential source of risk" requiring management. Risk is not tied to an intentional threat but to a set of factors that must be monitored and, in some cases, contained or mitigated.

In the shift from "dangerousness" to "risk", as Castel notes, control and management devices no longer act directly on the person as an individual, but on collective categories, on groups or populations, for whose manage-

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ment surveillance and preventive intervention mechanisms are employed. Managing risk involves constructing profiles of vulnerability and activating devices that intervene before a potentially problematic situation materializes.

For Castel, risk represents a form of preventive management that shifts attention from correcting deviance to regulating future probabilities through continuous management of social vulnerability.

This analysis has fundamental implications for understanding "dispositifs of incapacitation", for it is precisely within this context that subjectivity is deactivated. The subject is de-responsibilized—no longer addressed as a moral or legal agent, but treated instead as a bearer of risk factors: an object of technical intervention. Castel demonstrates that, in doing so, control mechanisms gradually erode the capacity for self-determination, rendering individuals increasingly dependent on logics of surveillance and assistance that, while framed as protective, in fact enact a profound delegitimization of social and political subjectivity.

Therefore, in Castel's vision

> what is emerging is not the administration of a definitive status, but the management of floating populations, or at least of populations perceived as unstable, precarious, or problematic. They are no longer dealt with in terms of integration or rehabilitation, but in terms of monitoring, support, or containment. The individual becomes less a subject of rights or obligations than the bearer of a potential risk, a case for intervention (Castel 1991, p. 288).

This dependency on medical treatment and erosion of subjectivity is clearly confirmed in the research, especially when we have discovered that 22% of people receive more than one TSO in the period considered[6]. This regularity definitely changes the aim of TSOs into a systematic apparatus on managing specific categories of individuals "at risk".

4. Old and new legal trajectories for the Compulsory Health Treatment (TSO)

Involuntary admissions and coercive psychiatric treatments, when regulated by specific legislation, generally follow one of two main models: the medical model and the legal model. In the medical model, healthcare professionals have the authority to impose treatment with little or no involvement from external authorities. In contrast, the legal model grants legal authorities the power to authorize, supervise, or enforce medical treatments, thereby limit-

6 Out of 1,058 individuals who underwent a TSO, 234 received more than one during the period under consideration.

ing the discretion of healthcare professionals (Wasserman et al. 2020; FRA 2012). Italy, in theory, aligns with the legal model; however, in practice, it more closely resembles the medical model, as we will further illustrate.

In the Italian legal system, healthcare is voluntary and contingent upon the patient's free and informed consent, in accordance with Articles 2, 13, and 32 of the Constitution and Law No. 219/2017. However, there are cases of non-voluntary medical treatments, that is, treatments administered without the consent of the individual. On this point, the Constitutional Court, in ruling no. 22/2022, although addressing a different issue[7], provided an important interpretation by distinguishing between compulsory health treatments and coercive medical treatments[8]. This distinction applies in the case of compulsory health treatment (TSO), mainly applied for psychiatric conditions and governed by Articles 33, 34, and 35 of Law No. 833/1978.

Beyond its coercive nature, there is another key distinction that sets the TSO apart from other forms of compulsory health treatment. According to the Court of Cassation, the TSO is a measure aimed exclusively at protecting the patient and cannot be regarded as a tool for social defense (Cass. civ., Ord. N. 509/2023; Cass. civ., Ord. N. 4000/2024; above all, most recently, Constitutional Court judgment no. 76/2025. See below). Historically, the TSO has represented the final stronghold of public authority exercised against the will of the individual, particularly individuals with mental illness. However, at least in formal terms, it is not a measure of public order and is therefore not intended to serve the protection of society. As affirmed by the Court (Cass. No. 509/2023), the TSO cannot be used to prevent or address a potential threat to the community.

