

External factors influencing length of stay in forensic services: A European evaluation

Catriona Connell^{1,2}, Allan Seppänen³, Franco Scarpa⁴, Paweł Gosek⁵,
Janusz Heitzman⁵, Vivek Furtado^{1,2}

¹ Warwick Medical School, University of Warwick, Coventry, UK

² Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham, UK

³ Helsinki University Hospital, Psychiatry, Division of Psychoses and Forensic Psychiatry, Helsinki, Finland

⁴ USL 11 Forensic Unit, Toscana, Italy

⁵ Department of Forensic Psychiatry, Institute of Psychiatry and Neurology, Warsaw, Poland

Summary

Objectives. A growing number of patients whose length-of-stay in forensic services is above average length are identifiable in several European countries. Forensic services are situated within a particular sociocultural setting. Accordingly, this trend to increased admission length cannot be solely attributed to patient characteristics. This is the first known study exploring the influence of external factors on length-of-stay in forensic services.

Methods. Representatives from 16 European countries, members of the international COST project, focused on forensic psychiatric service, analyzed their respective forensic services using a structured tool. Responses were combined and analyzed using thematic analysis.

Results. Four themes described the factors influencing length-of-stay: care and treatment pathways; resources; legal and systemic impact; and sharing expertise.

Conclusions. Findings suggest multidisciplinary consideration of the whole care pathway is required to address increased length-of-stay. Further research is required to support development of evidence-based standards applicable across Europe, and improve outcomes for patients at risk of increased length-of-stay in forensic services.

Key words: forensic psychiatry, long-stay patients, length-of-stay

Introduction

Forensic psychiatry as a discipline exists at the interface between mental health services and the criminal justice system. Contrary to general psychiatry, forensic psy-

chiatry encompasses additional responsibilities besides providing treatment for mental disorders. This includes risk assessment and management of offending behavior, so providing a public protection role in society. Compulsory detention and treatment, which is often at variance to the wishes of the patient, may lead to long-lasting hospitalization and social exclusion. Forensic patients are doubly stigmatized, because of severe mental disorder and because they committed a criminal offence [1]. Some data suggest that forensic patients typically spend more time in psychiatric services than if they had been convicted or treated as civil offenders [2].

Internationally, admissions to forensic services are rising [3]. An average 110% increase in forensic beds across nine Western European nations has been reported between 1990 and 2006 [4]. Concurrently, length of stay (LoS) is also increasing [5]. Within these overall trends, a subgroup of mentally disordered offender patients (patients from this point forward) have been identified, for whom existing forensic mental health services (forensic services from this point forward) are insufficient to enable their timely progression to less restrictive (outpatient) settings. There is no consensus on how to best meet the needs of these 'long-stay' patients with debate ranging from quality-of-life approaches to service reconfiguration [6, 7].

The increasing number and length of admissions to forensic services may be attributable to changing patient characteristics. Priebe et al. [8] hypothesize there may be increased incidence of mental disorder, or higher rates of substance misuse and criminality among those with mental disorder. Data testing these hypotheses are inconclusive [3, 9]. Identifying the characteristics of patients with increased LoS forensic services is increasingly subject to researchers' attention [10, 11]. In Germany, Ross et al. [12] compared the characteristics of long-stay (over 10 years) to short-stay (under 4 years) patients. Long-stay patients were more likely to have committed a serious offence, have diagnoses of personality disorder or mental retardation, and have lower social and occupational functioning (living with support, lower education and employment achievements, less participation in structured activity, and fewer successful intimate relationships). In Sweden, Andreasson et al. [13] identified contrasting associations with psychosis and substance misuse history. Drawing conclusions is further restricted by variation in the definition of 'long-stay' and in the factors considered important to measure.

