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The individual experience of ageing patients and the current service provision in the context of Italian forensic psychiatry: A case-study

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32 ## Abstract

33 Introduction. Following the recent development of residential units for the execution of
34 security measures (REMS) managed by the National Health Service and the closing down of
35 forensic psychiatric hospitals, no study has been conducted to investigate the individual
36 experience of ageing patients and to assess whether the new service is adequately meeting
37 their needs. We aim to explore the experience of the service of a sample of patients aged 50
38 years old and above living in one of the Italian REMS.

39 Methods. We adopted a case-study design and included a sample of five patients. We
40 collected their basic demographic data, administered the Camberwell Assessment Need
41 Forensic Short Version (CANFOR-S) and carried out in-depth qualitative semi-structured
42 interviews.

43 Results. Results from the CANFOR-S evidenced that met needs were more prevalent than
44 unmet needs. The qualitative interviews evidenced high levels of satisfaction around
45 accommodation, health care provision, activities, availability of benefits and company and
46 lower levels of satisfaction around psychological and practical support.

47 Discussion. This study gave voice to aging forensic psychiatric patients and provided through
48 personal accounts based on their lived experience, preliminary evidence around the benefits
49 and limitations of the Italian residential forensic psychiatric system for this age group.
50 Implications for clinical nursing forensic practitioners operating within different service
51 frameworks are discussed.

52 ## Introduction

53 Research around ageing forensic psychiatric patients shows that they present with unique
54 psychosocial and treatment needs, given the high rates of chronic mental and physical health
55 conditions, organic disorders, mobility issues, sensory impairment, risk of victimisation,

social withdrawal and reduced activity participation (Yorston & Taylor, 2009; McLeod, Yorston, & Gibb 2008; O'Sullivan & Chesterman, 2007; Shah, 2006; Tomar, Treasaden, & Shah, 2005; Curtice, Parker, Wismayer, & Tomison, 2003; Coid, Fazel, & Kahtan 2002). Ageing forensic patients remain in secure settings longer than younger patients (Lightbody, Gow, & Gibb, 2010), ageing prisoners sentenced for similar offences and patients in general psychiatric services (Völlm, Bartlett, & McDonald, 2016). The difference could be due to (i) possibly receiving less attention from staff, (ii) a lack of alternative suitable accommodation to be discharged to, or (iii) barriers to meeting their treatment and care needs.

Within the context of Italian forensic psychiatry, these questions remain unanswered, given the lack of empirical research around ageing patients living in the Residential units for the Execution of Security Measures (Residenze per l'Esecuzione delle Misure di Sicurezza - REMS), which are small residential units managed by the National Health Service dedicated to the treatment and rehabilitation of offenders with psychiatric disorder. REMS were established after the complete closure of Forensic Psychiatric hospitals (Ospedali Psichiatrici Giudiziari - OPG) managed by the Justice System, following a parliamentary investigation and a warning of violations of human rights issued by the European Council, which denounced their systematic failure to provide treatment to mentally ill offenders (Barbui & Saraceno, 2015). The process began in April 2015 and ended in January 2017, during which period all 500 patients of the six OPG were either moved into REMS or discharged to community mental health services.

In contrast with the emphasis on risk-reduction and restrictiveness typical of the old forensic psychiatric hospitals, the new service draws inspiration from the philosophy of recovery of mentally ill offenders (Drennan et al., 2014). This philosophy aims at successful re-introduction into the community through addressing the patients' individual psychosocial and treatment needs. In contrast to the OPG, which operated at the national level, REMS have

81 regional catchment areas, to facilitate visits from family and friends and continuity with local
82 mental health services on discharge.

83 To ensure high-quality standards and to prevent adverse events (e.g. security incidents), each
84 REMS offers a maximum of 20 beds and a staff-to-patient ratio of 0.9:1 (Scarpa, Castelletti,
85 & Lega, 2017). Only clinical personnel are present within the premises and security
86 personnel can gain access only in the presence of a safety emergency. Normally, security
87 measures are limited to fenced perimeters, CCTV and airlocked doors (Scarpa, Castelletti, &
88 Lega, 2017). A small number of REMS, however, have radically interpreted the new
89 philosophy and leave the units unlocked, as it is occurring in the very small REMS of in
90 Trieste, which provides two-to-four beds.