According to the law, Compulsory Health Treatment (TSO) is a forced psychiatric admission carried out in the psychiatric departments (Servizi Psichiatrici Diagnosi e Cura - SPDC), and can only be ordered when three conditions are met simultaneously: (a) the person refuses medical care; (b) there are mental and behavioral disorders that require urgent therapeutic intervention; (c) there are no conditions or circumstances that allow the adoption of timely and suitable extra-hospital healthcare measures. For this procedure, the law establishes a three-layered safeguard: the validation of

7 The constitutional issue concerned the principle of legality, the legislative reserve, and the authority of the Minister of Justice in relation to the imposition of the security measure involving placement in a REMS (Residential Facility for the Execution of Security Measures).

8 According to the Constitutional Court, a health treatment is considered compulsory when it is mandated by law and its non-compliance is sanctioned with an administrative or criminal penalty. A paradigmatic example is compulsory vaccination. A treatment is defined as coercive when it may be enforced through the use of physical force, thereby limiting an individual's personal freedom.

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the first proposed treatment by a specialist in psychiatry, a reasoned decision by the mayor, and finally, a second judicial validation by the guardian judge, chosen by the lawmakers for being considered the "least criminalizing" figure[9].

The initial admission period lasts seven days and may be extended, indeed, the law does not set a maximum limit on the duration of coercive hospitalization. Any extension must be proposed by the attending physician and approved by the mayor, with subsequent validation by the magistrate. The law also sets out provisions to safeguard the rights of individuals during compulsory admission, ensuring that treatment is administered with respect for the person's dignity, moreover, hospitalization must be accompanied by efforts to secure the patient's informed consent and active participation[10].

In this context, a final mention must be made on a reform proposal currently under discussion in Parliament. The draft law n. 1179, in fact, introduces a significant innovation through Article 5, titled "Emergency Situations and Health Interventions", which substantially redefines the framework for compulsory health assessments (ASO) and compulsory health treatments (TSO).

The draft law codifies many of the practices we will examine later. Briefly, its re-centers attention on the use of ASO and TSO outside hospital settings—contexts that typically involve fewer procedural safeguards. It broadens the scope of permissible treatment locations and introduces the possibility of initiating compulsory treatment even before the mayor's validation is received. Moreover, the draft introduces a new condition for resorting to coercive treatment: "d) a high risk of clinical deterioration in the absence of intervention" (Article 5, paragraph 9). This effectively legitimizes the practice of preemptively imposing coercive measures to prevent crises, rather than responding to them, which is one of the most frequently observed practices in this research.

5. Medical dominance in compulsory treatments

The analysis of TSO validation files in the City of Turin allows for an assessment of the extent to which the legal safeguards described above are effectively upheld. As of this writing, files from the years 2017 to 2023 have been analyzed, encompassing a total of 1,468 TSO procedures—averaging approximately 200 per year.

9 Stenographic record of the XIV Commission on Hygiene and Health, session of May 2, 1978.

10 Individuals subjected to such treatment, as well as any other interested parties, may file an appeal before the competent Court. Article 35 also outlines the procedure for appealing the guardian judge's validation of compulsory health treatment.

The procedural data collected in the study reveals that mostly every TSO requests were automatically validated by both administrative and judicial authorities. Of the 1,468 cases examined, only nine were rejected, primarily due to procedural irregularities or subsequent developments—such as the physician withdrawing the request or the patient being untraceable[11].

In practice, all administrative or judicial TSO orders are typically issued using standardized pre-printed forms, with no specific reference to the individual case. This underscores a high degree of procedural standardization, in which validation is granted with little to no consideration of the unique circumstances of each case.

Such a formalistic approach raises concerns, particularly given that individuals subjected to TSO are not afforded an opportunity to be heard or to challenge the decision. The process is so routinized and automatic that it effectively excludes the patient from any participation. This lack of involvement significantly undermines the possibility for meaningful defense or personal agency in the process.