The decision and justification for ongoing detention is influenced by several factors, and thus cannot be entirely accounted for by patients' individual characteristics. Forensic services are not unchanging systems operating in isolation. They exist within a wider environmental context, and thus external factors are likely to contribute to

rising admissions and LoS. Suggestions of external factors that influence LoS include changes in mental health and criminal legislation, inadequate and under-resourced general mental health services, lack of social and community support, court diversion schemes, aggression risk averse clinicians, and expanding admission criteria. The international deinstitutionalization movement in general mental health services has been linked to criminalization of mental illness [14]. Arguably, the additional failure to provide community mental health support has contributed to people with mental disorders being at increased risk of displaying problematic behavior and coming to the attention of police and forensic services [3, 15]. In the Republic of Ireland, O'Neill et al. [16] found an inverse relationship between reductions in general services and demand for forensic services. This trend is reflected across Europe. A survey of 11 European countries (including Austria, Belgium, Denmark, France, Spain, Ireland, Germany, Switzerland, Italy, the Netherlands, and UK) revealed that the ongoing reductions in psychiatric beds has happened at the same time as a reciprocal increase in places in other institutions, including prisons [17]. In a study of six nations, four had experienced increase in forensic placements that outweighed reductions in general services [4, 8]. Public expectations that society should be free from risk of harm, termed the 'safety utopia' [18], has implications for discharge, with clinicians held responsible for adverse outcomes [19]. Negative public perceptions result in patients facing barriers to integration, such as obstacles to accessing employment, housing and occupations of value [20]. Reducing these barriers may facilitate development of protective factors against recidivism risk and could accelerate safe and successful discharge [21].

Currently, empirical evidence to support or refute hypotheses about the influence of external factors on LoS is minimal and inconclusive [3, 8, 9]. As a result, forensic services lack complete information on which to design provision and base practice to better meet the needs of patients. This may lead to suboptimal use of restricted resources and cause prolonged LoS. Furthermore, legal and mental health systems vary between European nations because of historical, social, political, financial, and cultural differences. Consequently, there is variation in the external factors acting on forensic services in different nations that may influence LoS.

The aim of this study was to evaluate the external factors influencing LoS in forensic services in European countries.

Method

Participants

Participants were purposively sampled from the mailing list COST Action IS1302 on Long-Term Forensic Psychiatric Care (European Collaboration in Science and Technology, 2015)¹. The COST Action IS1302 was established as a basis for comparative evaluation and research on effective treatment, and the development of best practice in long-term forensic psychiatry in Europe. The aims of the COST Action IS1302 were to develop cost effective policies in forensic services, enhance evidence-based practice in long-term forensic care and optimize patients' quality of life. This group consisted of clinicians and academics with expertise in forensic services and interest in the needs of patients with above average LoS.

Measures

Participants completed a 'SWOT' (Strengths, Weaknesses, Opportunities, Threats) analysis using a data-collection tool in tabular format. A representative reported the strengths and weaknesses of forensic services in their country as they related to LoS. This was followed by an account of the opportunities and threats within forensic services to meet the needs of patients with above average LoS.

Procedure

Potential participants from 19 European countries were contacted by email via the COST Action mailing list. The data collection purpose and method were explained in the email and the data collection tool provided as an attachment. Participants completed and returned the table by email to the authors (CC and VF). Data were collected between July 2014 and May 2015. At least two reminders were sent; one of which was a personalized reminder to each participant. Data were received from 16 countries.

Data analysis

Completed tables were downloaded and provided to the first author (CC) in anonymized form. Data were analyzed following the six stage framework of thematic analysis [22]. During stage 1–3, categories (strengths, weaknesses, opportunities,

¹ <http://lfpc-cost.eu/>

threats) were analyzed separately to form initial codes and themes. Stage 4–5 involved comparing and contrasting these themes to develop, define and name overarching themes for the whole dataset. Selected extracts are presented throughout the paper to illustrate the content of the themes (Stage 6). NVivo (QSR International, 2012, NVivo qualitative data analysis software; Version 10, Melbourne, QSR International Pty Ltd.) was used to assist with analysis.

Peer review was adopted to enhance trustworthiness and credibility of findings. Peer review involved discussion in research supervision and scrutiny by a multidisciplinary group with international experience. Scrutiny by those with experience of the reported phenomena and ability to relate to findings is considered a sound credibility check [23, 24].

