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Long-term forensic mental health services: an exploratory comparison of 18 European countries

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Abstract

The objective of this study was to explore current provisions within forensic mental health inpatient services for people who require longer-term care within Europe. We used a structured questionnaire and follow-up semi-structured interviews with experts in forensic psychiatry in 18 European countries. All experts interviewed acknowledged the issue of 'long-stay' in forensic psychiatry with patient characteristics including chronic mental disorder, treatment-resistance and violent behaviour. Formal and informal definitions of 'long-stay' varied widely between countries. Eight experts stated that long-stay services are currently available in their country, either in a separate hospital or specific treatment wards. Of the countries without long-stay services, five experts expressed a need develop them. Improved quality of life and promotion of wellbeing were emphasised as the fundamental treatment philosophy. Even without an agreed definition of 'long-stay', it is clear that a proportion of mentally disordered offenders (MDOs) are 'stuck' in 'the system'. Experts shared common concerns in terms of political pressures to contain dangerous MDOs for ensuring public safety as well as ethical debates regarding long-term forensic mental health care. Further research is required to promote dialogue between and within countries to address the balance of patients' rights and public safety, and to produce longitudinal and economic analyses of existing long-stay forensic service provisions.

Key words: forensic psychiatry; mentally disordered offenders; long-stay services; European comparison.

Introduction

Scope of the Problem

Forensic long-stay in Europe

The appropriate care and risk management of mentally disordered offenders (MDOs) poses a number of complex treatment, moral and ethical challenges (Boyd-Caine, 2012; Buchanan & Grounds, 2011; Konrad & Völlm, 2010; Mullen, 2000). Though a rapid reduction of beds in psychiatric hospitals generally has been witnessed internationally, there has been a significant increase in demand for forensic services (Hodgins, Müller-Isberner, & Allaire, 2006; Jansman-Hart, Seto, Crocker, Nicholls, & Cote, 2011; Priebe et al., 2005, 2008). While the length of stay (LoS) in forensic inpatient mental health services has fallen, at least in some countries, and recovery principles have been applied to MDOs (Sugarman & Oakley, 2012), a number of patients still experience lengthy stays in forensic services, potentially at inappropriately high levels of security (Shah, Waldron, Boast, Coid, & Ullrich, 2011; Sharma, Dunn, O'Toole, & Kennedy, 2015; Shaw, Davies, & Morey, 2001). This is of concern for two reasons; firstly, low-volume inpatient forensic services are cost and resource intensive, and secondly, the quality of life in these restrictive environments may be poor (Joint Commissioning Panel for Mental Health, 2013; Vorstenbosch, Bouman, Braun, & Bulten, 2014). Data from a previous comprehensive European comparison highlights the wide variation across Europe regarding total numbers of forensic cases (ranging from 100 in Ireland to 5,400 in Germany in 2002) and prevalence rates per 100,000 population (ranging from two in Greece to 21.7 in Denmark (Salize & Dressing, 2005)). Costs are also high, with a general increase in LoS in medium to high secure hospitals in England and Wales (Rutherford & Duggan, 2007) and an average per person cost of £200,000 in medium secure settings per year (Walker, Craissati, Batson, Amos, & Knowles, 2012).

Factors Associated with Length of Stay

Forensic long-stay in Europe

There is currently no generally accepted definition of 'long-stay' in forensic settings, and little is known about the LoS of these patients in different countries. In England, research has found an average LoS in high secure care of eight years (Dell, Robertson, & Parker, 1987), and for medium secure care it is a little over two years (Edwards, Steed, & Murray, 2002). However, some authors have described a trend for patients to stay for five years or more (Rutherford & Duggan, 2007; Shah et al., 2011; Jacques, Spencer, & Gilluley, 2010) with around a third of medium secure patients deemed to need long-term care (Melzer et al., 2004). A more recent cross-sectional study identified that around 16% of patients resident in high secure settings in England had been resident for more than 10 years, and around 3% for more than 20 years (Völlm, 2015). The Netherlands and Germany have also experienced increasing lengths of stay in forensic inpatient mental health services and increasing numbers of patients in need of longer-term care (Giesler, 2012; Nagtegaal, van der Host, & Schonberger, 2011).

Some previous research has been directed towards identifying characteristics of patients who stay in forensic inpatient mental health services for excessive time periods (Alderman, 2001; Long et al., 2010; Wheatley, Waine, Spence, & Hollin, 2004; Yorston, 1999). Based on discharge samples, comparing those with longer versus shorter lengths of stay, severity of index offence was identified as most important in personality disordered, and psychopathology in patients with mental illness in UK high secure settings (Dell et al., 1987). In UK medium secure settings, research has identified severity of psychopathology, psychiatric history, seriousness of offending, being on a restriction order (requiring Ministry of Justice permission for transfer and discharge), non-engagement in interventions, dependency needs and lack of step-down facilities associated with longer stay populations (Brown & Fahy, 2009; Jacques et al., 2010; Kennedy, Wilson, & Cope, 1995; Long & Dolley,

2012; McKenna, 1996; Shah et al., 2011). Recent research in Sweden of a high-risk forensic cohort has highlighted that violent index criminality, among other factors, is an important factor associated with longer stays in forensic psychiatric treatment (Andreasson et al., 2014). Research has also highlighted severity of the offences committed (Baldwin, Menditto, Beck, & Smith, 1992; Green & Baglioni, 1998), neuropsychological impairment and low IQ as factors associated with LoS (Colwell & Colwell, 2011). Research from the USA has highlighted problematic behaviour and increasing physical health problems associated with long-stay (Fisher et al., 2001), and research from Ireland associated severe mental illness and violent offending with increased LoS (O'Neill et al., 2003). However, little is known about the patient characteristics of those who remain in secure care, how to formally identify them, or how to best meet their needs in existing services when they may require longer-term care than other patients. There exists a patient population who, due to a perceived long-term risk, spend their entire lives in secure forensic settings. As such the question needs to be asked whether this population's needs are currently being catered for in mixed populations (that is, with 'shorter-term' patients leaving the system quicker, but who may be more acutely unwell than the long-term patient population). With some individuals spending their entire lives in secure settings, restrictions on personal freedoms become more apparent, including restrictions on patients' rights to family life and sexual expression. For example, Tiwana and colleagues (2016) found that many countries lack national policies on sexual expression for patients in forensic mental health services, with the UK in particular being most prohibiting. For people subject to such restrictive settings, it is relevant to explore whether designated long-stay services are able to address fundamental rights and needs of this patient population.

International Perspective

Forensic long-stay in Europe

At the international level, complex differences in patient populations, diagnoses, legal frameworks, differing concepts of criminal responsibility, service provision as well as cultural, political and public expectations lead to heterogeneity in MDOs admitted to forensic care and mental health services providing this care (Edworthy, Sampson, Völlm, 2016; Salize & Dressing, 2005). Such differences impact on service provision and treatment outcomes for individuals; for example, certain countries provide various forensic inpatient and outpatient mental health services, while others either do not recognise forensic psychiatry as a separate specialty, or do not possess the sufficient resources or training in order to ensure satisfactory service provision for MDOs (Salize and Dressing, 2005). Some countries have developed policies and services specifically designed for long-stay patients and it is this service provision that is the focus of exploration in our study.