91 REMS employ risk assessment/management strategies which are commensurate with the
92 patient's level of symptoms. Thus, on admission patients undergo a multiaxial assessment
93 and risk assessment using the HCR-20 (Historical Clinical Risk Management – Version 20)
94 (Douglas, Hart, Webster, & Belfrage, 2013), the PCL-R (Psychopathy Checklist – Revised)
95 (Hare, 2003), and the VRAG (Violence Risk Appraisal Guide) (Rossegger, Urbaniok,
96 Danielsson, & Endrass, 2009). This enables the development of a provisional risk
97 formulation for each case, which is regularly updated, based on the evolving needs of the
98 patients.

99 Ageing patients currently represent a significant proportion of the total population in the
100 REMS. At the REMS in Castiglione delle Stiviere (Lombardy Region), one-fifth of the
101 patients are over the age of 50. Despite this, there has been no research investigating their
102 experience of the service and whether it adequately responds to their daily needs. This study
103 aims to bridge this gap by investigating the experience of a sample of ageing patients living
104 in the REMS of Castiglione delle Stiviere. The objectives were: (i) To assess the needs of

105 patients aged 50 and over in relation to key areas of daily living; (ii) to gather their
106 experience and views on the current service provision and to explore their ideas on how to
107 improve the system.

108 Methods

109 *Setting*

110 The REMS in Castiglione delle Stiviere has a catchment area of almost 11 million residents
111 in northern Italy. The personnel includes clinical, administrative and maintenence staff.

112 *Study design*

113 This investigation adopted a case-study design, which was deemed ideal to record 'lived
114 reality' and capture more of the 'noise' of real life compared to other research methodologies
115 (Hodkinson & Hodkinson, 2001). Understanding the individual perspectives of the patients'
116 experiences has become deeply enrooted in forensic research, along with increasing emphasis
117 on the Recovery Model (Drennan et al., 2014). Accordingly, we gave emphasis to the
118 individual 'voices' of the patients.

119 *Ethical approval and risk management*

120 As per Italian legal requirements, we obtained full ethical approval from the Directorate of
121 the REMS Castiglione delle Stiviere to conduct the study. During the process of study set-up
122 and ethical approval, we considered issues which could arise during the study. These
123 included the potential reluctance of patients to comment on service quality for fear of reprisal
124 from the staff, the risk of challenging behaviour, any cognitive challenges and/or fatigue
125 related to age and the sensitivity of some questions included in the needs' assessment scale
126 (e.g. continence or sexuality).

127 We minimised these risks by: (i) Clearly stating during the process of obtaining informed
128 consent that the participant could refuse to answer questions or withdraw from the study at

129 any time; (ii) adopting a flexible approach to interviewing, through active monitoring of any
130 signs of stress, discomfort, fatigue or cognitive difficulty in the participant; (iii) ensuring the
131 availability of emotional/psychological support for the participant, should the need arise.

132 *Selection of participants*

133 We selected participants who: (i) Were aged 50 years old or above (the usual cut-off age for
134 inclusion in the "ageing" category in forensic research (Moll, 2013)); (ii) had been staying in
135 the REMS for at least one year, to ensure that the patient had an established routine; (iii) gave
136 full consent to participate, capacity being assessed by the primary investigator; and (iv) were
137 deemed suitable for interview by the clinical team at the REMS.

138 The process of selection was based on purposive sampling and we relied on the judgment of
139 the clinical team in the REMS to identify the most suitable cases. Despite the risk of potential
140 selection bias, we deemed this strategy would be the best way to identify the patients who
141 were articulate enough to be able to provide enriched narratives of their experience. During
142 recruitment, we took into account variables such as socio-demographics, clinical
143 characteristics and index offence, in trying to obtain as diverse a sample as possible. We
144 stopped recruitment once we reached data saturation.