Results

Sixteen representatives provided data describing forensic services in every region of Europe. Disaggregation by region (using the classification adopted by the United Nations for statistical purposes), revealed that representation was geographically spread as follows: Northern Europe ($n = 5$; 31%), Eastern Europe ($n = 2$; 13%), Southern Europe ($n = 5$; 31%), Western Europe ($n = 4$; 25%). Themes and subthemes derived from the data are shown in Table 1. These are described below and illustrated by verbatim quotations.

Table 1. Themes and subthemes

Overarching themes and subthemes	
Care and treatment pathways	Admission criteria
	Route to discharge
	Community integration
Resources	Facilities
	Quality staff
	Funding
Legal and systemic impact	Legal frameworks
	Systemic factors
Sharing expertise	Collaboration
	Standards and guidelines
	Research

Care and treatment pathways

Participants described how components of the care pathway influenced LoS throughout an admission. This theme includes three sub-themes: admission criteria, route to discharge and community integration.

Admission criteria

Admission criteria were often reported as a factor influencing LoS, but differences existed in relation to whether it was a strength to allow admission of those with diverse needs, or to restrict it to a specific group. For example “Only imposed on delinquents with Axis I diagnosis (DSM-IV); delinquents with a main diagnosis on Axis II are not treated”; “It hosts every type of disabilities: psychosis, PD, learning disabilities”; “Only for dangerous prisoners and for short term care (most cases personality disorders with psychopathy 50%, psychosis 40%)”. More participants reported a strength if their forensic services excluded personality disorder, addiction, learning disability and dementia. Those who included these diagnoses, or where there was comorbidity, reported the lack of suitable treatment as a weakness that increased LoS.

Route to discharge

Where countries had the option to provide levels of security this was considered a strength, but only if transition could occur fluidly. When coupled with insufficient capacity, multi-level systems risked contributing to increased LoS, inappropriate placement and delayed treatment, e.g., “Tiered system results in <bottlenecks> and long waiting times to move from one service to another”. One participant described a focus on enhancing quality of life for those who could not progress. However, more participants reflected a belief that failure to progress was because their services were not meeting the patient’s needs, compromising their quality of life by delaying progress to less restrictive settings, e.g., “Lack of specialized treatment programs for specific groups of forensic patients (i.e., personality disorders, drug dependency)”. There was disagreement about legally defined endpoints to treatment. Whilst it prevented extended LoS among patients who did not progress, it also increased risk if treatment needs were outstanding, e.g., “Due to the determined SM duration, it might be that a patient still poses a high risk after completion of the sentence, and thus when returning into society” (in Poland, after termination of a custodial sentence). Some participants identified that being able to operate more flexibly without seeking judicial permission to

discharge was beneficial to reduce LoS. Others recognized a potential weakness in that it did not protect clinicians if there were adverse consequences, leading to risk aversion potentially increasing LoS, e.g., “A lot of responsibility on clinician for discharge decisions – affected by fear to get it wrong”.

Community integration

Participants identified the absence of a rehabilitative approach throughout the care pathway as a weakness, which influenced likelihood of successful community integration and increased LoS, e. g., “No systemic approach to social rehabilitation in the forensic psychiatry. Restricted funds for tasks related to the social rehabilitation in forensic psychiatry setting”. Institution-centric approaches and the absence of community treatment options were widely discussed as a weakness that increased LoS, as those who could be discharged with community support remained institutionalized in inappropriately restrictive settings, e.g., “Lack of forensic outpatient facilities, there are neither specialized community units nor ambulant facilities. Patients will be treated in psychiatric facilities with unspecialized staff”. The lack of rehabilitative support was continued from inpatient treatment to the community and thought partially responsible for poor outcomes including risk of recidivism. This was particularly problematic for patients whose prolonged LoS and removal from society often left them ill equipped to cope with demands of modern life, e.g., “Absence of individual rehabilitation programs for forensic patients outside the hospital. The problem of patients who have nowhere to live. The problem of unemployment after discharge”; “Such patients can find themselves remanded to prison soon after they have been discharged from their local approved centre”.