Objective of Current Study

This study sought to explore current service provisions within forensic mental health inpatient services for those who require longer-term care within Europe. In order to put provision for this patient group in context, we also describe briefly the legal framework governing forensic mental health services in each country, as well as availability and access to services for MDOs. We then investigate the availability of long-stay services in 18 countries within Europe, with a focus on definitions of long-stay, legal frameworks, service configuration, patient populations, quality of life and ethical issues.

Methods

Context

Forensic long-stay in Europe

All but three included countries are members of the European Union (the exceptions being Switzerland, FYR Macedonia and Serbia), and all countries in this study are state parties to the *European Convention on Human Rights and Fundamental Freedoms* (ECHR, Council of Europe, 1950), which provides a common-ground that '*legitimises international scrutiny of mental health policies and practices within a sovereign country*' (Salize & Dressing, 2005). Furthermore, all included countries, as of 2015, have signed and ratified the *European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment* (CPT, Council of Europe, 1987) with most also ratifying the *Convention on the Rights of the Persons with Disabilities* (CRPD, United Nations, 2006; Finland, Ireland and The Netherlands are all signatories but have yet to ratify the CRPD). Each of these conventions place responsibilities and obligations on state parties to ensure and promote certain human rights and fundamental freedoms for all people without discrimination, particularly when deprivation of liberty has been ordered by a public authority after the commission of a crime or in the context of a persons' mental disorder or other disability.

Design

We approached experts associated with the EU-funded COST action IS1302 (Cooperation in Science and Technology) 'Towards an EU research framework on Forensic psychiatric care'.[1] A national selection process is required to join this network, which ensures all COST country representatives are leading clinicians and researchers with expertise in forensic psychiatry and a particular interest in long-term forensic psychiatry. A written questionnaire was developed by the core group of the COST action (grant holder, chair, co-chair, scientific advisor; see online materials). Topics addressed included system and definition elements,

[1] http://www.cost.eu/COST_Actions/isch/Actions/IS1302; this website also lists all national experts.

admission and discharge, patient characteristics and service provisions. This questionnaire[2] was designed to provide context, prepare for and direct the content and structure of the subsequent semi-structured interviews[3]. Semi-structured interviews were conducted by telephone with the experts that had provided the questionnaire for their country (see online materials). The interviews focused on service provision for long-stay populations in each country, characteristics and practice of service provision, key challenges and hindrances in their implementation and outcomes. Information about practical aspects of such services (e.g. size of wards, level of security) as well as clinical and risk factors, treatment pathways, legal frameworks, perspectives on quality of life and ethical considerations of long-stay facilities were also discussed. Interviews were recorded with consent of the participant and were subsequently transcribed and analysed using thematic qualitative analysis. All participant data were anonymized, with all names removed from within transcripts, and stored securely as per the Data Protection Act 1998. The study was part of a larger, national, multi-centre project, sponsored by Nottinghamshire Healthcare NHS Trust, which provided Research and Development (R&D) approval. Due to the nature of the study (expert interviews) separate NHS research ethics approval was not required.

Procedure

We gathered data from 18 separate countries in total. Out of the 19 countries participating in the ISCH COST action IS1302, we were able to interview 17 representatives from 16 countries (one per country, with two from the Netherlands);[4] all interviews took place via

[2] Countries completing the questionnaire: Belgium, Croatia, England, Finland, Germany, Ireland, Italy, Latvia, Lithuania, FYR Macedonia, Poland, Portugal, Serbia, Slovenia, Spain, The Netherlands

[3] Countries interviewed: Belgium, England, Finland, France, Germany, Ireland, Italy, Latvia, Lithuania, Poland, Portugal, Serbia, Slovenia, Spain, Switzerland, The Netherlands

[4] For the full list of ISCH COST action IS1302 participants, see: http://www.cost.eu/COST_Actions/isch/Actions/IS1302?parties. We were unable to obtain any data from Cyprus or

teleconferencing (in the English language) between June 2013 and November 2014. For the remaining two countries (Croatia and Macedonia), we were only able to use data from the initial structured questionnaire.

Analysis

Data analysis was conducted using thematic analysis (Braun & Clarke 2006) to identify common themes, and was coded using NVivo qualitative data analysis software by one researcher, with 20% (i.e. four interviews) double-coded by the senior author (NVivo, 2014). Data were analysed both inductively (with themes that emerged from interview content) as well as deductively via the use of coding determined by the themes explored in both the initial questionnaires and subsequent semi-structured interviews (Fereday, 2006). All participants checked the full interview transcripts for accuracy of their statements before analysis.

Results

Legal Frameworks and Service Provision for Mentally Disordered Offenders

Legal frameworks

The majority of countries included in this study operate under civil law jurisdiction, with only England, Wales[5] and Ireland operating under common law jurisdiction. Procedural differences between admission and diversion provisions can be partly attributed to legislative differences. In some countries, e.g. Germany and Switzerland, local variations exist in the various 'states'

Greece. Switzerland is not a party to COST, however, and was additionally recruited through the Forensic Section of the European Psychiatry Association due to the long history of forensic psychiatry in Switzerland.
There were two experts from the Netherlands as the first participants did not have a clinical role but was interviewed as having an overview of service organisation across the country as part of their role.

[5] The MHA 1983 and the criminal laws referred to throughout this paper apply to England and Wales, however the representative interviewed as well as the figures and comments on service provision are specific to England only.

('Länder' in Germany, 'Kantone' in Switzerland). In Germany, however, state laws define patient rights and staff duties, which vary considerably between states with no standardised procedures beyond admission and discharge of forensic patients.

The majority of countries' legal frameworks relevant to the management of MDOs are found under criminal laws and penal codes as well as dedicated mental health legislation. The seven countries in which MDOs are managed mainly via mental health legislation (i.e. separate to penal codes or criminal codes) include England and Wales (Mental Health Act 1983), Ireland (Mental Health Act 2001), Croatia (Protection of Persons with Mental Disorders 2015), Lithuania (Mental Health Care of the Republic of Lithuania 1997), Serbia (Protection of Persons with Mental Disorders 2013), Finland (Mental Health Act 1990) and Slovenia (Mental Health Act 2008). With the exception of Latvia and Macedonia, the former Soviet Socialist Republic (Lithuania) and three former Yugoslavia Republics (Croatia, Serbia and Slovenia) have designated new mental health legislation separate from criminal laws or penal codes, with the intention of more closely complying with shared international legal obligations under the ECHR, the CPT and the CRPD.

