

Across the walls. Treatment pathways of mentally ill offenders in Italy, from prisons to community care

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SUMMARY

The process of deinstitutionalization of psychiatric care in Italy has recently included also the care of psychiatric patients who committed offences. This happened following a set of laws enacted since 2008. The Departments of Mental Health (DMH) belonging to the public National Health System (NHS) are now providing care along the whole psychiatric system, from the treatment of inmates in prisons to care plans in the community. This change requires new cultural paradigms and organizational models. Some DMHs have set up Forensic Psychiatry Units (FPU), dedicated to providing care of such patients with specific treatment pathways both inside and outside the places of detention. The DMH of Bologna set up a FPU dedicated to offer mental health care in prison, juvenile prison and secure residential unit for "not guilty by reason of insanity and socially dangerous" offenders (Residenza per l'Esecuzione della Misura di Sicurezza, REMS).

According to this model, mental health in penitentiary settings is warranted by a multidisciplinary team comprising psychiatrists, psychologists, nurses and psychiatric rehabilitation professionals. Addiction treatment staff closely cooperate with the FPU in the treatment of dual diagnosis inmate patients. FPU aims to ensure continuity of care for inmates with mental health issues, from their access (or from the onset of the psychiatric disorder) up to community care under any form of release.

FPU has further expertise areas, supporting Community Mental Health Services in developing and monitoring therapeutic pathways for psychiatric patients under judicial order. This include assessing violence risk at the request of the supervisory courts, and working closely with courts and expert witnesses in developing tailor-made prescriptions for offenders sentenced to the safety measure of probation.

In view of the complexity of these cases, in which the needs of care, control and reintegration into the social fabric are intertwined, we consider mandatory to widespread specific skills regarding offenders assessment and treatment, relying whenever possible on evidence-based tools.

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Conflict of interest

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Introduction

The relationship between mental illness and violent or criminal behavior has always been one of the most debated and controversial topics in psychiatric literature. Italy is renowned for its Psychiatric Reform of 1978 that brought to the closure of all mental hospitals and the implementation of a radical community care system. Less discussed is the fact that the management and treatment of the mentally ill offenders remained till recently in the hand of the penitentiary system and outside the general mental health care system.

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Italian Government decided not to include in the deinstitutionalization process the Forensic Psychiatric Hospitals, which were only renamed as Judicial Psychiatric Hospitals (Ospedali Psichiatrici Giudiziari, OPG) ¹, probably in order not to overload the National Healthcare System and its Mental Health Service ². The price for this was an institutional and cultural mismatch between psychiatry and justice, which has seriously hindered the development of a shared practice concerning the areas of joint intervention ³. This gap has only been addressed since 1999 with fluctuating trends and minor adaptations rather than with organic reforms ⁴⁻⁷. Still today many procedural and welfare problems in prisons and mental health services need to be addressed.

The transition of Penitentiary Medicine (and psychiatric care with it) to the NHS was set up with a Presidential Decree of 2008 (DPCM 1 April 2008) ⁸, which was inspired by some pilot experiences of deinstitutionalization such as the “Antares” Project in Emilia Romagna and the “Eracle” Project in Tuscany (D.lgs 502/92, n. 2593, 30 December 1999 Emilia Romagna; D.lgs 230/99 Tuscany). One epidemiological study provided reliable data on the population of OPGs and suggested that such a Reform was feasible with due investments. Among other things, it showed that 72% of the in-patient population was affected by non-affective psychosis and 60% was already cared for by the Community Services before the commission of the crime ⁹. More recent data have substantially confirmed these findings since in current psychiatric-forensic facilities 60.7% of patients are affected by a Schizophrenia spectrum and other psychotic disorders while an even higher proportion of forensic patients (82%) were already in care by mental health services at offense time ¹⁰.

After a transition period, only in 2015 the OPGs were closed and DMHs started to display a range of management and treatment options, from mental health care in prison settings to community care, from mental health residential communities for the acquitted (Residenze per la Esecuzione della Misura di Sicurezza, REMS) to diversion schemes to ordinary residential settings.

In Emilia-Romagna, a region of 4.4 million inhabitants in Northern Italy with the capital in Bologna, the progressive overcoming of the OPGs was based on three strategies, which were accompanied by substantial financial investments: 1) reduction of admissions through the provision of diversion schemes to community-based alternatives to inmate care; 2) during detention: careful assessment, planning of prison-to-community pathways, establishment of observation wards mostly hosting inmates fallen ill in prison; 3) increase in discharges through assertive community-based care programs by the Local Mental Health Centers (Centro di Salute Mentale, CSM) including residential rehabilitation services.