Resources

A consistent theme across participants and nations was the need for adequate resources to meet the needs of long-term patients in forensic services. Three interrelated subthemes describe facilities, quality staff and funding.

Facilities

For some, the existence of forensic services was a strength. Although even in these situations, capacity to meet the level of demand and attempting to provide specialist intervention within the general mental health system was acknowledged as a weakness, e.g., “There are some specialized settings but not enough [...]”. Where hospital

facilities were modern, purpose-built, and nearby local amenities, it was considered a strength for rehabilitation, e.g., “Good chances for integration and rehabilitation for patients due to easy access of urban facilities and closeness of natural environment with good options for physical and recreational activities”. The absence of purpose-built facilities and multidisciplinary treatment was conversely viewed as a weakness that limited therapeutic intervention and delayed recovery, e.g., “Poor condition of most facilities, poor access to sport and therapeutic infrastructure [...] all the facilities have been adapted from general psychiatry units”; “No long-term stay possible except in psychiatric hospitals but number of beds dramatically reduced [...]”; “Few specialized institutions in forensic mental health”; “Poor possibilities for maintenance and development of daily life – productive activities due to lack of adequate space at the forensic hospital wards”.

Quality staff

The requirement for specialist skills was recognized by the majority of participants. In some countries, forensic psychiatry exists as a recognized medical specialty. However, many participants reported a lack of skilled staff, attributed to financial underinvestment, and few training and professional development opportunities. In some countries, an ageing staff group was recognized as a weakness. The benefit of a stable and experienced multidisciplinary team was emphasized, e.g., “Shared awareness to be able to manage difficult patients”. Intra-national variety in the level of care, and staff quality and experience in forensic psychiatry have been recognized in some countries as a weakness of the forensic system.

Funding

A few participants were confident that adequate resources were committed to developing forensic services. The relative autonomy of forensic institutions, patients' quality of life and the adequate level of financing were highlighted. The majority identified funding as a weakness that influenced LoS, e.g., “Insufficient number of staff in all subgroups [...] due to insufficient financial efforts”; “Financial restrictions for psychiatric evaluations (quota system) which leads to long investigation time”, and identified social and political influence on funding decisions, e.g., “Society not in favor of investment of this patient group as times of cuts [...] Financial constraints – less therapy on offer – worse outcomes”. Funding was reported to impact staff retention, which consequently influenced quality care. For some participants, the additional com-

plexity of the work needed to be reflected in remuneration, e.g., “Low salary of staff accompanied with a high risk of violence, no differences between general psychiatry and forensic psychiatry”.

Legal and systemic impact

Participants referred to national legal frameworks as an important influence on LoS. The need to balance restrictions and personal autonomy was identified, as well as the political and public perceptions that influenced legal and clinical decision-making. Two sub-themes were described: legal systems and systemic management.

Legal systems

International variation in the strength and complexity of mental health and criminal law was evident. For some, well-established legislature was a strength, detailing who can be detained and ensuring patient rights are protected, e.g., “Acts exclude from the criteria for detention anyone who is only (a) personality disordered, (b) socially deviant or (c) addicted to drugs or intoxicants. This has the beneficial effect that such persons cannot be indefinitely detained [...] relatively modern statutes are compatible with the European Convention on Human Rights”. Conversely, absence of or poorly applied legislation was reported as a weakness, e.g., “Totally unregulated situation concerning the hospitalization of mentally ill patients (very different not harmonized laws, e.g., criminal law and mental health law)”.

Separation of political and public opinion through use of the courts was considered important. However, participants perceived that judicial personnel did not always have enough knowledge of pertinent issues. Where forensic psychiatry was recognized as an independent specialty within the legal system, participants considered this a strength, e.g., “Forensic psychiatry is an independent medical specialty”; “Responsible psychiatrist can advise the judge upon placement in units with more/less restrictions. In other words, patient can be transferred to different security levels, e.g., prison psychiatric unit, civil psychiatric hospital, community (outpatient) treatment”. The alternative, where forensic psychiatry was not recognized as an independent medical specialty the converse was true, and the potential for increased LoS in inappropriate settings was raised, e.g., “Increased prevalence of psychiatric patients in prisons (a lot of experts think they are partly responsible)”.