Croatia (the EU's most recent member state to join in 2013) introduced the country's law on the 'Protection of Persons with Mental Disorders', which came into effect January 2015. This new legislation intends to replace the traditional medical model approach to treatment with a human rights based approach to reflect the principles of the CRPD (Bagarić, Živković, Curković, Radić, Brečić, 2014). This is an important development in mental health law in Europe, with implications for the way in which the CRPD is acknowledged and implemented by countries that are signatories to the convention. For individuals with disabilities deprived

of their liberty, provision of 'reasonable accommodation' (Article 14) is of particular concern to long-stay forensic populations.

Access to forensic mental health services

Forensic mental health services and general mental health service provision for prison populations vary widely between countries (see Table 1 for an overview of services, and Table 2 for patient population characteristics, admission and discharge procedures).

Most countries included (with the exception of England and Wales, Finland and Latvia) stipulate that a treatment order/ forensic placement and a prison sentence can be imposed at the same time, with the order by which they are served differing between countries (as also detailed by Salize & Dressing, 2005). Most countries' admission procedures allow for MDOs to be 'diverted' from the criminal justice system to forensic mental health services either before or after sentencing (Table 1).

Diversion from prison to a designated forensic or psychiatric hospital is not possible in Croatia, Germany, Italy, Lithuania, the Netherlands or Serbia; if a prison sentence is imposed and subsequently a mental disorder emerges, then treatment is provided for via prison general psychiatric services or a designated prison hospital. After diversion from prison to forensic mental health services for treatment, should treatment be considered complete, most countries require the patient to be sent back to prison to complete their sentence. Finland, Italy, Latvia, Lithuania, Poland and Portugal are the exceptions, where patients are either discharged back to the community or sent to facilities of lower security. Each country expert stated that there was no fixed release date for people admitted to forensic mental health services, with the key criterion of dangerousness as justification for lengthier stays. It is worth

noting, however, that since the time of the present study, new legislation has been introduced in Croatia and Italy specifying that patients cannot remain in forensic settings for longer than what would have been their sentence for the same offence had they been healthy and sent to prison. Furthermore, in the case of Portugal, for crimes punishable by imprisonment for less than eight years, length of stay in a forensic mental health service cannot exceed this time. However, should dangerousness not be found to justify continued stay in a forensic mental health facility (as reviewed every two years), then the patient must be discharged. In England and Wales, patients may either be moved back to prison (while their sentence is still active) or remain in the hospital system, depending on the needs of the individual. Each country provides some inpatient prison psychiatric services, with either designated 'prison hospitals', psychiatric wards within prison, or via visiting mental health professionals (psychiatrists or psychologists); however, these services are not standardised throughout prisons in the included countries (Table 1).

Admission criteria for forensic and/or general psychiatric inpatient services for MDOs share some similarities across countries, including that a mental disorder needs to be present in order to be admitted, e.g. psychotic disorders, personality disorders (typically associated with another mental disorder), cognitive disorders, learning disabilities and substance misuse (typically associated with another mental disorder). Substance use related disorders and personality disorder (as the sole disorder) might constitute an exclusion criterion for forensic services in some countries (Table 2).

In order to be admitted as a forensic psychiatric inpatient, the majority of countries' laws and regulations stipulate that a person needs to have committed a crime and that there was a relationship between the mental disorder and the criminal behaviour. This is not the case in

England, Wales or Ireland in which patients can be admitted to forensic mental health services under civil legislation if they are in need of treatment but have not committed an offence. Although MDOs in Belgium and Slovenia must have committed a crime in order to be admitted as a forensic patient, they are the only other European countries that do not require a relationship between the mental disorder and the criminal behaviour. In Germany, the seriousness of a crime (usually a violent crime) and a high risk of reoffending are requirements for admission to forensic services.

In most countries, it is necessary for the offender to have diminished or absent criminal responsibility in order to be admitted to forensic inpatient services. England, Finland, Ireland, Portugal, Serbia, Slovenia and Switzerland are the exceptions to this rule. In these countries, admission is typically on the basis of the need for treatment and 'therapeutic security' (Table 2).

Length of Stay

Definitions

Seven of the 18 countries were able to offer a formal definition of 'long-stay', either under legislation, regulations or based on national health research, and thirteen countries' experts provided an informal observation of length of forensic inpatient stay in secure settings (Figure 1).

The formal definitions do not necessarily reflect what would constitute a 'long-stay' in forensic mental health services in practice in Finland, Ireland, Portugal, Spain and the Netherlands. For example, Finland's law on Social and Healthcare Service Fees (1992) defines 'long-stay' as three months of continuous institutional treatment regardless of the reason for

treatment (i.e. applicable to forensic psychiatry, general psychiatry and somatic treatment). Subsequently, *'as Finnish law defines long-term as being over three months practically all forensic patients are long-term'* (Finland). Finland's expert stated that national data relating to inpatient forensic hospitalisations gathered by the Institute of Welfare and Health (HILMO) estimated a median LoS of forensic inpatients at nine years in 2012, and around five to six years between 2010-2012. Ireland and Spain have formal definitions of 'long-stay' for general mental health services of two or more years.

In the Netherlands, long-stay is defined as a forensic measure lasting for six years or longer (see TBS, as described below). One expert from the Netherlands observed that stays of ten years or more can be seen in designated long-stay services; however, with pressure to reduce LoS in compliance with performance indicators.

'[W]e have to reduce length of stay from ten to eight years… you can expect people to stay longer than those ten years, so we have to get a filter for them…' (Netherlands, Expert B).

The Netherlands was the only country where a legal definition specific to forensic services exists, and patients may be transferred to specific forensic long-stay facilities once this time has lapsed under a separate legal section.

Other countries that offer a formal definition of 'long-stay' include Lithuania, FYR Macedonia and Portugal, legally defined as a lapse of six months, treatment of more than one year, and more than three years respectively. Representatives from these countries were, however, not able to provide national research data regarding LoS in forensic populations.

Figure 1 illustrates LoS in forensic care for the 13 countries where such information was provided, ranging from four years in Italy to ten years in Belgium, England and Serbia and the

Netherlands. These figures include participant observations of LoS in what they described as a 'longer-stay' population in various forensic services for MDOs, including high-secure populations in England and populations in designated long-stay facilities in the Netherlands.

Generally, between four to eight years was considered 'long-stay' (at varying security levels) in eight of these countries. Some countries identified that LoS had decreased in recent years:

'*The cross-sectional mean length of stay for the 94 secure beds here is about seven years. That has fallen over the last ten years from being in the region of 12-13 years.'* (Ireland).

'With the new medications and new treatments we do not have many situations in which patients stay for twenty years or thirty years' (Portugal).

However, the fact that some patients do spend their entire lives (or a vast amount of it) in forensic mental health services was highlighted in some interviews*:*

'There are also patients who stay for actually their whole life' (Latvia).

'I: What are the long-term prospects for people who don't go back to the community? R: To die in prison, something like that' (Belgium).

'Offenders who won't be discharged – it's clear they can't get out during their lifetime. So they stay till they die' (Switzerland).