> Q: To what extent are patients aware that they are receiving coercive treatment, and do they know they can intervene personally?
> A: Yes, except for patients who are delirious, that is, those who have a TSO due to natural incapacity, other patients are aware that they are under TSO because we tell them so. They ask to leave or refuse the treatment, and you have to say no. The hospitalization was done precisely because they refuse the treatment, so there are also quite a few protests; some are even aggressive, trying to break down the door. It's not the norm, but there are those who express their dissent clearly.
> Q: And does it ever happen that they ask to speak with the judge?
> A: Very rarely, it has happened to me once or twice in 24 years.
> Q: Instead, do other officials, for example, municipal administrative staff or judges, ask you for information?
> A: Yes, it has happened that the TSO office asks because there are some errors in the ordinance, and they ask for clarifications, things like that.
> Q: But procedural, not regarding the patient's condition?
> A: No, someone has approached the guardian judge, I think one or two times in 5 years. Then, more than one patient, protesting, says they will now call their lawyer, but then they don't actually do it. Sometimes they call the police from the ward saying they are being detained, and then the more diligent officers might call and ask if Mr. So-and-So is hospitalized and if they are under

11 The administrative authority denied validation only in five cases: one due to a violation of notification deadlines, one for lack of territorial jurisdiction, and three because the request was withdrawn by the physician prior to the issuance of the order. The judicial authority denied validation in an additional four cases: two for delayed notification, one due to revocation by the mayor, and one because the TSO involved a minor and was carried out with the consent of the guardian, and was therefore considered voluntary.

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> TSO. (Interview with A., psychiatrist at the hospital's Department of Mental Health (SPDC), female, with over 20 years of service).

> They are absolutely told that if they are upset with the idea and do not agree, they can contact the lawyers. We even give them the phone number of the doctor's office to contact them, and if they want, we can also speak with the lawyer on their behalf. If they want to call the police, because that happens, or sometimes they call from their own phone, we explain to them that they can speak with the guardian judge if needed or write to them. I must say that, generally speaking, when they are this upset, it calms them down, meaning that they almost never do it. Maybe they call the lawyer, but the lawyers tend to be sensible and explain to them that the doctors believe… and sometimes they come to visit them...however, I have to say that by giving them this space, this somewhat aggressive need to throw it back at us—claiming that we are forcing them—often subsides. They are absolutely given the possibility, if they wish, to write with paper and pen. We give them paper and pen to write, rather than making phone calls. But I've never had to go to a magistrate to justify why I had to carry out a compulsory health treatment. (Interview with C., psychiatrist at the hospital's Department of Mental Health (SPDC), female, with over 20 years of service).

The formal issues briefly outlined above were addressed in a recent judgment of the Constitutional Court. For the first time, the Court amended the legislative provisions governing TSO, finding them to be in violation of the constitutional rights to defence and access to a fair trial[12]. The Court intervened by introducing the hearing of the person concerned by the guardianship judge during the course of the procedure, as well as the notification to that person of all acts relating to them, thereby restoring the individual's right to participate in the proceedings. At present, it is not possible to assess the impact that this amendment has had on the implementation of compulsory treatments; however, it is noteworthy that the Court left open the possibility for the judge, within the context of the hearing, to activate formal and informal protective measures for the patient. In doing so, the Court urged the legislature to intervene with regard to the direct appointment of a special guardian, circumstances that would bring the event of compulsory treatment closer to a recognition of the individual's legal incapacity, with significant consequences for the person concerned. In light of the observations made above (par. 3), this interpretative opening may be read as framing compulsory health treatment as a device of incapacitation.

The findings of the present study, developed prior to the legislative amendment, show that the existence of merely formal legal guarantees of participation and defence legitimises medical intervention overriding any individual safeguards, thereby reproducing the very "asylum logic" that the Basaglia

12 Constitutional Court, judgement no. 76/2025.

Law sought to dismantle[13]. Although the intention of the legislature at the time was to strengthen the system of guarantees in order to prevent medical necessity from justifying a measure involving deprivation of personal liberty, such guarantees today appear devoid of substantive meaning in light of a clear and concrete imbalance of power between healthcare professionals, on the one hand, and administrative and judicial authorities, on the other. This situation is unlikely to change if the newly introduced safeguards remain purely formal in nature.