145 Enrolment and data anonymity

146 Once the patients were identified, the primary investigator met with them to explain the
147 purpose and procedure of the study and answer any questions. After the patients confirmed
148 their interest to participate, the primary investigator arranged a date for the interview no
149 sooner than 48 hours, to allow for adequate time to re-consider. On the day of the interview,
150 the participants were invited to read, date and sign two consent forms, one copy of which was
151 left with the patient and one retained by the primary investigator. To ensure the full

152 anonymity of data, each patient was assigned a number (P01 to P05) for use on all study

153 documents and dissemination material.

154 *Data Collection*

155 Participants' basic demographics (age, marital status, index offence and data on admission)

156 were provided in fully anonymised form to the primary investigator by the clinical staff.

157 Objective 1

158 The patients were administered the CANFOR-S (Camberwell Assessment Needs Forensic

159 version – Short Italian version), a tool which has been validated across different clinical

160 settings (Castelletti, Lasalvia, Molinari, Thomas, Stratico', & Bonetto, 2015). The CANFOR-

161 S investigates needs related to areas of daily living which may impact on the patient's

162 wellbeing. We added four items (eyesight/hearing, mobility, risk of abuse/neglect, and

163 incontinence) from the CANE-S (Camberwell Assessment Needs for the elderly – Short)

164 (Orrell & Hancock, 2004) to tailor our assessment to ageing patients. This process did not

165 impact on scoring, as both scales share the same scoring system. The presence of needs and

166 the quality of support received was assessed for each domain by two independent raters to

167 avoid single-researcher-bias. A scoring of 2 was attributed for unmet needs, of 1 for met

168 needs (i.e. the need was present but help was given) and of 0 when there was no problem.

169 Objective 2

170 The primary investigator undertook and audio-recorded a semi-structured interview with the

171 participants around their experience and potential improvements in the service to enhance

172 their recovery journey.

173 The themes included support, wellbeing, control, activities and improvement of the service

174 and were identified through: (i) Review of policy around promoting the wellbeing of ageing

175 people; (ii) review of the prison literature (Di Lorito, Völlm, & Dening, 2016), which was

176 deemed appropriate given the limited research around ageing forensic psychiatric patients,
177 that most of them are referred from prison and the shared element of restrictiveness; and (iii)
178 liaison with forensic psychiatrists.

179 *Data analysis*

180 The demographic data were transferred onto SPSS 22 (IBM, 2013). Cross-tabulation
181 established absolute and relative frequencies for categorical variables. Means were calculated
182 for continuous variables.

183 Objective 1

184 Data from the CANFOR-S were transferred onto SPSS 22 (IBM, 2013). For each patient, we
185 computed the number and percentage of met needs (i.e. items rated as 1) and unmet needs
186 (i.e. items rated as 2) and the number of needs present (items rated as either 1 or 2). We
187 further determined the areas with the highest (i.e. with the fewest 0 scores) and lowest (i.e.
188 with the most 0 scores) percentage of present needs and those with the most (i.e. with the
189 most 1 scores) and least (i.e. with the most 2 scores) met needs.

190 Objective 2

191 The primary investigator transcribed the interviews and imported them onto NVivo 11 (QSR
192 International Pty Ltd., 2012). We undertook a procedure of back-translation to ensure the
193 integrity of the patients' quotes during translation from Italian to English. We adopted a
194 directed approach to content analysis, which is most suitable when preliminary evidence
195 about a phenomenon requires further research (Hsieh & Shannon, 2005).

196 We used the five themes of the interview (support, wellbeing, control, activities and
197 improvement of the service) as initial key coding categories. We read the transcripts fully and
198 coded quotes relevant to the five categories. At this stage, any quotes that did not fit in this
199 scheme but which were still considered relevant were attributed a tentative new theme. We

200 then restructured/merged the preliminary themes and worked on the tentative new themes.