Dedicated forensic mental health long-stay services

Representative experts from eight countries stated that specific services are available for long-stay forensic inpatients, either in a separate hospital or specific treatment wards (Table 3). The representative from Croatia stated in the questionnaire that specific services are currently available to forensic patients who are long-stayers; however, because it was not

possible to undertake an interview we were not able to obtain further information. Portugal's expert stated that services were available for long-stay patients, but upon closer questioning it emerged that these services do not differ to those for patients with shorter lengths of stays. The remaining countries currently offering some form of 'long-term' forensic inpatient mental health services include: England, France, Germany, Ireland, the Netherlands and Spain (see Table 3).

Only in the Netherlands are admission criteria for these services standardised by law nationally (under a separate TBS long-stay order: Terbeschikkingstelling, translated as '*at the discretion of the state*', allocating a prison sentence followed by a psychiatric treatment order for mentally disordered offenders. The prison sentence serves as punishment, followed by a treatment order to promote reduction in risk of further offending). After having been an inpatient at two separate forensic mental health hospitals for six years or more, where a patient has completed relevant treatment programmes but with little discernible progress and no foreseeable reduction in risk from further treatment, they can then be transferred to a long-stay facility following review by an independent national panel. Where other countries, such as England, France, Germany, Ireland and Spain, have specified treatment wards within forensic mental health hospitals, there are no national laws or policies to govern these and so the design of such services is left to individual units resulting in inconsistencies. The expert from Ireland provided a detailed definition of forensic long-stay, namely having been under forensic care for at least five years but with no recovery pathway to the community in the foreseeable future. In Portugal, 'long-stay' is understood as *'forensic patients in inpatient safety measures for an indefinite time'*. Patient characteristics in long-stay services were described by experts as displaying violent or dangerous behaviour, '*therapeutic non-*

responders' (or treatment-resistance), those who present a '*danger to society'* (having committed violent crimes or presenting with continued violent behaviour) and those who are in the service for longer than average or '*indefinitely'* (Portugal). Treatment within these facilities includes general psychiatric and medical treatment, however, with less focus towards risk reduction and greater focus on *'wellbeing'* (Germany), *'quality of life'* (England, Ireland and the Netherlands) or preparation for intensive rehabilitation and educational interventions (Spain).

There is greater emphasis on '*maintenance'* and improving standards of living for chronic, treatment-resistant patients who present a continued risk to society, in what would otherwise be a highly restrictive environment,.

'…[W]e are doing everything we can to prevent institutionalisation to keep their minds stimulated… essentially to maintain a decent quality of life' (Ireland).

'In a long-stay facility… they get [the] *regular psychiatric or medical treatments they need, but not to reduce their risk… it makes no sense to keep these patients in very expensive forensic services where they are supposed to get treatment* [if] *they don't respond to treatment or do not engage in treatment'* (Netherlands, Expert A).

The expert in England acknowledged that different services are available to different patient groups, with *'low stimulus', 'homely environments'* for treatment-resistant populations and a *'recovery-focused'* pathway for low-secure, complex-diagnosis populations (with the latter identified as being effective in terms of discharge rates).

Quality of life

Forensic long-stay in Europe

The importance of addressing quality of life in service provision and care was generally recognised by all participants.

'… [W]e have absolutely no other rehabilitation plans except to uphold the quality of life of this person, that's all we can do' [Finland].

'When you finally say, okay, listen we don't know how to get you out of the service [or how] *to significantly reduce your risk of reoffending, so you have to stay here… what can we do to improve your quality of life?'* (Germany).

In the countries that offer specialised long-term forensic mental health services, a common theme of quality of life was difficult to measure amongst patients.

'…[Y]*ou ask this patient on Monday morning his opinion about his quality of life [and at the end of the day it changes]'* (the Netherlands, Expert A).

'For some service users, particularly longer stay and longer-term, they have very limited capacity to give you an opinion of what they see as their quality of life' (England).

Difficulty in ascertaining patient-rated quality of life has led to uncertainty amongst practitioners as to how to achieve an improved standard for long-stay populations.

'…[W]*hat was much more useful, in a structured way, was to assess what we deemed their needs as being. And if we deemed what their needs were through the Camberwell assessment of needs… then we have to provide an environment where those needs can be met.'* (England).

Forensic long-stay in Europe

Experts from the Netherlands detailed a study regarding comparisons of self-reported quality of life and proxy assessments in the Netherlands (Schel, Bouman, & Bulten, 2015). This research compared quality of life ratings of long-stay forensic inpatients with the ratings of psychiatric nurses, who predicted patients' responses. It was found that there was poor agreement between the patient scores and the nurse's proxy scores, indicating maybe that more staff training on quality of life issues will be beneficial in supporting and optimising patient's quality of life experiences.

In countries without long-stay forensic services, quality of life was not regarded as high within prison or other mental health inpatient services for long-term populations, with lack of financing and uncertainty in meeting patients' needs as potential barriers to improvement.

'[Q]*uality of life for the patients is very, very low … [a]ctual forensic hospitals are really prisons… and prison does not make [for] easy therapeutic treatment*' (Italy).

'…[T]he quality of life is bad - they have nothing to do on the psychiatric wards, no hobbies, no friends, I don't know, no family - what more can I say' (Poland, Expert A).

The experts in Serbia and Slovenia detailed lengthy travelling distance to centralised inpatient services as having a potential impact on a patient's quality of life, in terms of family visits and its impact on treatment. This highlights how it is not only the material conditions within long-stay services that may influence the complex issue of quality of life, but also external factors, including physical distance from family members. Quality of life factors were considered by all experts and remain a conscious focus in improving the quality of care for long-stay populations, where there is current uncertainty as to how to improve care and living conditions if treatment progression is not made.

Challenges in the development of long-stay services

Long-stay services in Hessen (Germany) appear to have developed gradually over the past twenty years with little organisational or legal resistance. Some obstacles, however, were noted in the development of these designated long-stay services; difficult to manage and treat patient populations were simply secured in long-stay facilities (including those with personality disorders), which led to patient challenges regarding their right to treatment due to little prospect of recovery or release.

Experts in the Netherlands described difficulties in a lack of prescribed criteria regarding admission and discharge of patients when establishing long-stay services, an issue which is still being clarified.

In the countries without separate, designated long-stay facilities, according to experts interviewed (England, France, Ireland and Portugal), the term 'long-stay' is not a widely used concept amongst practitioners, nor is it always considered a helpful categorisation. Opinions regarding the further development of specific long-stay services were mixed, with ideological and cost-related factors impeding further development.

'I think if I was [a] *commissioner I'd be a bit worried about* [developing long-stay services] *because, you know, obviously commissioners want as short a stay as possible in secure care because the cost is so high'* (England).

'[T]he general consensus is that the psychiatrists are unhappy with the long-stay proposal… the right wing is strongly in favour, the left wing is strongly against… but if it's regularly checked [then] *I think we need one'* (France).

