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Abstract

The Italian Law n. 9/2012 provided the Italian Regions with a new decisional role by demanding the management/rehabilitation of prisoners judged as partially/fully mentally ill to care and protection delivered by the psychiatric services of the Regional Health Service. Healthcare has to be guaranteed by the so-called High-Security Forensic Psychiatry Residences (Italian: Residenze per l’Esecuzione delle Misure di Sicurezza: REMS) and by community mental health centres. Ensuring patients’ and professionals’ health and safety is a complex issue which requires effective strategies to cope with several structural, technological, and organisational problems.

The present paper summarises the historical evolution of the Italian laws towards the development of the High-Security Forensic Psychiatry Residences in Italy, focusing specifically on the Tuscany Region situation. The paper also presents the key issues emerging after the implementation of the Law 81/2014 which complemented the Law 9/2012. Since these reforms included the need for assessing to what extent the patient may be considered as a danger to society and for ensuring the safety of National Health Service (NHS) professionals, they underscored the importance of a preventive use of specific clinical governance tools aimed to reduce risk of adverse events.

The present work has the strength of proposing a new, evidence-based scientific approach to the implementation of assessment and care pathways in High-Security Forensic Psychiatry Residences. Clin Ter 2020; 171(2):e97-100. doi:10.7417/CT.2020.2196

Key words: violence risk assessment, clinical risk management, psychiatric patients, violent behaviour, mental health services, REMS

The pathway of the Italian laws from mental health hospitals to High-Security Forensic Psychiatry Residences

In Italian National Health Service (NHS), the management of patients with mental disorders (Law 833/78) started with the Law 180/78 (the so-called “Basaglia law”) which replaced the Law 36/1904 and the Royal Decree 615/1909 on mental health hospitals and mentally ill patients. The focus of the Italian NHS shifted from control and containment to care, treatment, and rehabilitation. Although this change led to mental health hospitals gradually being shut down and to community mental health centres being opened nationwide, it pointed out the difficulties in the management of severe chronic psychiatric disorders in outpatient settings, rather than in inpatient settings (1).

Since both care and social safety are necessary outcomes in the management of prisoners with psychiatric disorders dangerous to society, forensic psychiatric hospitals, defined as Prison Asylums before the 1975 Prison Reform Law (354/75), continued as before under the jurisdiction of the prisons’ administration. Forensic psychiatric hospitals were excluded by later laws (DPR 07/04/1994 and DPR 11/11/1999) until 31st July 1999 when changes were implemented by the Law 230/99 (“Re-ordering medical services in prisons”, according to article 5, Law 419, 30th November 1998).

Prison regulation reform came through the Law 230/00 (“Regulations on prison organization and on means to deprive or limit freedom”, Article 11) which specifically regarded mental health in prison focused on individuals with “physical/mental illness or disability”. Since offenders with severe mental disorders needed care and treatment, they were provided with a special healthcare management including contractual agreements with NHS psychiatric services, in accordance with the article 113.

Furthermore, the economic legislation made in 2008 (article 2, section 283 Law 244, 24th December 2007 and the 1st April 2008 Ministerial Decree, implementing Article 5 of the Law 419, 30th November 1998 and Article 2, section 283 of law 244) transferred the management of prison health services from forensic psychiatric hospitals to the NHS in the respective regions.

In light of these legislative reforms, the Marino Commission was set up in 2011 (2). Its recommendations emphasized the need for closing down forensic psychiatric hospitals because they were housed in dilapidated buildings that were...
no longer suitable for treating mentally ill individuals dangerous to society. This recommendation was accepted in the Decree 211 of the 22nd December 2011, which became Law 9 on the 17th February 2012 (transfer into law, with some modifications, of Decree 211, of the 22nd December 2011, on urgent interventions to counter detention tensions due to prison over-crowding) and forensic psychiatric hospitals were definitely closed down on 1st February 2013.

Closure was, however, postponed until 1st April 2014 by Decree 24 made in 25th March 2013 and then until 31st March 2015 by Decree 52 made in 31st March 2014. The reasons for these delays were that the Italian Regions were unable to cope with the structural, technological and organizational issues arising from the Law 9/2012 which had completely changed the management and rehabilitation of mentally ill prisoners dangerous to society. Law 9 (17th February 2012) and Decree 52 (31st March 2014) which was converted into Law 81 (30th May 2014) (3), abolished forensic psychiatric hospitals and changed the treatment of the mentally ill prisoners by confining them in High-Security Forensic Psychiatry Residences (4). It is worth noting that legislation has not changed for mentally ill patients who are not judged as dangerous to society. They are allowed to live in their communities freely with no obligation to undergo treatment.