Compulsory hospital treatment without time-limits was recognized by some of the experts as a weakness, leading to inappropriately long stays in the case of minor

crimes. Whilst a judge-determined duration of sentence (in Poland, during a stay in forensic services) prevented patients becoming ‘stuck’ in the system, it also presented a risk to society and a patient’s mental wellbeing if he or she was released with unmet treatment needs.

Systemic factors

Robust external monitoring was reported as a strength where present and weakness where absent, e.g., “Standards and means of ensuring compliance. These include [...] ensuring that mental health detention can occur only in approved centers, and setting standards for approved centers which are enforced”; and “Insufficient engagement of Ministry of Health and Ministry of Justice in development of optimal forensic mental health system”. Whilst levels of bureaucracy were cited as a weakness by one participant, a more commonly cited weakness was disorganization and services working in isolation impacting on patient progression, e.g., “Hospital is not into a functional network of collaborations with other health services, the Courts, Civil Social Service”; or “High risk facility operates solely. There’s is no link between this setting and the forensic field”.

Systemic design led to financial incentives that could help or hinder patient progress, e.g., “Home-towns pay for treatment, so they have an incentive to take back their patients for continued rehabilitation after (expensive) forensic treatment”; and “Perverse incentives – keeping beds occupied, etc.”.

Participants also reported the perceptions of the courts and wider public as a weakness that potentially contributed to increased LoS or poor outcomes, e.g., “Attitude and misunderstanding of society (and also a court) about mental illnesses”; “dangerousness for society”; “Risk averse society affects clinical decision-making”.

Sharing expertise

The final theme described how participants wanted to be able to share and develop expertise. Three subthemes were identified: collaboration; standards and guidelines; and research.

Collaboration

Collaboration at individual, organizational, government and international level was recognized as a strength where present. Participants referred to criminal justice and health systems, non-governmental organizations, and government departments,

e.g., “Treatment of prisoners in the hospital out of prison system and concomitantly adequate support of security service from the prison”. An absence of collaboration within and across national borders was considered a weakness in meeting the rehabilitation needs of patients with increased LoS. The participants acknowledge that external factors also influenced the ability of collaborators to support the ambitions of forensic services, e.g., “Lack of interest from general psychiatry on collaborating in planning pathways of care”; or “Decline of longer term care in community and civil settings. Forensic services are having to fill this vacuum for those whose behavior in the community proves unacceptable”.

Standards and guidelines

Where a few participants reported presence of standards of practice, this was considered a strength, e.g., “The use of treatment guidelines in forensic hospitals is actively encouraged and followed-up”. However, more participants identified that standards and guidance were absent or inconsistent, contributing to difficulties making evidence-based decisions, e.g., “Lots of policy changes in short timeframe without sufficient evidence to back them up”; or “Lack of consensus in guidelines between different settings”.

Research

A few participants recognized research activity as a strength in their country, though this was relative and generally viewed as insufficient, e.g., “Scientific research is possible under some conditions in the forensic psychiatry setting”. Many more considered the minimal research as a weakness, partly attributed to lack of attention, and partly due to the challenges of researching this vulnerable group of patients, e.g., “Few scientific research”; “Lack of a structured, nation-wide forensic research”; “Lack of national studies/research of forensic patients”. Some participants pointed out difficulties adopting new research findings in practice.

Discussion

This study explored the external factors influencing LoS in forensic services in Europe. Thematic analysis of data pertaining to forensic services in 16 European countries revealed broad consensus among the participants regarding which external factors impact progression through forensic services towards less restrictive settings and the community. This conclusion was drawn from the symmetry between

factors identified as strengths where present and weaknesses where absent, and vice versa. This symmetry was reflected in each of four themes: care and treatment pathways; resources; legal and systemic impact; and sharing expertise. Within the themes there were different perspectives of the ideal situation for reducing LoS. This was evident in contrasting views about appropriate admission criteria, particularly whether patients with primary diagnosis of personality disorder should be admitted to forensic services. This reflects the wider debate on whether individuals with personality disorder lack criminal responsibility [25]. Where forensic services were not initially designed to include patients with personality disorder, this reportedly led either to exclusion and potentially harmful detention in prison, or to admission and potentially increased LoS due to a lack of specialized treatment. Primary diagnosis of personality disorder was found to be associated with increased LoS by Ross et al. [12]. Other studies considered comorbid personality disorder and identified no association [7, 13].