Forensic long-stay in Europe

'…[T]he idea that anybody with a mental illness has a long-term need isn't acknowledged. This isn't just a forensic problem but it's an ideological non-scientific view that nobody with a mental illness… will not recover to complete autonomy in complete independence.' (Ireland).

'…[C]urrently we are trying to deal with lack of funding to provide very basic health services in prisons.' (Portugal).

In the aim of reducing costs, one expert from the Netherlands contested whether long-stay facilities in fact reduced costs in the long-term.

'… [T]he fact is, because these people are older they actually need more care, they need different care than the… regular TBS patients, they need more somatic care, they need more nursing… so I'm not sure that these facilities are really cheaper' (the Netherlands, Expert A).

Countries with no Long-Term Services

For the remaining countries in which long-stay services for forensic inpatients have not been implemented, three offer a definition of 'long-stay' (Table 4). These definitions, however, apply to all patients receiving healthcare and as such are not limited to forensic mental health services.

Most country's experts stated that there has been an increase in focus on LoS in recent years and most experts observed a typical 'long-stay' of between four to ten years, with care needs not necessarily being met for these typically chronic, treatment-resistant, violent populations. Experts from Poland and Lithuania highlighted that increased LoS is not a typical problem within their forensic mental health care systems, with both country's experts indicating that

efforts are currently underway to create a database for the monitoring of patient characteristics and LoS.

The five countries that expressed a need for long-stay service provisions include Belgium, Latvia, Serbia, Slovenia and Switzerland; only the expert from Slovenia was able to confirm that there are current plans to develop long-stay forensic services. Many country's experts commented that more investment and focus is needed on improving and developing regular inpatient forensic care as well as outpatient care before discussions regarding long-stay services can be considered (Finland, Latvia, Lithuania). Anticipated barriers to setting-up potential future long-stay forensic services included institutional barriers, lack of financing and public attitude towards MDOs.

'Money, money, money and attitude towards offenders in society' (Belgium)

'[H]ealthcare professionals are not pushing the issue forward and again this isolation keeps them on the level that they have been working ten years ago' (Serbia)

Ethical Issues

Amongst the countries, attitudes to long-stay were mixed and experts raised some pertinent ethical issues regarding treatment philosophies and lengths of stay. The expert in Belgium specifically emphasised that ethical issues regarding coercion and mandatory treatment, as well as the right to have a sexual life, were important factors, particularly when patients are detained for prolonged periods of time. The expert in Serbia identified general institutional ethical considerations, including 'professional isolation' of forensic psychiatrists:

' *… [P]rofessionally, they are isolated; meaning that they don't receive on a regular basis, let's say training on issues of health and human rights and ethics'* (Serbia).

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Not all country experts identified specific ethical issues concerning the development of long-stay services and anticipated populations:

'… I think you have to have a good structure for arguing why you need to continually detain somebody and as long as you've got that clear structure… I don't think the ethical issues arise, to be frank' (England).

Experts in Poland and Portugal acknowledged the conflict between the personal freedom and autonomy of patients as well as safety of the public, particularly when patients lack insight into their mental disorder:

'...[T]o *what extent shall these patients be treated as general criminals and to* [what] *extent must they be regarded as someone who has some mental disorder?'* (Portugal).

Experts in the Netherlands identified the negative association that emerged after the (initially positively perceived) development of long-stay services.

'… [W]hen you are [in long-stay] *that's life-long detention in a very awkward situation where you will not be treated because in the* [court] *ruling it says when somebody's not treatable…. now we are fighting back a bit because our rates* [demonstrate] *that people are in fact leaving the system… but people don't understand it* [or] *take notice'* (the Netherlands, Expert B).

Providing efficient, effective treatment, beneficial for improving mental health as well as risk reduction and achieving a higher quality of life for patients, is challenging in a forensic environment, in which restrictions are placed upon patients (Buchanan et al., 2011; Mason, 1999). It has been suggested that addressing quality of life for patients within a restrictive forensic psychiatric setting may have an important part to play in improving treatment

outcomes and lowering recidivism risks in the long-term (Nieuwenhuizen & Nijman, 2009; Völlm, Bartlett, & McDonald, 2016). These competing concerns were, unsurprisingly, recognised by all country experts.

Discussion

Main Findings

The purpose of this study was to explore existing long-stay forensic mental health service provisions, as well as identify characteristics in potential long-stay populations and services offered in the included 18 European countries. Each country offers some form of mental health care for MDOs either in prison, general psychiatric practice or in forensic settings. Representative experts from eight countries stated that specific services are available for long-stay forensic inpatients, either in a separate hospital or specific treatment wards.

It is clear from the information we gathered that what constitutes a 'long-stay' varies widely between countries, as do treatment philosophies, service provisions and attitudes towards potential long-stay services. What is not clear from the information gathered is whether long-stays are due to an inappropriateness of treatment interventions in various jurisdictions, or whether the interaction with service provision promotes recovery or rehabilitation of patients. In order to answer these questions, all countries would need to make seismic efforts to contribute towards establishing an evidence-base for appropriate treatment and outcome measures for particular patient populations, including personality disorder and sex offenders (which at present is limited – see Khalifa et al., 2010; Khan et al., 2015), as well as improve record-keeping and progress of individual patients. The Netherlands and Germany are highlighted as providing the most well established specific long-stay services. These two countries are identified as having progressed the furthest in the development of long-stay

services, but are still in the process of justifying their need in terms of demonstrating that it is possible to discharge patients - not all are lost to long-stay.

The remaining countries that currently provide long-stay services (or 'slow-stream' or similar terms used in England and Ireland) do so in special wards or treatment units, with the aim of improving quality of life and the promotion of wellbeing forming the fundamental treatment philosophy when attempts to engage in traditional or standard models of treatment have failed. Of the countries that do not currently offer specific long-stay services, five expressed a need to initiate the development of such services for their longer-stay populations. Importantly, the label *'long-term'* and any potential specific long-stay services carry a political and ideological concern, as identified by some of the countries' experts.

For countries that are in the process of developing long-term forensic mental health services, international dialogue can serve to be invaluable by learning from other countries, particularly those with which we share a common bond in unity under the EU or through our understanding and promotion of international human rights. It is clear that long-stay patients are a reality in many of this study's included countries, demonstrating that care is happening either formally (for countries that currently provide long-stay services) or informally (for those who do not). The perceived importance of developing designated forensic long-stay services rests in recognising the proportion of patients who do not necessarily respond well to standard treatment and who are still deemed to present a risk to society. The balance seemingly to be had is differentiating between the 'long-stayers' and those with shorter stays who are more 'able' to move through services. Indeed, not all countries expressed a need for separate services for 'long-stayers' and 'non-long-stayers'. The Netherlands was the only country included that provided a clear process of assessing patients suitable for transfer to a

long-stay facility (TBS), while other countries markedly differed. Other countries also offering some type of long-stay services were not necessarily guided by specific national laws or policies, meaning that the design of such services is left to individual units, resulting in inconsistencies. This is a potential conflict with the CRPD, notably in terms of 'reasonable accommodation', in which persons who are deprived of their liberty through any process should be able to exercise, on an equal basis with others, human rights and fundamental freedoms. With services so varied in definition and delivery between countries (all signatories to the convention) this leads to lack of clarity as to what would constitute 'reasonable accommodation' for the purposes of the CRPD.