In summary, High-Security Forensic Psychiatry Residences are managed by the NHS; they feature direct detention, have a maximum of twenty beds and are directed by psychiatrists. They are aimed to the planning of a targeted therapy and rehabilitation for each inmate in collaboration with community psychiatric and social services. Mental health departments are the fulcrum of this innovative healthcare system as they provide therapeutic and rehabilitation programmes in the community. According to their directive, detention in a High-Security Forensic Psychiatry Residence “should be not only exceptional but also transitory”. The assessment of a potential “danger to society” has become a crucial part of abolishing prison psychiatric hospitals.

Workforce safety in psychiatric services

In “open-plan” units, patients are free to move without any physical barriers. The development of “open-plan” units raised some issues in the management of aggressive patients’ behaviour towards health workers in all units, since evidence showed they are at a higher risk of being victims of aggression than in other workplaces that are open to the public. In 2007, the European Union-OSHA declared that, with a 15% incidence of violence in the workplace, health and social services are associated with the maximum risk of exposure. The Italian Ministry of Health had been aware of the problem since 2007, when it promulgated a “recommendation to prevent violent acts that harm health service workers”, setting out risk factors, protective measures and specific prevention strategies. In 2009, the Italian Ministry of Work, Health and Social Policy stated that the risk of violent episodes for healthcare workers should be considered carefully as warning signs and needed to be monitored to ensure the safety of the staff.

These findings underscore the importance of an in-depth and systematic analysis of warning signs of violence. This is aimed to improve the workplace safety of the health workers as employers would have to adopt the necessary safety and prevention strategies while employees would play an active role in prevention and safety at work. In fact, the Decree 81/2008 stated that they were obliged by law to report any eventual risks.

The attention should be focused on workplace safety in psychiatric services such as wards, out-patients clinics, community centres, day centres, particularly when treating severe mental health disorders such as schizophrenia, bipolar disorders with psychotic symptoms, delirium, severe personality disorders, which can represent a source of violent behaviour against healthcare workers. In fact, in 2008 the American Psychiatric Nurses Association stated that in psychiatric units 62% of the staff and over 75% of the nurses were victims of an attack by patients at workplace. A recent investigation on three types of violent acts (self-harm, harm to another, harm to a bystander) found that 58% of the patients with mental disorders had carried out at least one type, 28% two types, and the other 7% all the three types. Finally, in 2007 the Italian monitoring protocol classified psychiatric units as at high-risk for the occurrence of violent behaviour which emerged as the 4th cause of adverse events in the entire country (6).

The need for violence risk assessment tools in High-Security Forensic Psychiatry Residences

Analysing the potentiality for outbreaks of violence is crucial in High-Security Forensic Psychiatry Residences since these patients have been identified as a danger to society. They have more, and often different, risk factors that need for a timely risk management in order to prevent violent acts against staff or other patients. Although the specific guidelines incorporated into the Law 24 made in 8th March 2017 (the so-called “Gelli Law”) must be applied to avoid incurring professional responsibility charges, the Law only states that the NHS should draw up Italian national guidelines for specialist settings where they are missing. Since this includes the High-Security Forensic Psychiatry Hospitals, attention has turned to applying best clinical practices and international guidelines.

The US MacArthur Violence Risk Assessment Study proposed a Classification of Violence Risk (COVR) as a specific risk assessment tool for foreseeing and preventing violent outbreaks among dangerous mentally ill prisoners. In the UK, it emerged as efficacious in foreseeing risk and consequently, preventing it (7). Although these tools are suitable for present use, further research is undoubtedly needed to improve them (8). Future directions include the development of specific tools for risk assessment to be used in Italy and the construction of Inter-Regional High-Security Forensic Psychiatry Residences aimed to provide high-level care and protection for patients resistant to High-Security Forensic Psychiatry Residences. According to international results (9-13) there is a concrete risk of violent behaviour by patients who suffer from severe mental illness. Even though their victims rarely suffer from serious harm, the problem should not be underestimated, since aggression and violence are stressful events that may facilitate the onset of stress- and work-related psychopathologies (14-15).
The current situation in Tuscany: the Volterra High-Security Forensic Psychiatry Residence

A recent study (16) described the application of the Law 81/2014 in Tuscany. In Volterra, a High-Security Forensic Psychiatry Residence has two wards, each one containing fourteen beds, a shared dining room and a recreation area. The multi-professional team includes psychiatrists, psychologists, psychiatric rehabilitation, and educational specialists, nurses, and social workers. The team’s work focuses on stabilising patients clinically, on transferring them within a brief time period to one of the six Tuscany Intermediate Security Residences (type-1 ISR). These contain fifty-eight beds for mentally ill prisoners who are on an experimental early release scheme or subjected to non-custodial probation with security measures. As soon as inmates achieve full living and housing self-sufficiency, they are transferred to an ISR with a less intensive rehabilitation and care programme (type-2 ISR). When the conditions for mental health are achieved, the patient may return home, even under security measures, into the care pathway provided by the community psychiatric service.