Rehabilitative input throughout the care pathway is identified as a strength where present and weakness where absent. Participation in occupational therapy and psychological interventions has been associated with reduced LoS, although only investigated in a relatively small sample [26]. Lower premorbid social functioning among patients with above average LoS [12, 13] suggests rehabilitative needs are likely to be higher amongst this group. However, measurement of long-term community integration and agreement on what outcomes are investigated is lacking. Furthermore, the level of multidisciplinary involvement in forensic services varies internationally. For example, forensic occupational therapy is well-established in the UK and Sweden, under development in Finland, not recognized in Greece and Spain and recently introduced in Belgium and Slovenia [27]. The limitations of traditional treatment models for patients with above average LoS, and limited research to determine effective treatment that achieves improvements in community functioning post-discharge/release, present challenges to all forensic professionals working towards social outcomes.

Deinstitutionalization in general mental health was explicitly mentioned as contributing to increased admission rates and LoS. The criticism leveled at the deinstitutionalization agenda more widely, is that insufficient resources have been redirected to community support, and that this has implications for the criminalization of mental illness [14]. This is reflected in the challenges participants reported in collaborating with general mental health services and in discharging patients to the community. Limited or absent community treatment options were often and

unanimously identified as a weakness, which informed clinical decisions to detain patients for longer.

Risk aversion during the discharge due to fear of a patient reoffending or reprimand from society was recognized by a few participants in this study. However, equally prevalent was a wish to protect patients from the risk of poor quality of life affecting their mental health, or concern for their vulnerability to hardship and social stigma. Compared to general mental health community patients, forensic community patients have higher levels of risk and fewer protective factors in the areas of social life, daytime activities, intimate relationships and physical health [28]. Additionally, forensic patients whose LoS is above average have lower premorbid global functioning [12, 13]. In some countries, e.g., in England and Wales, standards developed for community forensic services include that patients should have access to multidisciplinary professionals in the community [29]. Findings from this study indicate that multidisciplinary community support remains an ambition rather than a reality throughout Europe. The presence of more risk factors and fewer protective factors suggest that without multidisciplinary community support, the combination of these factors may justify continued detention on the grounds of protecting health and reducing risk.

Webster et al. [30] suggest integrating forensic and general mental health treatment would not be detrimental. Participants in this study disagreed, highlighting that patients with increased LoS require specialist treatment, facilities and staff, and are often those patients whose presentation rendered their care too challenging in general mental health services. Training and remuneration to reflect the demands and complexity of working in forensic services was considered essential. Without this, participants reported staff attrition and a lack of expertise to effectively treat patients, potentially resulting in extended LoS. To counter staff attrition, participants reported the need to expand opportunities to share expertise, conduct research, and develop professionally.

There was agreement in relation to legislative and systemic influences that impacted LoS, however, a balance has to be established to avoid bureaucracy or disorganization. Legal frameworks were cited as a key influencing factor, with agreement on the desirability of criminal and mental health law harmonization, robust external monitoring, recognition of forensic psychiatry as an independent specialty to advise the courts, and systemic coherence that avoids perverse financial incentives. When funded by a patient's local area, there was an incentive for treatment to be provided locally (at a reduced cost), reducing LoS in out of area of forensic services. However,

this requires suitable local alternatives, which the majority of participants noted did not exist. Consequently, services may face pressure to relocate forensic patients to overstretched general mental health services which cannot adequately meet their needs, and that may increase LoS in general services instead.