> We never interface with anyone. Sometimes it happens with the TSO office, but only on formal matters, like signature, date, time, or something unclear from a formal point of view. But we don't have any contact with judicial authorities anymore. (Interview with C., psychiatrist at the hospital's Department of Mental Health (SPDC), female, with over 20 years of service).

> As far as I'm concerned, the figure of the guardian judge, who has 48 hours from the mayor's ordinance to validate the treatment, is someone I absolutely respect, of course, and I am sure they will do their job according to their expertise and conscience, but for me, they never interact with me. If the guardian judge, as they say, looks at my work, I don't know, I have no idea. If the patient is hospitalized, it gets to the SPDC, but the guardian judge, who I am sure does their job, is for me an irrelevant figure. (Interview with B., psychiatrist at the Community Mental Health Services (CSM), female, over 30 years of service).

> The judge doesn't even do a check, it's just a procedure now… Yes, it happened to me only once that I received a phone call asking for a clarification, maybe, but it happened two or three times as far as I can remember. (…) Once, maybe, for example, because the patient was already hospitalized and they asked, but it was really trivial things, absolutely. (Interview with C., psychiatrist at the hospital's Department of Mental Health (SPDC), female, with over 20 years of service).

> In my opinion, this bureaucratic process is protective for the patient in a certain sense, and I believe that the TSO, as a tool, is objectively a powerful tool. There's a significant limitation on freedom, and I realize that it has complicated implications. If you take a crazy psychiatrist, and there are some, and give them the power to carry out TSO, what can come out of it is terrifying. I think it has even happened in the past, so obviously there must be a system to protect the patient. I'm not sure if this method is working and functional for that, because right now it really seems like just a series of checkboxes that need to be ticked, because in the end no one has real control. It's true that it's not purely a healthcare task, but the procedure is in fact absurd (Focus group,

13 Cass. Civ., judgement no. 24124, 09/09/2024, para 4.8.

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psychiatrists of Community Mental Health Services (CSM), female, less than 10 years of service).

Drawing on Pierre Bourdieu's theory of the juridical field (Bourdieu 1987), the observed dynamics within the TSO process reveal a clear disjunction between the formal structures of legal oversight and the informal distribution of actual decision-making power. In the case of compulsory psychiatric treatment, the medical field, endowed with substantial symbolic capital, tends to colonize the juridical field, transforming what should be procedural safeguards into mere formalities. As stated by the interviewed psychiatrists, the safeguard authorities provided for by the law of the mayor and of the guardian judge seems to play an almost non-existent role in the actual implementation of coercive measures. Instead, the medical profession occupies a central position in defining, controlling, and legitimizing practices of psychiatric containment. This form of medical dominance (Freidson 2002) is grounded in the core assumption that only healthcare professionals possess the specialized knowledge required to act competently in such matters, thereby reducing other involved actors, such as the patient, family members, and non-medical professionals (the mayor, the guardian judge), to mere bureaucratic formalities. The full medicalization of the procedure effectively endows the physician with decision-making authority that goes well beyond therapeutic considerations, enabling control over the patient's coercive subjection within the context of compulsory admission (for instance, by influencing the duration of hospitalization).

6. The oxymoron of the "planned" TSO

The standardized nature of the administrative-judicial procedure appears even more incongruous when considering additional significant factors. In 70% of the TSO files analyzed in Turin, the subject was identified as a "known", "familiar", or "previously followed" individual. This data suggests that coercive treatment primarily targets individuals already in contact with or under the care of mental health services. This trend is further confirmed by the recurrence of TSOs: as mentioned, at least 22% of individuals during the analyzed period had undergone more than one TSO.