In January 2017, the Volterra High-Security Forensic Psychiatry Residence was managing thirty patients, 58.6% of whom had already been sentenced while 41.4% were on remand. Crimes included attacks on individuals (86.2%) or on property (13.8%). Charges of murder or attempted murder accounted for 44.82% of attacks on individuals. Only one patient was charged with manslaughter.

The Volterra High-Security Forensic Psychiatry Residence is the only one in Tuscany. Although the total planned capacity for Tuscany and Umbria was twenty-eight beds, it hosts thirty inmates with as many more on the waiting list, compared with the one-hundred places in the now closed Montelupo prison psychiatric hospital. Thus, approximately one-third of those inmates are hosted in prison and people who could potentially constitute a danger to society, but have not yet been condemned, remain without due care (17). Waiting lists become longer, reaching thirty-one patients in Tuscany. They reflect the lack of places and the difficulty in applying a law which states that individuals should be referred to High-Security Forensic Psychiatry Residences only after sentencing.

Future directions and conclusions

Applying the Law 81/2014 highlighted legal and logistical gaps that created several structural and organizational problems that Italian Regions have to overcome. Management of mentally ill people who are potentially aggressive and thus only partially responsive to treatment, is not easy for Regional health services. Such services are legally obliged to guarantee care and treatment in High-Security Forensic Psychiatry Residences as well as in the community through mental health centres, ensuring delivery of proper, effective, evidence-based therapies, allowing patient’s safety to be monitored while preventing any harm to the workforce. Few beds are available in the High-Security Forensic Psychiatry Residences, long waiting lists continue to persist, and there is a lack of inter-Regional and NHS protocols (18) that could offer alternative custodial arrangements and different ways of managing/monitoring patients on the waiting list.

Currently, High-Security Forensic Psychiatry Residences are under-staffed and the workers are often poorly skilled. An effective educational/training programme should be promoted in this field, similarly to what is proposed by the Occupational Safety and Health Administration in the US Guidelines (19). We also suggest that a future direction is a timely and reliable assessment of work-related stress in healthcare workers of the High-Security Forensic Psychiatry Residences. Psychometrically sound assessment tools are available in the literature and may be introduced in these settings (20-22). Another important issue which needs for a more careful assessment may be the health status of the foreigners/immigrant patients who typically are more vulnerable to severe psychiatric disorders than natives (23-24). Finally, an avenue for the improvement of the effectiveness of the High-Security Forensic Psychiatry Residences may be the assessment of positive outcomes which can provide a more comprehensive overview of the effectiveness of the rehabilitation programmes, such as wellbeing, functioning, and quality of life measures (25-26). In forensic sciences, positive outcomes are an overlooked research area which might help policymakers to develop early detection and intervention strategies for violent behaviour (27). Quality of life and functioning may be impaired also in less severe/ remitted patients and should be considered as markers of adequate long-term adjustment (26).

Franco Corleone, as single commissioner for the abolition of forensic psychiatry hospitals pointed out that not only these problems but also several other crucial issues would weigh down on regional health services as they acquired a double function as a) guarantor of patients’ health in the High-Security Forensic Psychiatry Residences and community mental health centres and b) employer that is responsible for workforce safety and professional performance (28-29). The psychiatrist has the role as a head of the unit and is legally obliged to consider the patient as a source of danger towards third parties which needs to be contained and neutralized while he/she is obliged to protect the patient from prejudicial behaviour (30).

In conclusion, in light of the above-mentioned observations, one can envisage an increase in potential sources of responsibility in terms of civil, penal and administrative law as cases are taken against the Regional Health Services, which would result in increased costs. Therefore, clinical governance tools should be implemented preventively to reduce the risk of adverse events including incidence of work-related violence and negative medical outcomes (31-32). Mental health programmes should be developed specifically for mentally disabled prisoners and the use of reliable assessment tools (33) should be implemented for risk management and Inter-Regional Ultra-High Security Residences with high intensity care/protection should be developed for patients resistant to the treatments available in High-Security Forensic Psychiatry Residences.

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