201 We gave the final themes titles describing their content.

202 Results

203 We included five patients, age range 51-77 years old ($\bar{x}$=66) on the census date (23.09.2016).

204 Two of the patients were divorced, one separated, one married and one single. Index offences

205 included robbery, kidnapping, domestic violence, attempted murder and manslaughter. Four

206 patients had sentences lasting from two to ten years ($\bar{x}$=6), while one had an 'indeterminate'

207 sentence with no fixed length of time.

208 *Objective 1*

209 The number of identified needs among the patients ranged from 14 to 21 out of a highest

210 possible score of 28 (Table 1). Needs were met from 60% to 92.8% of the cases, while unmet

211 needs ranged from 7.2% to 40%. Overall, the maximum number of present needs (n=5) was

212 found for accommodation, food, daytime activities, physical health, information about

213 condition and treatment, psychological distress, basic education, telephone, money, benefits

214 and treatment. This means that all five participants had a need in each of these areas.

215 The minimum number of present needs (n=0) was found for incontinence (item of the

216 CANE), sexual expression and child care. The highest percentage of met needs was found for

217 money and accommodation arrangement (100%), followed by physical health (80%), basic

218 education (80%), benefits (80%) and company (80%). The lowest percentage of met needs

219 was found for sexual expression (0%) and psychological distress (40%). [Table 1 near here]

220 *Objective 2*

221 We obtained four final themes.

222 ### Happiness and self-determination

223 The question “How happy do you feel overall?” received mostly negative responses. Only
224 one patient reported feeling happy enough. The reason often reflected their mental health
225 condition, as highlighted through one patient’s comment:

226 *“There is always a dark side in me” (P01)*

227 It was living in a forensic psychiatric setting, including the deprivation of basic freedom and
228 the lack of prospects about the future, that most impacted on wellbeing:

229 *“It is simply being here. The system makes it difficult” (P02)*

230 *“The absolute lack of certainties prevents me to plan my future. Because I do not know*
231 *whether I will be here one month, one year…” (P02)*

232 Despite these difficulties, when prompted to reflect on self-determination through the
233 question “Do you feel you have control over your life?”, one patient stated:

234 *“Absolutely. I am the master of my choices, the centre of my life. I am driving change” (P01)*

235 However, the other patients reported a perceived lack of control:

236 *“My destiny is not in my hands. It is in the hands of others” (P05)*

237 *“The restrictions are such that there is very little I can do” (P02)*

238 This perceived loss of control led in one case to pessimistic views about the future:

239 *“I will be disabled and destitute because I will not have my driving license, my home” (P05)*

240 ### Coping strategies

241 Further prompted on how they best cope with these emotional difficulties, the patients
242 reported several strategies, such as reminiscing:

243 *“I live on the memories of my nice past. In my own way, I was fully realised” (P04)*

244 Others reported finding comfort in their family*:*

245 *"I find strength in knowing that my children come to visit me every week" (P03)*

246 Spirituality also played a central role in promoting the patients' wellbeing. Some resorted to
247 prayers to gain inner peace:

248 *"Every night I listen to the rosary on the radio and say my prayers" (P03)*

249 However, the patients lamented that the REMS are not supportive enough of religious needs:

250 *"There is a mass on Saturday and that is it. If I wanted to confess, I would not know how to*
251 *do it. There should be daily availability of a priest" (P02)*

252 Another frequent coping strategy was bonding with fellow patients:

253 *"I am happier on the days I know I will be going to the library and when I am with my*
254 *friends and we play cards or bowling" (P03)*

255 Most of the interviewees reported having a special friend or a small group of friends, with
256 whom to spend quality time and receive support:

257 *"We have come together in a small group and we talk with each other" (P03)*

258 *"My friend is happy to help. He is not in my room but he is available. I trust in him" (P04)*

259 Other patients instead reported that friendship within the REMS was difficult, given the
260 differences in background, interests and lack of trust towards other patients:

261 *"I find it very difficult to talk with other patients about things that interest me" (P02)*

