EU-COST Long Stay in Forensic Psychiatric Services
Training School

2nd – 4th September 2015

Speaker List

Dr Allan Seppanen

Dr. Seppänen works as clinical director at Helsinki University Hospital (HUH), Division of Psychoses and Forensic Psychiatry. Previously, he has worked as a consultant forensic psychiatrist at Vanha Vaasa forensic psychiatric hospital and general medical doctor at Vaasa prison, Finland. His work involves assessing offenders for courts, i.e. conducting forensic psychiatric examinations, and treating mentally ill offenders (forensic patients) and civil patients that have been referred to the forensic hospital because of challenging behaviour, usually involving self-harm or violence. The patients treated in his unit at HUH are typically triple- diagnosed: psychosis, personality disorder and substance abuse. Dr. Seppänen holds a PhD in molecular neuroscience. His publications range from brain histology to mental health legislation. He has worked as a forensic psychiatric expert in Egypt and Kosovo and given workshop presentations in Finland, Albania and Russia.

Prof Hans Joachim Salize

Prof Salize is internationally renowned for research in mental health services. He is currently the Head of Mental Health Services Research Group at Central Institute of Mental Health, Mannheim in Germany. His significant research awards include Research Award of German Society for Social Psychiatry (Deutsche Gesellschaft für Soziale Psychiatrie DGSP) for the study - Cost and Cost-effectiveness of Community Care for Schizophrenic Patients“; the Hermann-Simon-Award for Social Psychiatry and Psychiatric Epidemiology for the Study - Mental Disorders and Homelessness” and the Christian-Roller-Award (Illenau Foundation) for the study “Reducing the Untreated Prevalence in Mentally Disordered Persons at Risk for Getting Homeless”.

Dr Kevin Murray + Broadmoor Team

Dr Murray is a consultant forensic psychiatrist with significant experience in treating mentally disordered offenders. He was the Clinical Director at Broadmoor hospital between 2001 and 2014 which is one of the three high secure hospitals in England. He and his team have significant experience of caring for patients with longer term care needs and have a long stay service for those needing long term care. He will provide a pragmatic insight into the workings of a high secure hospital and will be supported by members of his team.

Dr Jeremy Kenney-Herbert

Dr Kenney- Herbert trained in psychiatry in Australia and his first forensic mental health experience was in a maximum security prison in Sydney. He has worked in Secure Care in UK since 1995. He has worked in Medium Secure Unit inpatients and the community; acted as visiting forensic psychiatrist to Elliott House approved premises (1997-2006) and as visiting forensic psychiatrist to HMP Long Lartin (since 1997). He has been Clinical Director since 2006 for male/female secure care services comprising 3 Medium Secure units and one Low Secure Unit (200 plus beds); a Forensic Outreach service and now HMP Birmingham Health Care as well as Specialist (Deaf, Perinatal, Eating Disorder and Neuropsychiatry) Mental Health services. He sits on the Quality Network for Mental Health Services Advisory Board (2009-present) and has led on developing Quality Standards for Community Forensic Mental Health Services, published by the Quality Network for Forensic Mental Health Services in 2013. He is currently contributing to the review of Quality Standards. He joined the High and Medium Secure CRG in 2013 and is chair of that group. He has recently led on the development of Forensic Outreach Service Specification on behalf of the Low and High/Medium secure CRGs.

Dr Jonathan Hurlow

Dr Hurlow is a consultant psychiatrist at Birmingham and Solihull Mental Health NHS Foundation Trust and leads a team of multi-disciplinary professionals caring for those with a primary diagnosis of personality disorders. He has a significant interest in philosophy and its link with mental health and plays an important role at the Royal College of Psychiatrists Philosophy special interest group. He has published research into exceptional creativity and mental disorder. Amongst other popular events, he has produced several Maudsley Debates on 'Mad Genius', Assisted Suicide and Private Sector Mental Health Services with speakers including Baroness Mary Warnock, Claire Fox and Sir David Goldberg. His interest in 'hard questions' led him to work with the All Party Parliamentary Group for Drug Policy Reform to carry out an Inquiry into the Alternative Regulation of Novel Psychoactive Substances.

Dr Vivek Furtado + Cedar Team

Dr Vivek Furtado is an Associate Clinical Professor of forensic psychiatry at the University of Warwick. He is also Consultant Forensic Psychiatrist on a specialist enhanced rehabilitation forensic psychiatry ward for those with longer term care needs. He along with a multi-disciplinary team care for patients who have been in secure services for a number of years. He has experience in both old age and forensic psychiatry having gained specialist qualification in both areas. He is a member of the EU-COST group looking at long term care in forensic psychiatry and is the organiser for this training school!