Since then, social dynamics of greater marginalization, the closure of the OPGs and the increase in the application of judicial orders, have produced an increase in the population belonging to the penitentiary system, causing a transformation of the epidemiological situation within prisons, which today face complex populations and uncertain boundaries, which are difficult to frame in diagnostic categories ¹¹, whose common denominator is often early traumatic experiences that seem to contribute to violent behavior, as evidenced by the extensive scientific literature on the outcomes of traumatic experiences ¹²⁻¹⁴. The same social dynamics and the overcoming of the OPGs have also led to a substantial increase in judicial orders that require care by Community Psychiatric Services.

These epidemiological and institutional changes call for specific skills by health professionals at the interface between Psychiatric Services and the judiciary system (e.g.: second level assessments and with the use of clinical and design assessment tools).

Forensic Psychiatry Units (FPU) within Departments of Mental Health (DMH) is one possible response to these new needs, as far as they can provide for alternative treatment pathways for offending patients to ensure an adequate care supply chain. FPUs are already operating in various DMHs (e.g.: Bologna, Parma, and Brescia) and ensure psychiatric care in prison, manage REMS, and above all support CSMs and other DMH facilities in drafting and managing clinical and psychosocial pathways for judicial patients, in continuity between the penitentiary institution and the community.

At the DMH of Bologna, an FPU has been set up and is currently directed by one of the authors (F.B.). It covers the following areas of expertise:

- organization and management of the REMS “Casa degli Svizzeri”;
- organization and management of the psychiatric service at the Bologna Prison and consultancy at the Juvenile Prison;
- monitoring of all intra-departmental individual care pathways for psychiatric patients under judicial order;
- collaboration with expert witnesses and judicial authorities either in the early phases of evaluation and planning of care for mentally ill offenders or when mental illness breaks out while in prison;
- training, technical support, consultancy, and consultancy activities for the Community and hospital structures of the DMH;
- collaboration with the Risk Management and Legal Medicine Unit;
- collaboration with public administrations and users/carers associations about guardianship and supported decision-making procedures.

FPU team comprises 4 doctors, 3 psychologists, 1 social worker, 3 nurses, and all the care staff (nurses, educators, and psychiatric rehabilitation therapists) to manage the REMS. Care for inmates with substance abuse and psychiatric care of minors are not provided by FPU, but by different specific DMH Units for addiction and Child and Adolescent Mental Health care. We are aware that in other DMHs these activities fall within the responsibilities of FPUs.

Clinical and psychosocial pathways comprise also 4 “rapid access from prison” beds by the “Arcipelago” Intensive Treatment Residence, for patients with judicial orders for observation and treatment in the acute phase. Most of the staff of these facilities have undertaken challenging and complex training courses on the topics of forensic psychiatry, criminology, psychotraumatology, transcultural psychiatry and psychiatric clinic in institutional settings. This constitutes a professional investment that so far has ensured stability to the working group and coordination between the various Units involved.

Currently, there are about 80 out-of-prison pathways of offending patients monitored by Bologna FPU and managed together with CSMs. Work with the judiciary and penitentiary institutions requires daily contacts and court decisions are rarely taken without having consulted the DMH. Professional and financial commitment required by establishing these care pathways for offending patients has increased considerably over the years and the trend seems to be for further increases.

Mental health care in prison

Prisons are a very specific setting in which to provide mental health care. The practice stands on an intrinsic contradiction of having to develop pathways to health within an institution which by its nature maintains an afflictive function, albeit modulated by the re-educational needs and recovery introduced by the 1975 reform.

The transition of penitentiary medicine to the NHS is relatively recent (2008) and there are relevant regional organizational differences. So far we have only a few valuable experiences and a few steering documents as references.

According to the paper ¹⁵ released by the “National Construction and Development Committee of the PDPA”, a prerequisite for working in the penitentiary field is the establishment of a multidisciplinary team comprising psychiatrists, nurses, psychologists, and professionals dedicated to addictions and possibly psychiatric rehabilitation staff.

One common problem is the lack of vocations to work in prisons. As a result, there is frequently a high turn-over of staff, often lacking specific skills and with a high risk of burn-out. This is a major weakness both for therapeutic continuity and for the development of specific

skills. It is, therefore, necessary to ensure adequate resources, duly trained and working “across the walls”, i.e. in prison and the community. Under this respect, FPUs can contribute to the development of specific skills, which can be used both in the intra- and in the extramural setting.