262 *"I am not looking for friends. People take advantage of you if they have the opportunity"*
263 *(P05)*

264 In terms of social networking, the patients complained about gender separation, the lack of
265 social opportunities with women and the barriers to sexual expression:

266 *"I do not see why we cannot have social contacts, talk and discuss with women too" (P03)*

267 *"I would love to have contact with a woman but it is forbidden here. For me it is quite*
268 *important. My sexual life does not exist" (P03)*

269 We also asked the participants their views on potential REMS for ageing patients, offering
270 dedicated activities and programmes. Some preferred the prospect of a mixed environment:

271 *"In my opinion a mix is better. It is good to have contacts with people of different ages. It is*
272 *nice to live among young people" (P01)*

273 *"If there is an older patient in need, you usually find someone younger helping him" (P05)*

274 When asked about potential risk of victimisation in a mixed environment, these patients did
275 not show concerns:

276 *"If they threw words at me, I would ignore them and if they harassed me, I would refer to my*
277 *doctor" (P04)*

278 Others acknowledged irreconcilable differences between younger and older patients and
279 voiced their preference for dedicated REMS for ageing patients:

280 *"There should be [REMS for ageing patients], because we have different mentalities" (P03)*

281 Support from members of staff

282 Feedback around staff support was generally positive, as summarised by one patient:

283 *"I see there is an interest in my wellbeing. When I am sad, they invite me to talk" (P01)*

284 Most, however, felt that that despite the extensive support, the patient is ultimately alone
285 during the recovery journey:

286 *"I can talk to the volunteer or an empathic nurse, but eventually I must do the work" (P01)*

287 These positive views on support extended to physical health care:

288 *"I'm very well taken care of. When I experienced pain in my lower abdomen, they*
289 *immediately took me to the hospital" (P01)*

290 When asked to nominate the elements of the REMS that work best, physical health care
291 ranked consistently highly (Table 2). This was despite the lack of a general practitioner:

292 *"From a medical point of view, the situation is quite peculiar, as there are only psychiatrists*
293 *who know very little of general medicine" (P02)*

294 The feedback on the nursing staff was variable, depending on the quality of the relationships
295 they had established with the patient:

296 *"Some nurses are great; some pretend they don't see. It depends on who is on duty" (P04)*

297 The same applied to other professional figures. Overall, the doctors and the nurses received
298 positive feedback. The director was ranked highly among those aspects of the system that
299 seemed to work best (Table 2). The psychologists and health care assistants (Operatori Socio-
300 Sanitari) received less positive comments:

301 *"Health care assistants cannot attend to our emotional needs and the presence of*
302 *psychologists is very limited. Psychological support should be provided at least once a week.*
303 *A 40-minute session every 15 days is insufficient" (P02)*

304 The patients were mostly satisfied with the medical treatment they were receiving. One
305 patient reported:

306 *"My relationship with doctors and nurses has been good. If I needed it, they would be ready*
307 *to prescribe painkillers for my knee pain" (P03)*

308 Satisfaction was expressed with some other aspects of care. For example, mobility aids such
309 as walking sticks/frames or wheelchairs provided to patients in need gave the impression that:

310 "*The staff are attentive toward those with mobility issues" (P01)*

311 The participants also greatly appreciated the staff's flexibility in applying rules to meet their
312 needs:

313 *"They allow me not to queue for food. They bring it to my table" (P02)*

314 Practical aspects of everyday life

315 The patients appreciated activities such as watching movies, reading and discussing books
316 and newspapers, going to the gym, bowling and playing cards. Less accessible activities for
317 those with limited mobility, such as swimming and volleyball, ranked lower in preference.
318 They praised the efforts of volunteers to develop and coordinate the activities:

319 *"They do things despite their limited capacity" (P04)*

320 The existing activity programme was frequently mentioned in the question "What works best
321 within the REMS?" (Table 2) but the patients wished further implementation of cultural
322 activities:

323 *"Newspaper reading is an interesting activity but we only do it once a week" (P03)*