As individual country experts indicated, common characteristics associated with long-stay included treatment non-response, chronic mental disorder, and dangerous or violent behaviour. Long-stay services emerged in part as a response to this chronicity and treatment-resistance to focus less on risk reduction and more towards improving quality of life, where standard services are not perceived to suitably cater for the needs of long-stay patients, nor provide positive treatment response. An anticipated benefit of long-stay services, particularly in the Netherlands, was also to reduce costs of lengthy stays in low-volume, resource intensive inpatient forensic services; however, country experts cast doubt onto these expectations, with an aging population requiring much higher, costly levels of care and support.

With a move towards longer periods of care, it is understandable that concerns are raised regarding potential (re)institutionalisation of patients. In conflict with this concern is the political and societal ideology of risk-based containment integral to modern day European society (Priebe et al., 2005). The responses of experts involved in this study largely confirm

this conflict, with no current answers on how to overcome the complexities of balancing patients' rights whilst ensuring public safety.

Study Limitations

To our knowledge, this is the first exploratory study that has compared the availability of long-stay services from 18 countries within Europe. We were able to interview individual experts with extensive experience, training and knowledge who could offer authoritative observations regarding service use, implementation, current provision and future prospects of long-term forensic care in their countries. This study also builds upon the existing (now relatively dated) comparative work (Salize & Dressing 2005; Salize, Dressing, & Kief 2007; Salize, Dressing, & Peitz, 2002). This study contributes towards this developing area of long-stay service provision, with both questionnaires and follow-up interviews adopted in methods. Further, the addition of two former Soviet Socialist Republics (Lithuania and Latvia) and four former Yugoslavia Republics (Croatia, Macedonia, Serbia and Slovenia) provides for more inclusive discussion, and sheds light on service provisions in countries with still a relatively young history under modern governments. In acknowledging these strengths, weaknesses must also be considered.

Firstly, all experts interviewed were able to provide insight into their local practices, which may not necessarily be representative of their entire country. In the same vein, interview data rely largely on the observations and impressions of individual experts, rather than empirical data on LoS, recidivism and risk, and differences in treatment approaches. Further research should be directed towards these areas, as well as gauging the use of evidence-based treatment practices.

Secondly, each country operates under differing governments with widely varying populations and markedly different histories (particularly in the provision and practice of psychiatry and the availability of experts in the sub-speciality of forensic psychiatry) making comparison between countries difficult, with heterogeneity of concepts, legislation and practice greatly expected. This heterogeneity, however, serves as a reminder of the pluralism and diversity within Europe.

Thirdly, all questionnaires and interviews were conducted in the English language, which presents a challenge in fairly representing and interpreting participants' responses for non-native English speakers (Van Nes, Abma, Jonsson, & Deeg 2010). Context-bounded concepts may also pose an obstacle to *'effective and meaningful international comparison'* (Hantrais, 2009). However, we sought to understand the interpreted experience of the participants and represent their opinions and responses in a meaningful way within the appropriate contexts. We also sent participants their transcript to read and amend as necessary to ensure we captured the correct meaning.

Also, not all European countries were included in this study; therefore results are not generalizable or representative across Europe.

Finally, all participants interviewed were psychiatrists, academics and other highly trained specialists in the field of psychiatry or forensic psychiatry; however, patient voices are missing from this discussion. In particular, patient perspectives on quality of life from those currently within long-stay services would be invaluable in order to paint a more holistic picture.

Conclusions

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Our findings have important implications for policy and service developments. Efforts are needed to identify a definition of what constitutes 'long-stay'. Without a clear definition, whether based on actual years of detention or a measure relative to the average length of stay, it is not possible to develop specific policies for this patient group. Given the specific needs to long-stay patients such specific policies are necessary, whether or not they include separate service provision.

Further research should encapsulate the patient perspective of long-stay service provisions, as well as performing longitudinal outcome and economic analyses of existing long-stay forensic service provisions. Such observational research will inform us about how long-stay services are currently performing, their associated costs, and the attitudes of their patient populations and allow the development of best practise recommendations for this group.

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Conflict of interests

The authors declare that they have no conflicts of interest concerning this research.

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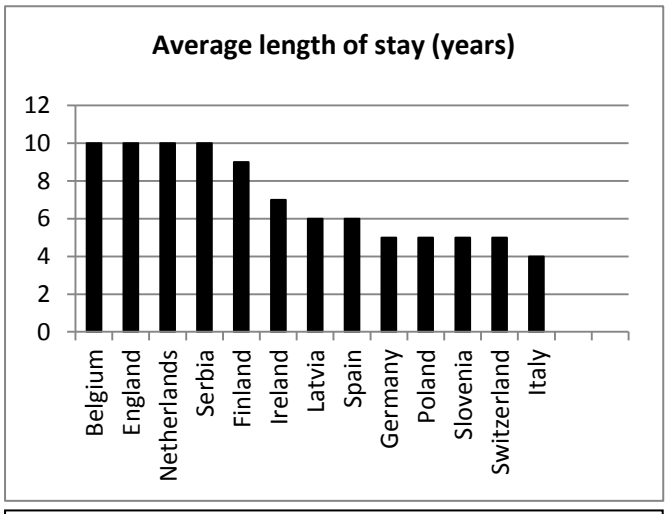

Figure 1: Expert participant observation of average length of stay in forensic inpatients at medium and high secure levels (not defined) and long-stay services (Spain, Netherlands)

Table 1

Country	Type of state & population[6]	Facilities[7]	Diversion from prison to hospital possible (post-sentencing)	Hospital security levels (approx. number of beds)	Governance and funding
Belgium	Federal 11 million	• 3 social defence establishments • 2 high secure hospitals • 3 medium secure forensic wards • Basic prison psychiatric services	Yes	High (370) Medium (150) Low	• Joint Federal Ministry of Justice and Federal Ministry of Public Health (forensic services) • Federal Ministry of Justice (prison services) • Wallonia: joint Minister of Social Welfare and Ministry of Justice • Paifve: largely subsidised by Ministry of Justice
Croatia	Unitary 4.5 million	• Forensic psychiatric departments in 4 out of 5 psychiatric hospitals • 1 prison hospital • Prison psychiatric services for substance misuse	No (Sent to prison hospital)	High Medium Low	• Ministry of Health (forensic services) • Federal Ministry of Justice (prison services)
England	Unitary (UK), devolved healthcare provision 53 million[8]	• 3 high secure forensic hospitals • Approx. 60 medium secure forensic hospitals • Low secure forensic hospitals • Prison psychiatric services (wards and prison 'in-reach' teams)	Yes	High (800) Medium (3-4000) Low (3-4000)	• Joint Ministry of Justice and Department of Health (forensic and prison services) • Private/ independent providers for up to 60% of medium and low secure services
Finland	Federate 5 million	• 2 state hospitals • 3 university hospital wards	Yes	High Medium Low	• Ministry of Social Affairs and Health (forensic services)