As revealed in interviews, the City of Turin, in the aftermath of Andrea Soldi's death, has developed a distinctive organizational model for managing psychiatric emergencies. This includes a shared intervention protocol between the local police and the Community Mental Health Services (CSM), a model now largely adopted across the region.

When the local psychiatrists detect early signs of a patient's potential relapse—such as missed appointments for long-acting medication or con-

cerns raised by family members—they initiate a graduated response. This typically begins with a relational approach, encouraging the patient to comply with treatment, which may include home visits or a compulsory health assessment (Accertamento Sanitario Obbligatorio, ASO). This is commonly a prelude for the TSO. If the patient remains unwilling, a mandatory medical evaluation is conducted, which may lead to further coercive measures if necessary.

This intervention requires careful coordination: the availability of a physician to conduct the visit, a second doctor to validate the treatment, the presence of law enforcement, and the assurance of an available bed at the hospital's psychiatric ward (SPDC).

Extensive information gathering is carried out by both CSM personnel and police officers. When possible, officers prepare a "risk assessment" of the patient, using data from CSM or their own inquiries. This assessment determines the composition of the intervention team, whether it should include specially trained officers from a dedicated unit (established in the wake of the Andrea Soldi case) or officers from the local territorial service. Although, as noted by the operators, a TSO is often predictable in how it begins but not in how it ends, the structured organization of the intervention provides them with greater confidence in achieving a successful outcome—defined as one that avoids excessive use of force and minimizes the expenditure of time and resources.

> The current situation is as follows: We are here, and then, well... The events that occurred here in Turin, aside from creating agreements with the ASL and so on, and that famous round table that was an attempt to... We set ourselves this goal, which is to work with maximum security to carry out this procedure, since the TSO is never an "emergency" intervention, but it is always a planned activity, which always allows for 24-48 hours to be organized. Sometimes there are relations with psychiatry, and we can even plan with more time... The goal is to collect as much information as possible about the person. The information is very diverse, but, for example... Clearly, we are not doctors, but knowing what kind of pathology they have is important for... the body type of the person, because depending on the body type, we can prepare the service with suitable staff, and so on... If they have had previous TSOs or even non-TSO situations where they have been violent... If they have engaged in anti-conservative actions... [..] For example, knowing if the person has a communicable disease, if they have any particular pathologies, if they are cardiopathic, etc., [...], we also need to know if there are relatives who can help or, sometimes, if not, sometimes relatives can be a triggering factor for particular situations, so we need to know that in order to try to identify non-obvious ways of managing things. [...] Based on all this information we gather, both from psychiatry, if they are already known subjects, from neighbors, or from other police interventions that may have occurred in other

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> situations, relatives, or anyone who can provide us with information, we basically decide which department should intervene. Usually, it's the territorial department from the area where the subject lives, so where the CSM (Mental Health Services) is located. If the situation, based on the information we have received, seems a little more delicate, the personnel from the Territorial Command is supported by personnel from the Special Operational Department. (Interview with D., senior officer of the local police force, male, with over 20 years of service).

The "planned" TSO has thus become a standard practice among Community Mental Health Services (CSM) and local police in Turin. Far from its original conception, TSO is often employed either as an anticipatory measure to prevent the onset of acute episodes — conditions which, according to the law, would typically justify the use of coercive treatment — or as a means of administering specific therapies, particularly in the case of long-acting injectable treatments. This constitutes a typical example of the control exercised over patients who avoid scheduled appointments for therapy administration, allowing for forced treatment through a single intervention that may not necessarily require prolonged hospitalization. While a full discussion falls beyond the scope of this work, the issue clearly raises numerous contradictions, particularly concerning the possibility of enforcing the validity of consent in relation to a therapy whose effects unfold over the long term (Daly 2024, p. 189).