The paucity of national and international standards, guidelines and research efforts were recognized as a major weakness. Participants indicated that further attention to forensic mental health and the needs of patients with increased LoS is timely. Inconsistency of terminology and definitions related to forensic LoS is evident in the existing literature, which limits comparability and will need clarification to support the developing evidence base.

Strengths and limitations

One representative from each participating nation provided data. A different person may have offered an alternative view. Data analysis followed a structured framework to reduce potential for bias. Although findings were peer-checked, and accepted to represent understandings in a multidisciplinary group with mixed international experience, independent second coding may further increase confidence in the findings.

Conclusions and implications

1. External factors have potential to influence LoS and this may disproportionately disadvantage some patients, for whom treatment and care is not currently designed.
2. Implications for practice include the need to ensure multidisciplinary staff are trained and supported to deliver effective care and treatment for forensic patients, and that skilled multidisciplinary intervention continues into the community.
3. Consistency in legislation and its application, and a coordinated system of multiple agencies were identified as necessary to reduce LoS. To achieve change requires the involvement of multiple stakeholders.
4. To enhance the evidence available to those responsible for planning and delivering forensic services, research investigating the impact of identified external factors on both LoS, but also on effectiveness of individual therapeutic procedures. To achieve this, consistency is required in the terminology and definition of long-stay and agreement is required on the outcomes of importance to patients, clinicians and communities.

5. Findings provide a basis for progressing toward more consistent multidisciplinary practice in forensic services for patients with increased LoS. This is essential to ensure all European citizens have access to effective care and treatment wherever they are mandated to receive forensic services.

Acknowledgements

The authors extend thanks to the participants for completing the data collection process.

Funding for this research was provided by COST Action IS1302. Reference code: COST-STSM-ECOST-STSM-IS1302-300715-060686.

References

1. Brett A. *Psychiatry, stigma and courts*. Psychiatr. Psychol. Law 2003; 10(2): 283–288.
2. Harris GT, Rice ME, Cormier CA. *Length of detention in matched groups of insanity acquittees and convicted offenders*. Int. J. Law Psychiatry 1991; 14(3): 223–236.
3. Jansman-Hart EM, Seto MC, Crocker AG, Nicholls TL, Côté G. *International trends in demand for forensic mental health services*. Int. J. Forensic Ment. Health 2011; 10(4): 326–336.
4. Priebe S, Frottier P, Gaddini A, Kilian R, Lauber C, Martínez-Leal R et al. *Mental health care institutions in nine European countries, 2002 to 2006*. Psychiatr. Serv. 2008; 59(5): 570–573.
5. Rutherford M, Duggan S. *Forensic mental health services: Facts and figures on current provision*. London: Sainsbury Centre for Mental Health; 2007.
6. Vorstenbosch ECW, Bouman YHA, Braun PC, Bulten EBH. *Psychometric properties of the forensic inpatient quality of life questionnaire: Quality of life assessment for long-term forensic psychiatric care*. Health Psychol. Behav. Med. 2014; 2(1): 335–348.
7. Shah A, Waldron G, Boast N, Coid JW, Ullrich S. *Factors associated with length of admission at a medium secure forensic psychiatric unit*. J. Forens. Psychiatry Psychol. 2011; 22(4): 496–512.
8. Priebe S, Badesconyi A, Fioritti A, Hansson L, Kilian R, Torres-Gonzales F et al. *Reinstitutionalisation in mental health care: Comparison of data on service provision from six European countries*. BMI. 2005; 330: 123–126.
9. Hodgins S, Müller-Isberner R, Allaire JF. *Attempting to understand the increase in the numbers of forensic beds in Europe: A multi-site study of patients in forensic and general psychiatric services*. Int. J. Forensic Ment. Health 2006; 5(2): 173–184.
10. Furtado V, Völlm B. *P-657 – Long-term forensic psychiatric care in the united kingdom: An epidemiological study*. Eur. Psychiatry 2012; 27(Suppl 1): 1.
11. Edworthy R, Furtado V, Vollm B. *EPA-0119 – Characteristics and needs of long stay patients in high and medium secure forensic psychiatric care – implications for service organisation*. Eur. Psychiatry 2014; 29(Suppl 1): 1.