324 The patients also strongly wished that their views be more heard when designing new
325 activities and proposed potential ways of addressing this issue:

326 *"A survey among patients would identify which activities could be offered" (P03)*

327 Nonetheless, they acknowledged the difficulties in developing age-friendly activities. In
328 relation to meals, the patients commented on the lack of variety and the excessive use of
329 processed food and carbohydrates:

330 *"It is not only about taste, but about nutrition. The diet is full of carbs and the patients tend*
331 *to put on weight" (P02)*

332 Indeed, food ranked highest among the improvable aspects of the REMS (table 2).
333 Dissatisfaction was also reported with the limited frequency of phone use and the limited
334 length allowed for phone conversations:

335 *"We should be able to use the phone more. Once a week for ten minutes is too little" (P04)*

336 [Table 2 near here]

337 Discussion

338 Here we present the first study of ageing patients in the recently established Italian residential
339 units for the execution of security measures. Given the prevalence of ageing patients in
340 REMS, it is important to report on their experiences, identify their needs and assess whether
341 these are currently met. Although we are aware that our findings have little generalisability,
342 this fell beyond the remit of our study, which was to give voice to the individual patients by
343 reporting rich narratives of their experience.

344 Despite the limited number of participants, we included a diverse group of patients in terms
345 of socio-demographics, clinical characteristics and index offences. Regrettably, we did not
346 include female patients, as only men agreed to participate. Research has evidenced that
347 women living in restrictive settings have specific gender-related health needs and poorer
348 health status compared to men (Williams, Stern, Mellow, Safer, & Greifinger, 2012; Reviere
349 & Young, 2004; Kratcoski & Babb, 1990). We therefore recommend inclusion of female
350 participants in future studies.

351 Findings from the needs assessment indicated that these were mostly met. Overall, the lowest
352 number of present needs was reported for child care, incontinence and sexual expression.

353 However, given the sensitivity of these topics, the patients may have been reluctant to discuss
354 them fully. Results from the qualitative interviews provided information from the patients'
355 accounts of their life in the REMS. Some patients complained about inconsistent practical
356 and psychological support and limited programme of activities, which expose them to
357 potential apathy and social withdrawal. Nonetheless, the patients reported overall positive
358 experience of the service, especially around accommodation, health care provision,
359 availability of benefits and company.

360 Although we cannot really generalise from our small sample, our findings have allowed us to
361 derive some preliminary considerations that are likely to be salient to forensic psychiatric
362 professionals working elsewhere. The Italian reform is revolutionary, in that it identified the
363 community as the primary place for treating mentally ill offenders. Social inclusion, rather
364 than containment, has become the chosen means to achieve recovery. Following through this
365 philosophy, the Italian reformers did not merely convert OPG into new smaller and better
366 "forensic" units/judicial residencies. They instead have implemented a comprehensive plan
367 through which every patient in the old OPG was discharged into community mental health
368 services, if deemed suitable. Alternatively, if security measures were required, the patient was
369 admitted into the new REMS, which are conceived of only as a purely transitory solution
370 aiming at full discharge.

371 At this stage, given that REMS have only been recently established, the long-term
372 effectiveness and sustainability of the visionary Italian reform cannot be fully determined.
373 However, when the system has become more embedded, there will be the opportunity to
374 assess the impact of the reform, and there may be much to be learned from the Italian forensic
375 experience.

376 ## Implications for Clinical Forensic Nursing Practice

377 Our study adds to the existing evidence around the potential benefits of recovery-based
378 approaches to care (Drennan et al., 2014), which contends that by nurturing the patients'
379 personhood and reducing restrictive practices, recovery is more likely to be achieved.
380 Although the ethos of recovery has gained increasing recognition, the treatment and care of
381 mentally ill offenders worldwide is still largely founded upon restrictive practices, which are
382 justified in terms of incident prevention and patient and staff welfare. While a correlation
383 between restrictiveness and patients' recovery outcomes remains to be ascertained, our
384 findings suggest a potential link between reducing restrictiveness and patients' enhanced
385 experience of the service.