> I'm not sure if it's still the case, but last year the officers were available only on Tuesdays and Thursdays. Not because you wake up in the morning and decide to do it, obviously these are emergency interventions. Sometimes the problem is that the legal definitions of what you're doing and the practice you can carry out, both for clinical reasons—which I think is the most important reason—and for bureaucratic reasons, which I find absurd, don't match up. Because sometimes I carry out an intervention that, by its very nature, must be done urgently. But in theory, I schedule a TSO a week ahead—does that make sense? Clearly, it makes no sense, but either you do it like that, or... (Focus group, psychiatrists of Community Mental Health Services (CSM), female, less than 10 years of service).

In different cases, it is not possible to "plan" the TSO, being perceived as too slow, bureaucratic, and obstructive. In such cases, actions are instead taken under the legal justification of a "state of necessity", as defined by Article 54 of the Penal Code. Medical professionals involved in these situations do not consider this legal framework to be a post hoc justification for unlawful conduct, but rather as "another procedure", an alternative and legitimate procedural route.

There is also another procedure, which is the state of necessity, where we intervene without TSO, because in real emergency situations, sometimes there's no time to organize everything. It happened to me once with a patient on a balcony who was about to jump, and you have to catch them and contain them, you can't perform this procedure because it's a state of necessity; you do it and then you calmly do everything else... But in somewhat planned situations, generally, we have a moment with the law enforcement officers where we explain the problem a bit, even from a logistical point of view because everything is planned to minimize the risks. For example, the situation is clearly different if you are going to a raised floor with a single window that opens onto a small courtyard, or to the eighth floor of a building. The police also ask about these logistical situations to understand how to intervene.
[...]
But I definitely think that some procedures are not that efficient, because it's fine for there to be a psychiatrist, it's fine that a proposal is made for validation, etc. But the fact that you don't lift a finger until the request from... that in fact, let's be honest, is a bureaucratic practice because there's no one assessing if what you wrote is true or not. I mean, you just stamp it and sign it, okay, fine, but this is an aspect that often holds us back, and from our point of view, in our intervention, it can become problematic. I've spent four hours with a severely ill patient, in an acute psychotic crisis, at home, yes, with law enforcement, and I'm supposed to wait for that paper to arrive. In my opinion, this is a critical aspect because it can be dangerous. Every minute you're in such a situation with the patient, who may be thinking of how to act against you, and you have to wait for this damn paper signed by the mayor to arrive, sometimes it puts us in check... (Interview with E., psychiatrist at the Community Mental Health Services (CSM), male, over 30 years of service).

Well, I wouldn't know how to think differently or better. It's clear that we find ourselves a bit between a rock and a hard place, almost always operating within the framework of Article 54 of the Penal Code. We almost always act based on a state of necessity, yes, it's clear I don't know if it can be done differently, because it's evidently not going against a rule which, in my opinion, is fair enough. But it's clear that 48 hours from the proposal for validation to a possible ordinance can feel like an eternity, and another 48 hours from the confirmation of a guardian judge, well, then anything could happen, so in reality, a lot of what is done clinically with patients, to hold them still if they want to jump off a balcony or administer therapy because they are doing things that put them and others at serious risk, is done under Article 54. That's the problem, though—it's a big gap because Article 54 wasn't designed for a medical act. The TSO, on the other hand, is designed in a healthcare context, but perhaps one is too protective, the other is too vague, and there's no middle ground. (Interview with F., psychiatrist at the hospital's Department of Mental Health (SPDC), male, with over 20 years of service).

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The outlined framework reveals the selective criteria through which healthcare professionals regulate therapeutic practices within the context of compulsory treatment. The TSO emerges as a practice predominantly applied to a particular patient profile—typically Italian, already engaged in treatment for a specific diagnosis, and possessing a social support network. It also reveals a legal gray area, wherein coercive measures are sometimes implemented via the formal procedure, while in other instances actions are taken without clear procedural safeguards. In such cases, the assessment of consent and medical necessity is left entirely to the discretion of the healthcare provider. This approach reveals an underlying criterion of selectivity - and almost of perceived eligibility - in determining who will be subjected to a TSO, complete with its formal, albeit hollow, safeguards, and who will instead be managed through an emergency intervention.