[6] All country population estimates from The World Bank (2013) http://data.worldbank.org/indicator/SP.POP.TOTL
[7] Data complemented by reference to Salize and Dressing 2005 and the World Health Organisation mental health atlas (WHO 2005)
[8] England population estimates from Office of National Statistics, annual mid-year population estimates (2013) http://www.ons.gov.uk/ons/dcp171778_367167.pdf

		• Basic prison psychiatric services		Open-ward (470 total)	• Ministry of Justice (prison services)
France	Federate 65 million	• Regular psychiatric hospitals • 2 high secure hospitals • 2 prison psychiatric units • Minimal prison psychiatric services (for MDOs who accept treatment)	Yes	Maximum High	• Ministry of Health and Social Affairs (forensic services and two prison psychiatric units)
Germany	Federal 80 million	• Approx. 65 high to open-ward forensic psychiatric hospitals (50-400 patients in each) • Forensic wards within general psychiatric hospitals • Prison psychiatric wards	No	Each hospital offers high, medium and low secure services (7000)	• Federal Ministry of Health (forensic services) • Federal Ministry of Justice (prison services)
Rep. Ireland	Unitary 4 million	• 1 forensic hospital (Dublin) • Prison psychiatric services (wards and prison 'in-reach' teams)	Yes	High Medium Low (each provided in the 1 forensic hospital) (94 total)	• Department of Health (forensic and prison services)
Italy	Devolved 60 million	• 6 forensic hospitals[9] • Prison psychiatric services	No	High Medium Low	• Ministry of Health (1 forensic psychiatric hospital and prison services) • Ministry of Justice (majority of forensic psychiatric hospitals)
Latvia	Unitary 2 million	• 1 secure forensic unit (Riga) • Secure psychiatric clinics • Prison psychiatric services	Yes	High Medium Low Open-ward	• Ministry of Health (forensic services) • Ministry of Justice (prison services)

[9] However, see Barbui & Saraceno (2015), detailing new legislation that calls for downsizing and closure of these forensic hospitals.

Lithuania	Unitary 3 million	• 1 secure forensic unit (Rokiškis) • Prison psychiatric services	No	High Medium Low (320 total)	• Ministry of Health (forensic and prison services)
FYR Macedonia	Unitary 2 million	• Forensic departments in 2 out of 3 psychiatric hospitals • Prison psychiatric ward (short term treatment)	Yes	High Medium Low	• Ministry of Health (forensic services) • Ministry of Justice (prison services)
Netherlands	Federate 16 million	• Forensic Psychiatric Clinics (TBS), including long stay TBS • Forensic Psychiatric Units (FPA) within general psychiatric hospitals • Prison psychiatric services (PPCs); 5 Penitentiary Psychiatric Centres • 1 prison Forensic Observation Unit (FOBA)	No	High Medium Low TBS (1867) FOBA (66)	• Ministry of Safety and Justice (forensic services; some private)
Poland	Unitary 38 million	• 3 high secure forensic hospitals • 17 medium secure forensic hospitals • 22 low secure forensic hospitals • Prison psychiatric services	Yes	High (193) Medium (827) Low (1495)	• Joint Ministry of Health and Ministry of Justice (forensic and prison services)
Portugal	Unitary 10 million	• 2 high secure forensic hospitals • 7 general psychiatric hospitals • 1 special prison hospital (medium secure) • Prison psychiatric services	Yes	High Medium Low	• Ministry of Justice (forensic services) • Private/ independent providers of prison psychiatric services

Serbia	Unitary 7 million	• Closed forensic psychiatric wards in 2 of 5 general psychiatric hospitals • Special prison hospital • Prison psychiatric services	No (Sent to prison hospital)	High Medium Low	• Ministry of Health (forensic departments or wards in general psychiatric hospitals) • Ministry of Justice (prison hospital and services)
Slovenia	Unitary 2 million	• 1 forensic hospital • Prison psychiatric services (outpatient)	Yes	High Medium Low	• Joint Ministry of Health and Ministry of Justice (forensic and prison services)
Spain[10]	Devolved 46 million	• 3 psychiatric penitentiary hospitals (2 in Spain (398 beds), 4 in Catalonia (154 beds)) • 1 hospital for pre-trial MDOs (Barcelona) • Prison psychiatric services	Yes	High (603 total) Medium Low	• Joint Department of Health and Ministry of Justice (forensic and prison services)
Switzerland	Federal 8 million	• 7 closed forensic psychiatric hospitals • 22 'half-open' forensic psychiatric hospitals • Prison psychiatric services	Yes	High Medium Low	• Federal Office of Public (forensic services) • Federal Department of Justice and Police (prison services)

[10] Forensic and penitentiary services and admission criteria differ between Catalonia and the rest of Spain, with services more heavily privatised in Catalonia.

Table 2

Country	Included populations	Excluded populations	Connection between mental disorder and crime required?	Diminished/ absent criminal responsibility required?	Decision to discharge from forensic psychiatric hospital	Fixed release date from forensic psychiatric hospital?
Belgium	• Psychotic disorders • Personality disorder • Cognitive disorders • Learning disabilities (LD) • Substance misuse (associated with other mental disorder) • Mood disorders (high comorbidity)	• None	No (Yes - prior to sentencing)	Yes	Court (based on one or more expert evaluations)	No
Croatia	• Psychotic disorders • Personality disorder • Cognitive disorders • Learning disabilities • Substance misuse	• None	Yes	Yes	Court (based on one or more expert evaluations (forensic psychiatrist/ team of in complicated cases))	(not specified)[11]
England	• Psychotic disorders • Personality disorder • Cognitive disorders • Learning disabilities • Substance misuse (associated with other mental disorder)	• None (though individuals with LD can only be admitted if associated with 'abnormally aggressive or seriously	No	No	Ministry of Justice, responsible clinician (usually a consultant psychiatrist), hospital managers, Mental Health Review Tribunal (depending on Section)	No

[11] Since the time of the present study, new legislation has been introduced in Croatia specifying that patients cannot remain in forensic settings for longer than what would have been their sentence for the same offence had they been healthy and sent to prison.