12. Ross T, Querengässer J, Fontao MI, Hoffmann K. *Predicting discharge in forensic psychiatry: The legal and psychosocial factors associated with long and short stays in forensic psychiatric hospitals*. *Int. J. Law Psychiatry* 2012; 35(3): 213–221.
13. Andreasson H, Nyman M, Krona H, Meyer L, Anckarsäter H, Nilsson T et al. *Predictors of length of stay in forensic psychiatry: The influence of perceived risk of violence*. *Int. J. Law Psychiatry* 2014; 37(6): 635–642.
14. Kim D-Y. *Psychiatric deinstitutionalization and prison population growth: A critical literature review and its implications*. *Crim. Justice Policy Rev.* 2016; 27(1): 3–21.
15. Hodgins S. *The major mental disorders and crime: Stop debating and start treating and preventing*. *Int. J. Law Psychiatry* 2001; 24(4–5): 427–446.
16. O'Neill C, Sinclair H, Kelly A, Kennedy H. *Interaction of forensic and general psychiatric services in Ireland: Learning the lessons or repeating the mistakes?* *Ir. J. Psychol. Med.* 2002; 19(2): 48–54.
17. Chow WS, Priebe S. *How has the extent of institutional mental healthcare changed in Western Europe? Analysis of data since 1990*. *BMJ Open* 2016; 6(4): e010188.
18. Boutellier H. *The safety utopia. Contemporary discontent and desire as to crime and punishment*. Dordrecht, The Netherlands: Kluwer Academic; 2004.
19. Morgan JF. 'Giving up the Culture of Blame'. *Risk assessment and risk management in psychiatric practice: Briefing Document for the Royal College of Psychiatrists*. London: Royal College of Psychiatrists; 2007.
20. McQueen J. *Towards work in forensic mental health: National guidance for allied health professionals*. Carstairs: Forensic Network; 2011.
21. De Vogel V, De Ruiter C, Bouman Y, De Vries Robbé M. *SAPROF. Guidelines for the assessment of protective factors for violence risk*, English version. Utrecht: Forum Educatief; 2009.
22. Braun V, Clarke V. *Using thematic analysis in psychology*. *Qual. Res. Psychol.* 2006; 3(2): 77–101.
23. Patton MQ. *Enhancing the quality and credibility of qualitative analysis*. *Health Serv. Res.* 1999; 34(5 Pt 2): 1189–1208.
24. Lincoln YS, Guba EG. *Naturalistic inquiry*. Newbury Park, CA: Sage; 1985.
25. Peay J. *Personality disorder and the law: Some awkward questions*. *Philos. Psychiatr. Psychol.* 2011; 18(3): 231–244.
26. Castro M, Cockerton T, Birke S. *From discharge to follow-up: A small-scale study of medium secure provision in the independent sector*. *British Journal of Forensic Practice* 2002; 4(3): 31–39.
27. Connell C. *Forensic occupational therapy in Europe: A comparative evaluation*. COTEC-ENOTHE Congress, 2016 June 15–19. Galway, Ireland; 2016.
28. Humber N, Hayes A, Wright S, Fahy T, Shaw J. *A comparative study of forensic and general community psychiatric patients with integrated and parallel models of care in the UK*. *J. Forens. Psychiatry Psychol.* 2011; 22(2): 183–202.

29. Kenney-Herbert J, Taylor M, Puri R, Phull J, editors. *Standards for community forensic mental health services*. London: Royal College of Psychiatrists Centre for Quality Improvement; 2013.
30. Webster SL, Sheitman BB, Barboriak PN, Harmon SH, Paesler BT, Gordon PA et al. *Integrating forensically and civilly committed adult inpatients in a treatment mall program at a state hospital*. *Psychiatr. Serv.* 2009; 60(2): 262–265.

Address: Paweł Gosek
Institute of Psychiatry and Neurology
Department of Forensic Psychiatry
02-957 Warszawa, Sobieskiego Street 9
e-mail: pgosek@ipin.edu.pl