

Commentary on “the new Italian Residential Forensic Psychiatric System (REMS). A one-year population study”

Edward W. Mitchell¹, Rob Cornish², Seena Fazel³

¹ ST6 specialist trainee in forensic psychiatry, The Oxford Clinic MSU, Oxford Health NHS Foundation Trust, Littlemore Mental Health Centre, Oxford, UK; ² Consultant forensic psychiatrist, The Oxford Clinic MSU, Oxford Health NHS Foundation Trust, Littlemore Mental Health Centre, Oxford, UK; ³ Professor of forensic psychiatry & Honorary consultant forensic psychiatrist. Department of Psychiatry, Warneford Hospital, Oxford, UK

Catanesi and colleagues¹ are to be commended on their publication of a substantial survey of patients in the Italian ‘Residences for the Execution of Security Measures’ (REMS). The REMS system consists of a regional system of around 30 secure units, focussing on mental health recovery and rehabilitation rather than the high security and more penitentiary-like large hospitals they replaced (the six *Ospedali Psichiatrici Giudiziari*, OPGs). These smaller units, however, with approximately 20 beds each, only provide approximately a third of the capacity of the OPGs (604 beds *versus* 1639), raising the important issue of the characteristics of the patients who are admitted to this new, reorganized forensic mental healthcare system. This is the question Catanesi and colleagues answer. Between June 2017 - June 2018, they detailed the socio-demographic, criminological and mental health characteristics of over 95% of those residing in the REMS.

In many respects this redesign of the Italian forensic mental health system parallels the journey of the UK, which has also sought to supplement and replace the function and capacity of its original four high security (‘Special’) hospitals. Two key reports^{2,3} from the government’s Department of Health and Social Security found that these Special hospitals were significant barriers to the rehabilitation and eventual discharge of patients back to community living. Firstly, they were generally located far from their patients’ family, friends, and sources of community support. Secondly, there was no formalised ‘step-down’ pathway for gradual reduction in security and supervision of patients prior to their discharge. The result was the founding of a tier of regional ‘Medium Secure Units’ (MSUs) within forensic psychiatric hospitals, currently providing around 3500 beds. Patients are detained under the Mental Health Act 1983 (amended 2007), and most have either received a ‘hospital order’ at the point of sentencing (a direction for detention in hospital rather than prison) or have been identified as mentally ill in prison and transferred to hospital. Like the REMS, the units focus on recovery, relatively shorter stays, and are designed to integrate with low secure and community forensic services.

Catanesi and colleagues found that most REMS patients are male (89%), had a long disease duration (mean 11.5 years), and were already being treated by public mental health services (82%) or had previous civil hospital admissions (71%). 13% had more than four previous admissions. In terms of diagnosis, patients were frequently comorbid (mean 1.4 diagnoses per patient) but predominately suffered from schizophrenia-spectrum

Received: December 12, 2020
Accepted: January 4, 2021

Correspondence

Seena Fazel

Professor of forensic psychiatry & Honorary consultant forensic psychiatrist. Department of Psychiatry, Warneford Hospital, Oxford, OX3 7JX, UK. E-mail: seena.fazel@psych.ox.ac.uk

Conflict of interest

The Authors declare no conflict of interest

How to cite this article: Mitchell EW, Cornish R, Fazel S. Commentary on “the new Italian Residential Forensic Psychiatric System (REMS). A one-year population study.” *Journal of Psychopathology* 2021;27:8-10. <https://doi.org/10.36148/2284-0249-414>

© Copyright by Pacini Editore Srl



OPEN ACCESS

This is an open access article distributed in accordance with the CC-BY-NC-ND (Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International) license. The article can be used by giving appropriate credit and mentioning the license, but only for non-commercial purposes and only in the original version. For further information: <https://creativecommons.org/licenses/by-nc-nd/4.0/deed.en>

disorders (60%). 30% had a diagnosis of personality disorder (with borderline personality disorder being the most common subcategory), and 21% substance use disorder. In terms of crime, approximately 80% of patients had a conviction for a crime against the person involving violence, of which homicide or attempted homicide was the most common (and family members were often victims). Almost half (48%) of patients had criminal convictions prior to the index offence.

Treatment with antipsychotic medication was common. Overall, 71% received an oral antipsychotic medication, with 47% prescribed a long acting injectable antipsychotic (mostly haloperidol or paliperidone palmitate); more than half of these patients (57%) also received a different oral antipsychotic medication (with almost half receiving a mood stabiliser). We note no use of clozapine in the treatment of this Italian sample, a typical choice in the UK for treatment resistant psychosis.

These patient characteristics are broadly similar to those in British MSUs. For example, in a sample⁴ of 409 forensic patients discharged from MSUs, 87% were male and had a mean age of 30.2 years. Over two thirds (72.5%) had previous admissions, with a mean of previous 3.6 admissions. Diagnoses were predominately schizophrenia or schizoaffective disorder (63%), drug dependence (26%), alcohol dependence (26%), anti-social personality disorder (21%), and other personality disorder (14%). Index crimes were homicide (17%), other violence (52%), sexual offences (7.8%), acquisitive crime (17%), and arson (13%).

Now the baseline characteristics of REMS patients are known, the key issues facing the REMS system will be to evaluate the service by examining admissions and patient outcomes. Who *should* the REMS admit, given the system has only about a third of the beds of system it replaced? What are the goals of admission? How will these be measured along the patient pathway through the whole forensic service, from before admission through to after discharge?