Patients have a right to continuity of care from their access into prison (or from the onset of the psychiatric disorder, in the case of patients who develop the first episode during detention) up to community care under any form of release.

It is therefore important to identify patients who show psychiatric symptoms in progress, a history suggestive of psychopathological vulnerability and those already cared for by psychiatric services, or those who simply are under psychopharmacological treatments, also to avoid abrupt withdrawals or inappropriate changes to therapies already in progress at the time of admission to prison. Psychiatric history must be immediately investigated, for example by providing physicians who make a first general medical assessment with structured screening tools or by providing a psychological interview for all newcomers. Early link with CSM is highly recommended.

Once the presence of a clinically significant psychiatric disorder is ascertained, the patient is taken in charge by the team: key workers are identified for each case, in order to promote continuity of care, therapeutic and rehabilitative interventions, planning of following controls. Once the acute phase has been overcome, follow-up is continued consistent with the interventions implemented, maintaining periodic visits to promptly intercept any exacerbations. Another possible critical moment is that of release ¹⁶, not only due to the inmate’s expectation and anxiety to return to freedom, which can be so strong as to cause a feeling of estrangement and extreme concern for the situations he will face “out” (“the so-called “Vertigo of the exit”), but also due to the need to build a connection with the local services (CSM, and Social Services above all) for the continuation of treatment. It is useful to implement a “discharge” protocol according to which the Penitentiary Administration reports to FPU, as early as possible, the imminent release from prison to allow Community services to be informed and ensure continuity of care, even with specific paths for the most fragile; such projects should also take into account social needs, which often constitute risk factors for relapse into crime far more relevant than mental disorders.

Intramural facilities

Currently, 16 prisons are equipped with Psychiatric Observation Units (POU) and 35 with the Mental Health Care Units (MHCU), specialized sections characterized by higher levels of psychiatric assistance.

POUs are responsible only for a second level differential diagnosis and for the evaluation of the appropriateness of placement in prison. In the penitentiary context atypical and difficult to classify clinical and behavioral pictures often appear, both for the frequent comorbidities and risk factors, and the relative frequency of fictitious or deliberately simulated disorders to access less afflictive forms of punishment.

MHCUs, on the other hand, host inmates whose illness has not been brought to acquittance or whose detention in the ordinary sections of the prison is not appropriate due to “supervening mental illness”. In these units, although located within the prison, work mainly health staff belonging to the NHS. They carry out both assessments and therapeutic treatments, including long-term ones. When managed by FPUs within the DMHs, their work ensures again continuity across the walls.

The acute phase of illness

The treatment of psychiatric acute disorders in prisoners, especially when there is a high risk of self-harm, is a complex challenge. Prisons are highly containing environments that imply at the same high control and monitoring of “risky” behaviors, and severe stresses that often trigger psychiatric disorders, behavioral problems and other risks for health and life ¹⁷.

Hospitalization is sometimes appropriate if intensive care of an acute condition is enhanced by a safe distance the patient from the pathogenic context. However, these hospitalizations put several problems both from the point of view of the ward and from that of the Penitentiary Police which, unless otherwise ordered by the Magistrate, must guard him at the place of treatment.

On the hospital ward side, logistical problems arise: the patient and his guards must be placed in a room for them alone, ordinary work of staff is changed, tension may arise with other patients. Stigma against offenders may add to the stigma against psychiatric patients.

On the prison staff side, agents often complain about the shortage of resources for ensuring single man guarding in the hospital setting, when shifts in prisons are difficult to cover.

Having “rapid access from prison” to a psychiatric residence (as it is in the case for FPU in Bologna at the RTI “Arcipelago”) or to a psychiatric ward equipped to host and care for inmates, is a highly valuable resource to overcome most of these problems.

Once the acute phase is overcome and the patient returned to prison, the psychiatrist assesses the inmate, reviewing the psychopharmacological therapy and appropriate prison section, in order to achieve better psychological conditions and minimize the impact of returning to prison after the period spent in the more comfortable healthcare environment. During the post-

acute phase, into account the increased vulnerability to new episodes of psychopathological and behavioral decompensation, psychiatric visits are generally more frequent and drugs are taken under nurse supervision, in order to ensure a better compliance and reduce the risk of harmful use of covertly accumulated drugs. Psychological and psychoeducational interventions are focused on illness awareness, therapy management and recognition of early warning signs.