7. The metamorphic scope of the TSO

The TSO thus functions as a metamorphic instrument, primarily used to manage known patients whose adherence to treatment requires oversight. In other cases, the boundaries of its application become blurred, hinging on the specific behaviors exhibited by the individual. Not infrequent, but more marginal, are the instances in which a person displays behavior that, although socially nonconforming, does not pose an immediate danger nor constitute a criminal offense. In such situations, law enforcement may turn to healthcare authorities in search of an immediate response. However, since no actual medical emergency is present, the use of TSO in these cases would not be appropriate. Ultimately, the decision rests with the individual operator, who must navigate the delicate balance between care and control.

> Because they know and don't know, because sometimes they bring in the internist, for instance in the emergency room, which is the front line, but then they tell you that the police arrived with a TSO, because they come in saying, "You have to do the TSO," maybe at triage, and then they leave. They tell you, "You have to do the TSO because there's a behavioral emergency," but they don't explain why, and then they leave, expressing a judgment that is healthcare-related. The TSO is something I decide if it should be done or not, the doctor decides, not the police officer. I need you, the police officer, to help me understand what happened because you brought the patient here, but you might tell me the patient is drunk, and when they've sobered up from their four beers, they'll go back to being their usual self. So, obviously, they don't need a TSO. (Interview with C., psychiatrist at the hospital's Department of Mental Health (SPDC), female, with over 20 years of service).

Law No. 180 of 1978, which laid the foundation for the regulation of compulsory health treatment, aimed to close psychiatric hospitals while simultaneously opening local centers for the care and treatment of individuals with mental disorders. Within this framework, the doctor–patient relationship assumed a central role, emphasizing personalized treatment paths that considered not only clinical symptoms but also environmental, social, and relational factors. Today, however, territorial mental health services face increasing pressure due to various factors, including the expansion of diagnosable psychiatric conditions and the reduction of stigma surrounding mental health issues. Despite these developments, there has not been a corresponding enhancement of available services, which are now often unable to provide timely and comprehensive care. This gap has led to a growing reliance on pharmacological interventions as the primary form of treatment.

> There is also the organizational aspect, in the broad sense, that we have fewer resources. So, when you can't manage, we are three, and we cover a population of 50-60 thousand people, with about 2,000-2,500 patients in care. Now, you understand that out of these 2,500, we mainly focus on the most severe conditions. Being three doctors, you understand that following these patients consistently can be difficult at times. It's clear that with fewer resources, patients are seen less frequently, so there is less monitoring. Therefore, it's easier that when you do see the patient, they are either decompensated or are in the process of decompensating. So, certainly, with a stronger territorial system, it would likely be easier to prevent this. (Interview with E., psychiatrist at the Community Mental Health Services (CSM), male, over 30 years of service).

> So, in my opinion, there are cases where unfortunately you can't do otherwise because you have to do it. Mental illness is complex, and at certain times, a person may not be able to make decisions for themselves. However, sometimes it may be slightly, let's say, abused. Not all the TSOs I've carried out and witnessed fit perfectly into the situation I'm describing. It's also true that when you have few resources—whether it's personnel, economic resources, or time—the result is that those patients are not followed as they should be. And then, at some point, you find yourself in a situation where if a caregiver didn't have 450 patients, they probably would do fewer TSOs, but when you have 450, you end up losing track of some patients. (Focus group, psychiatrists of Community Mental Health Services (CSM), female, less than 10 years of service).

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8. Conclusions

The analysis of Compulsory Health Treatments (TSO) in Turin certainly reveals a contrast between the formal legal safeguards designed to protect individual rights and the routine practices observed in the field. While the law establishes the TSOs as an emergency and extraordinary measures with specific legal guarantees, in practice these mechanisms often amount to little more than formalities, with limited oversight and minimal patient involvement. Following this interpretation, the pervasive role of medical dominance is evident, as a structural imbalance that allows healthcare professionals to exercise considerable discretion and authority within a system ostensibly based on inter-institutional checks and balances.