‘Dangerousness’ or ‘risk to others’ is the key admission criterion for forensic services, as well as an important metric during admission and pre- and post-discharge. This risk can be estimated through various methods, but all have had their validity and/or utility questioned. Clinical judgement is prone to overestimation of risk and a wide range of biases⁵. Structured professional judgement tools such as the HCR-20 are frequently time consuming and require specialist training⁶, and poorly validated in real world settings⁷. Actuarial assessments such as the VRAG (Violence Risk Appraisal Guide) may

have little predictive validity for the populations on which they are used, with ‘high risk’ false positives being a particular problem⁸. Categories of ‘high’, ‘medium’ and ‘low’ risk generally used by these instruments are also limited in utility: two patients may share the same ‘high’ risk category yet have considerably different absolute risks that range very widely⁹. Hence, at times, these categories can become meaningless in practice.

The future of risk prediction for forensic patients will be the use of scalable, evidence-based instruments which are derived from and validated for populations similar to the person for whom prediction is required. These should be based on the most important empirically derived risk factors, rather than those traditionally thought to contribute to dangerousness. Such instruments can be used to 1) help prioritise admissions to a service by assisting clinical decision making; 2) raise the ceiling of quality of risk assessment; and 3) communicate risk accurately and consistently both within REMS and to other agencies, for example when patients are discharged. They should be cost effective and allow reallocation of resources to risk management rather than risk assessment¹⁰.

An example is the OxRisk series of instruments from our research group (<https://oxrisk.com>) which has different tools for specific patient groups, assessing static and dynamic risk factors for outcomes of interest and giving a probability score of a specified outcome event (e.g. violent crime or suicide) for a given person over a specified time period. For example, OxMIV assesses risk of violent crime for people living in the community with severe mental illness¹¹, whereas FoVOx calculates the risk of violent reoffending for forensic psychiatric patients at the point of discharge using a probability score over 1 and 2 years and also pre-defined categories of low/medium/high¹² (<https://oxrisk.com/fovox/>). The scales typically take less than five minutes to complete and are free to use. Four complementary visualisations of the outcomes are provided on the online risk calculators.

Although prediction of risk to others (and management of that risk) may be the *sine qua non* of forensic psychiatry, a large range of instruments, indicators, and other outcomes are available¹³. Domains other than risk will also be important for the service and its patients, such as mental health, quality of life, social function, and psychosocial adjustment. The Italian REMS, as with MSUs in the UK, seem to have been designed with these latter goals in mind as much as minimizing risk and reducing reoffending. Choosing service eligibility criteria and the right outcome measurements will be key in evaluating whether the Italian REMS succeed in their goals.

References

- ¹ Catanesi R, Mandarelli G, Ferracuti S, et al. The new Italian residential forensic psychiatric system (REMS). A one-year population study. *Italian Journal of Criminology* 2019 (Special Issue):7-23.
- ² Home Office & Department of Health and Social Security: interim report of the Committee on Mentally Abnormal Offenders Cmnd 5698, HMSO, London (Glancy Report, 1974).
- ³ Home Office & Department of Health and Social: report of the Committee on Mentally Abnormal Offenders Cmnd 6244, HMSO, London (Butler Report, 1975).
- ⁴ Coid J, Hickey N, Kahtan N, et al. Patients discharged from medium secure forensic psychiatry services: reconvictions and risk factors. *Brit J Psychiatry* 2007;190:223-9. <https://doi.org/10.1192/bjp.bp.105.018788>
- ⁵ Ægisdóttir S, White MJ, Spengler PM, et al. The meta-analysis of clinical judgment project: fifty-six years of accumulated research on clinical versus statistical prediction. *Couns Psychol* 2006;34:341-82.
- ⁶ Fazel S, Singh Jay P, Doll H, et al. Use of risk assessment instruments to predict violence and antisocial behaviour in 73 samples involving 24 827 people: systematic review and meta-analysis. *BMJ* 2012;345:e4692.
- ⁷ Cornish R, Whiting D, Fazel S. Letter in response to: Silva E. The HCR-20 and violence risk assessment – will a peak of inflated expectations turn to a trough of disillusionment? *BJ Psych Bulletin* 2020:1-3. <https://doi.org/10.1192/bjb.2020.14>
- ⁸ Harcourt B. *Against prediction: profiling, policing, and punishing in an actuarial age*. Chicago: University of Chicago Press 2007.
- ⁹ Singh JP, Fazel S, Gueorguieva R, et al. Rates of violence in patients classified as high risk by structured risk assessment instruments. *Brit J Psychiatry* 2014;204:180-7. <https://doi.org/10.1192/bjp.bp.113.131938>
- ¹⁰ Cornish R, Lewis A, Parry OC, et al. A clinical feasibility study of the Forensic Psychiatry and Violence Oxford (FoVOx) tool. *Front Psychiatry* 2019;10:901. <https://doi.org/10.3389/fpsy.2019.00901>
- ¹¹ Fazel S, Wolf A, Larsson H, et al. Identification of low risk of violent crime in severe mental illness with a clinical prediction tool (OxMIV): a derivation and validation study. *Lancet Psychiatry* 2017;4:461-8. [https://doi.org/10.1016/S2215-0366\(17\)30109-8](https://doi.org/10.1016/S2215-0366(17)30109-8)
- ¹² Wolf A, Fanshawe TR, Sariaslan A, et al. Prediction of violent crime on discharge from secure psychiatric hospitals: a clinical prediction rule (FoVOx) *European Psychiatry* 2018;47:88-93. <https://doi.org/10.1016/j.eurpsy.2017.07.011>
- ¹³ Fitzpatrick R, Chambers J, Burns T, et al. A systematic review of outcome measures used in forensic mental health research with consensus panel opinion. *Health technology assessment* 2010;14:1-94. <https://doi.org/10.3310/hta14180>