Stepping out. Care in the community

Law 81/14 transferred responsibility for the therapeutic and rehabilitative pathways of psychiatric patients who have committed crimes to the DMHs and established that treatment outside prison walls should be the norm. Detention of the acquitted in specific REMS should be residual and transient, mental health and risk reduction must be sought through treatment in ordinary DMHs units, with specific plans for the mentally ill offenders.

These pathways provide, in most cases, some form of probation, the prescriptions of which are customized by the Magistrate to reduce “social dangerousness”.

Therapeutic programs of psychiatric offending patients are proposed by the expert, ordered by the Court, planned, monitored, and financed by the DMHs. The penitentiary system follows up the program through a specific extramural unit (Ufficio Esecuzione Penale Esterna, UEPE). The Post-sentence authority periodically checks the outcomes both in terms of health and risk, gathering information from DMHs and UEPE. Players are multiple and responsibility must be shared. Common language and agreement about standards, methods, and procedures are crucial.

The FPU in Bologna provides support to community psychiatric services, mostly for medico-legal advice and risk assessment procedures, to help them in ensuring real therapy and a safe interface with Justice (experts and magistrates).

Taking charge of an offender patient presents various critical issues. Crime generates stigma ¹⁸, which hinders the recognition of such patients as a person in need of care rather than containment and segregation. The complexity of needs in this population requires large use of resources, in a context that already suffers from a chronic lack of staff and funding. However, the intensive care of such patients appears scientifically rational, for example in the light of the Risk-Need-Responsivity model ¹⁹. According to this model, the level of intervention must be proportional to the relapse risk (Risk Principle: the greatest resources should be invested precisely in the most “difficult” cases), it should focus on the patient’s needs to minimize risk factors (Need-Principle), using evidence-based customized based on individual characteristics (Responsivity-Principle).

Finally, professionals may be concerned about the responsibility and legal implications of such taking charge, though it is acknowledged that good care constitutes the best protection for the patient, for society and the professional himself.

In most cases, psychiatric-forensic patients are entrusted to mental health centers with the safety measure of probation, which provides for specific prescriptions ordered by the Post-sentence Magistrate, aimed at reducing the risk of new crimes. The prescriptions must be sufficiently containing to protect society from the risk of new crimes, but also allow those therapeutic, rehabilitative and social reintegration activities that in the medium and long term can lead to the progressive reduction of risk. The Magistrate can gradually modify the prescriptions concerning the clinical conditions and the rehabilitation project.

For these reasons it is useful to design and monitor these pathways with the use of structured professional evaluation tools, such as the Structured Professional Judgment, SPJ^{20,21}, and the HCR-20 v3²². Since these tools require both an in-depth knowledge of the patient and of the social context in which he lives, as well as psychiatric-criminological skills, professionals of the FPU and those of the Community Services should work together with the development and project monitoring.

The residential setting

The development of rehabilitation projects graduated according to clinical needs and risk level requires often the access to community residential facilities with a rehabilitation vocation that has skills and organization suitable for psychiatric-forensic patients. In many Ital-

ian regions and Emilia-Romagna in particular, there is a network of residences (Therapeutic Rehabilitation Residences and Group Apartments) that underwent training for hosting and caring for mentally ill offenders. These facilities contribute to progressive social inclusion programs, within a sort of supply chain that includes NHS units and private accredited ones, ranging from the most “restraining” settings for patients acquitted who still have significant risk (REMS), for inmates who have yet to pay off their debt with justice (POU and MHCU), to settings of care that are gradually more open and suited to social inclusion where to offer rehabilitation to return to society as “free men”.

Conclusions

The regulatory reforms that led to the closure of the OPGs and the birth of the REMS, have imposed a new mandatory responsibility of the Psychiatric Services in the treatment of offenders with mental disorders. The complexity of these cases, in which the needs of care, custody and reintegration into the social fabric are intertwined, requires wide dissemination within the psychiatric services of skills regarding the psychiatry-justice interface and the development and monitoring of specific therapeutic-rehabilitation projects for offenders. Forensic Psychiatric Units are teams specifically established to take care of restricted patients in prison settings (REMS and Prison) and to assist community services in taking care of psychiatric patients who benefit from alternative measures to detention. Monitoring the outcomes of their work and patients pathways over time will make it possible to further refine the treatment model to encourage increasingly effective and efficient treatments.

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