Medical dominance is not merely symbolic and it finds its clearest expression in the emergence of the "planned" TSO. Rather than representing an urgent or exceptional response, the TSO is frequently applied to patients already well known to the system, typically those perceived as noncompliant or at risk of decompensation. The power to selectively determine when and to whom coercive care is applied illustrates the extent of professional discretion. In this way, the TSO—stripped of its symbolic status as an exceptional intervention—becomes a routine therapeutic practice, or a preventive tool for managing the perceived risks associated with individuals experiencing mental health issues.

Although this issue requires further empirical investigation, the analysis points to a significant division between so-called "long-term" —or "elite"— patients, for whom authorities mobilize complex and resource-intensive procedures such as TSOs, and less visible, institutionally marginal—or "underdog"—patients, for whom more informal or expedited practices are adopted to obtain adherence to treatment. Following Robert Castel and the post-Foucauldian tradition, TSOs can thus be seen as a contemporary manifestation of a *dispositif of incapacitation*.

Reform projects aimed at "simplifying" the TSO procedure, by expanding the discretionary authority of healthcare professionals and dismantling safeguards framed as bureaucratic obstacles, would further distance Italy from the tradition of democratic psychiatry that has historically defined its approach to mental health care. At the same time, they would contribute to transforming TSO into an increasingly routinized healthcare practice, including for interventions such as the administration of long-acting medication.

References

Bourdieu, P., (1987), The Force of Law: Toward a Sociology of the Juridical Field, *Hastings Law Journal*, 38, 5, pp. 805–853.

Castel, R., (1991), From dangerousness to risk, in G. Burchell, C. Gordon, P. Miller, eds., *The Foucault Effect: Studies in Governmentality*, Chicago, University of Chicago Press, pp. 281-298.

Chevalier L., (1958), *Classes laborieuses, classes dangereuses*, Paris, Éditions de Minuit.

Daly, E., (2024), *Profili costituzionali dei trattamenti medico-psichiatrici,* Pisa, Pacini Giuridica.

Freidson, E., (2002), *La dominanza medica. Le basi sociali della malattia e delle istituzioni sanitarie*, Milano, Franco Angeli.

Freidson, E., (2002), *Professionalismo. La terza logica*, R. Ioli (Trans.), Bari, Edizioni Dedalo.

Foot, J., (2023), *The Man Who Closed the Asylums: Franco Basaglia and the Revolution in Mental Health Care,* New York, Verso Books.

Hachtel, H., Vogel, T., Huber, C. G., (2019), Mandated Treatment and Its Impact on Therapeutic Process and Outcome Factors*, Frontiers in psychiatry,* 10, p. 219.

Larroche, V., (2019), *The Dispositif: A Concept for Information and Communication Sciences*, Hoboken, John Wiley & Sons.

Saraceno, B., (2024), Istituzioni totali e de-istituzionalizzazione*,* in C., Tarantino, a cura di, *Il soggiorno obbligato*, Bologna, Il Mulino, pp. 305-320.

Spicuglia, M., (2021), *Noi due siamo uno. Storia di Andrea Soldi, morto per un TSO*, Torino, ADD Editore.

Wasserman, D., Apter, G., Baeken, C., Bailey, S., Balazs, J., et al., (2020), Compulsory admissions of patients with mental disorders: State of the art on ethical and legislative aspects in 40 European countries, *European Psychiatry*, 63, 1, p. 82.

European Union Agency for Fundamental Rights, (2012), Involuntary placement and involuntary treatment of persons with mental health problems. [Online] Consultabile all'indirizzo: https://fra.europa.eu/en/publication/2012/involuntary-placement-and-involuntary-treatment-persons-mental-health-problems (Data di accesso: 20 aprile 2025)