		irresponsible conduct')				
Finland	• Psychotic disorders • Personality disorder (associated with other mental disorder) • Cognitive disorders • Learning disabilities (associated with other mental disorder) • Substance misuse (associated with other mental disorder)	• None (severe LD patients primarily treated separately from forensic patients)	Yes	No	Board of forensic psychiatry operating under the Ministry of Social Affairs and Health; administrative courts	No
France	(not specified)	• None	Yes	Yes	Court	No
Germany	• Psychotic disorders • Personality disorder • Cognitive disorders • Learning disabilities (medium-severe) • Substance misuse • Comorbidity	• None	Yes	Yes	Court	No
Rep. Ireland	• Psychotic disorders • Personality disorder (associated with other mental disorder) • Cognitive disorders • Learning disabilities • Substance misuse (associated with other mental disorder) • Autistic spectrum • Acquired brain injury	• Personality disorder (if sole disorder) • Substance misuse (if sole disorder)	No	No	Treating consultant, clinical director, Mental Health Review Board, court (remanded)	No

Italy	• Psychotic disorders • Personality disorder (associated with other mental disorder) • Cognitive disorders (associated with other mental disorder) • Learning disabilities • Substance misuse (associated with other mental disorder)	• None	Yes	Yes	Court (magistrate) (Magistrato di Sorveglianza or the Trial Judge who applied the security measure)	No[12]
Latvia	• Psychotic disorders • Personality disorder • Cognitive disorders • Learning disabilities • Substance misuse (associated with other mental disorder)	• Psychotic disturbance (if patient able to control criminal action at time of offence, then prison) • Personality disorder, cognitive impairment, LD, substance abuse (if sole disorder)	Yes	Yes	Court: based on evaluation of forensic psychiatrist	No
Lithuania	• Psychotic disorders • Cognitive disorders • Learning disabilities • Substance misuse (associated with other mental disorder)	• Personality disorder, LD (if sole disorder)	Yes	Yes	Court	No

[12] Since the time of the present study, new legislation has been introduced in Italy specifying that patients cannot remain in forensic settings for longer than what would have been their sentence for the same offence had they been healthy and sent to prison.

FYR Macedonia	• Psychotic disorders • Cognitive disorders • Learning disabilities • Substance misuse (associated with other mental disorder)	• Personality disorder, LD (if sole disorder)	Yes	Yes	Ministry of Justice after opinion of forensic psychiatrist	-
Netherlands	• Psychotic disorders • Personality disorder • Cognitive disorders • Learning disabilities • Substance misuse	• None	Yes	Yes	Court (guided by TBS clinic opinion)	No
Poland	• Psychotic disorders • Personality disorder • Cognitive disorders • Learning disabilities • Substance misuse	• None	Yes	Yes	Court (based on opinion of psychiatrist)	No
Portugal	• Psychotic disorders • Personality disorder • Cognitive disorders • Learning disabilities • Others (where associated with mental disorder and related to criminal behaviour) • All of the above on case-by-case basis	• Substance misuse	Yes	No	Court	No[13]
Serbia	• Psychotic disorders • Personality disorder • Cognitive disorders • Learning disabilities • Substance misuse	• None	Yes	No	Court (based on opinion of psychiatrist and psychologist)	No

[13] For crimes punishable by imprisonment for less than eight years, length of stay in a forensic mental health service cannot exceed this time (however, in practice this sometimes happens). However, should dangerousness not be found to justify continued stay in a forensic mental health facility (as reviewed every two years), then the patient must be discharged.

Slovenia	• Psychotic disorders • Personality disorder • Cognitive disorders • Learning disabilities • Substance misuse	• None	No	No	Court (based on opinion of independent psychiatrist)	No
Spain	• Psychotic disorders • Personality disorder • Cognitive disorders • Learning disabilities • Substance misuse (associated with other mental disorder)	• Personality disorder (if no diminished responsibility) • Substance abuse (if sole disorder) • Anxiety • Paraphilia • ADHD	Yes	Yes	Court	-
Switzerland	• Psychotic disorders • Personality disorder • Cognitive disorders • Learning disabilities • Substance misuse • Asperger's syndrome	• Personality disorder (if sole disorder) • Substance abuse (if sole disorder)	Yes	No	Court (based on opinion of treating clinician)	No

Table 3

Forensic long-stay in Europe

Country	Definition of long-stay (forensic psychiatric inpatients)	Service provision	Included populations	Treatment philosophies
England	None agreed (Term 'long-stay' avoided)	• Some long-stay wards ('enhanced rehabilitation' or 'slow-stream') • Private forensic sector provision for patients *'with little prospect of discharge'*	• *'Complex diagnosis of a psychotic disorder, personality disorder and drug and alcohol misuse'* • *'Treatment resistant schizophrenia'* • High security level • Assaultive behaviour • Risk to public	Greater focus on quality of life *'Low stimulus environments'* for treatment-resistant patients *'Recovery-focused'* Psychological and medical treatment for patients with complex diagnoses
France	None agreed	• 1 high-secure unit (Paris)	• *'Violent patients'*	*[No available data]*
Germany	None agreed	• Wards provided in forensic hospitals (open to high-secure hospital) • Some forensic hospitals specialising in the care of long-term patients (in Hessen)	• Forensic patients *'in the service longer than average'* • *'Not dischargeable in the foreseeable future'* • *'Therapeutic non-responders'* • *'Therapeutically unreachable patients'* • Psychopathy, chronic acute schizophrenia, chronically violent	Regular psychiatric and medical treatment Greater focus on wellbeing
Rep. Ireland	1. In the forensic hospital for more than 5 years; and 2. A recovery pathway to a community place cannot be foreseen in the next five years (not including those returned to prison and those frequently readmitted)	• Additional units at high or medium security • Special ward for longer-term low secure care ('slow-stream')	• *'Mentally ill prisoners, e.g. mentally ill life prisoners who are not currently in the hospital'* • *'Revolving door prisoner patients'* • Treatment resistant, multiple comorbidities, continuing challenging and dangerous behaviour	Greater focus on quality of life '*Stratified therapeutic security'* – five-tier security system Regular psychiatric and medical treatment (clozapine) Behavioural programmes

Table 4

Country	Formal definition of long-stay	Long-stay populations (length of stay in years)	Potential included populations/ diagnoses or 'blockages'	Need for long-stay services?	Current plans to develop long-stay forensic services?
Belgium	No	10 years	Treatment/ therapy-resistant Sex offenders presenting risk Schizophrenia	Yes	No
Finland	3 months	9 years	Hebephrenic schizophrenia (ICD-10) Non-engagement in treatment	Unsure	No
Italy	No	4 years	Violent patients Schizophrenia or psychosis Substance abuse Personality disorder Anti-social behaviour	-	No
Latvia	No	6 years	Chronic disorder 'High level of disability'	Yes	No
Lithuania	6 months	-	Chronic patients	-	No
FYR Macedonia	1 year	-	-	-	-
Poland	No	5 years	Treatment non-responders Chronic mental disorder Organic brain disease Substance misuse Sexual disorders Intellectual disability	Unsure	No
Serbia	No	10 years	-	Yes	No
Slovenia	No	5 years	Danger to society	Yes	Yes
Switzerland	No	5 years	Treatment non-responders Severe personality disorder Schizophrenia Asperger's syndrome Intellectual disability	Yes	No

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