386 Although we did not gather feedback from members of staff, we suggest that a less restrictive
387 regime may also benefit them, while overemphasis on relational security may create greater
388 tension between duties of "care" and "control" among members of staff and generate stress in
389 the workplace. Similarly, overly strict policies may constrain staff within the boundaries of
390 their professional duties and leave very little room to take personal initiative in supporting the
391 patient. We argue that a better balance between recovery-oriented practices and security,
392 which does not compromise on the safety of patients and staff, can be obtained. In this
393 regard, Italy represents a pioneering and (and so far) apparently successful experiment, given
394 the positive feedback of ageing patients around service provision and that no serious security
395 incidents have occurred at the REMS Castiglione delle Stiviere (as reported by the clinical
396 directorate). We therefore encourage staff working with ageing forensic psychiatric patients
397 in countries which adopt more restrictive regulations to consider challenging traditional
398 practices and experimenting with new approaches to care. This might enhance their work
399 experience, promote personal growth and add to their professional skillset, while providing
400 the patients with an enhanced therapeutic journey.

401 In practical terms, we advocate that nurses adopt a more holistic approach to care, adding
402 elements derived from the recovery model to the traditional nursing duties. For example, the
403 recovery model suggests that a truly therapeutic milieu develops when all professionals
404 involved in the caring process create an emotionally supportive infrastructure (Drennan et al.,
405 2014). Nurses can actively contribute to this endeavour by going beyond basic nursing and
406 care duties to nurture human connectedness with their patients. An essential tool that nurses
407 can resort to is effective communication with patients, as confirmed in a recent study around
408 the experience of nursing in forensic psychiatric settings (Dutta, Majid, & Völlm, 2016).
409 Current evidence suggests that older people in restrictive environments experience greater
410 neglect of their needs for human relatedness compared to younger age groups (Doron, 2007).
411 In response, nurses should work to foster truly genuine social interactions and enhanced
412 rapport with older patients, as this creates equal opportunities for recovery (Dutta, Majid, &
413 Völlm, 2016).

414 Nurses can also contribute to recovery within the multidisciplinary team by creating
415 opportunities for social inclusion and re-integration in the community. Our study participants
416 reported that the activities organised through the clinical team, including bocce (bowls)
417 games in the town community centre or periods of temporary leave from REMS (around 40%
418 of patients have at least one leave of a few hours per month) boosted their emotional
419 wellbeing. Given the extended periods of time they spend with patients, nurses have been
420 recognised as the members of staff that are most involved in caring interactions with the
421 patients (Dutta, Majid, & Völlm, 2016). Thus, they can play a contributing role in identifying
422 the patients' needs/preferences and in developing tailored activity plans.

423 Conclusions

424 The development of Italian REMS is very recent. Therefore, the service is still trying to
425 establish ways of more consistent emotional and practical support and developing a varied

426 programme of age-friendly activities, which hopefully will be achieved once the system
427 reaches a more mature stage. Notwithstanding, the patients reported receiving adequate
428 healthcare and service and an overall positive experience of the service. Given the limitations
429 of our study in terms of generalisability, further research is crucial to confirm our preliminary
430 findings on the effectiveness of the Italian recovery-based model to forensic psychiatric care.

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554 *Table 1. Results from needs assessment*

Patient	*Met needs (n; %)*	*Unmet needs (n; %)*	*Needs present*
P01	(15; 71.4)	(6; 28.6)	21
P02	(11; 64.7)	(6; 35.3)	17
P03	(13; 92.8)	(1; 7.2)	14
P04	(14; 77.7)	(4; 22.3)	18
P05	(12; 60)	(8; 40)	20

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559 *Table 2. Patients' nomination of what works best and what is improvable within the REMS*

What works best at the REMS	*What is improvable at the REMS*
Recreational activities	Implementation of more recreational activities
Health care provision	Hearing the preferences of patients
Managerial staff	Telephone allowance and food

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