Prof Swaran Singh

Direct quote from Prof Singh "I initially trained as a surgeon and became interested in mental health following involvement with human rights groups working with children traumatised in ethnic violence in New Delhi. I trained as a psychiatrist at the Post-graduate Institute of Medical Education and Research (PGI), Chandigarh, and moved to the UK in 1991. I was a Lecturer and Consultant in Nottingham and in 2001 was appointed Senior Lecturer at St George's University of London. There I developed the ETHOS early intervention service, which gained an international reputation for its success in improving outcomes for young people with psychosis and for its cost-effective use of resources. I was appointed Professor of Social and Community Psychiatry at the University of Warwick in March 2006." In addition he is a commissioner on the Equality and Human Rights Commission, UK.

Contact:

In case you have any queries please contact Dr Vivek Furtado (v.furtado@warwick.ac.uk) via email.

Organiser:

Dr Vivek Furtado
Associate Clinical Professor in Forensic Psychiatry
Division of Mental Health and Wellbeing
Warwick Medical School
Gibbet Hill Campus
University of Warwick CV4 7AL
Email: v.furtado@warwick.ac.uk

Funding:

EU-COST IS1302
http://www.cost.eu/COST_Actions/isch/Actions/IS1302
http://lfpc-cost.eu/

BACKGROUND TO THE ACTION:

Forensic psychiatric care is aimed at improving mental health care and reduction of risk of recidivism of mentally disordered offenders. The number of forensic beds has increased rapidly in several countries during the last two decades. The duration of treatment is also increasing. Strong societal demands for coercive measures against "dangerous" mentally disordered persons and an increasing focus on reducing risk, as well as reduced funding for aftercare are likely contributory factors for these changes. A significant proportion of mentally disordered offenders may require long-term, potentially life-long, forensic psychiatric care (Reed, 1997; Shaw, Davies & Morey, 2001; Harty et al., 2004; Melzer et al., 2004) although, depending of service provision in the different EU countries, some of them may reside in prison rather than in forensic psychiatric institutions.

A systematic literature review on characteristics of long-term forensic psychiatric patients identified a very limited number of studies. One early study in a high secure hospital in the UK identified severity of index offence as most important factor for personality disordered patients, while for those with a major mental illness psychopathology was a more relevant predictor of duration of stay (Dell, Robertson & Parker, 1987). Factors associated with the pro-longed stay in forensic psychiatric care are treatment history, seriousness of index offence, 'restriction orders', and lack of facilities with lower levels of care and security (Brown & Fahy, 2009; Knapp et al., 2007). Besides, clinical practice suggests that poor progress of these patients is caused by complex psychopathology, non-compliance in therapy and/ or learning disabilities.

In the few articles where long-term forensic patients are specifically mentioned, concerns have been expressed about the conceptual void regarding what services should be developed for this particular patient-population and the long-term effects of continuing involuntary treatment (Mason, 1999; Salize, 2005). Long-term inadequate placement of patients within excessively restrictive settings is harmful to these individuals, e.g. through becoming hospitalized. Nevertheless, not all these offenders need these restrictions as studies in the 1990's and early 2000nds highlighted that between one third and two thirds of forensic patients resident in high secure settings in the UK did not require that level of security (Maden et al., 1993; Reed, 1997; Pierzchniak et al., 1999; Shaw, Davies & Morey, 2001; Harty et al., 2004). In addition, a recent study showed that being a forensic psychiatric patient in itself as well as aggressive behaviours act as obstacles in being redirected toward community-based treatment (Dumont et al., 2012). The authors underline the need to further assess interventions targeting aggressive behaviours to allow a greater number of patients to access community-based care.

'Need' in long-term forensic psychiatry has to address a variety of mental and general health problems, as well as aging and psychosocial functioning. Findings from a study in long-term patients in a general psychiatric setting suggest that needs are strongly related to diagnosis and cognitive functioning and that unmet needs are strongly negatively correlated to quality of life (Wiersma & Van Busschbach, 2001). Mentally disordered offenders with an above average length of stay may well require a different type of services. For instance, a study about forensic patients over 55 years of age or residing for longer than 10 years, showed high rates of physical illness, mobility impairment, sensory impairment and poly-pharmacy (Lightbody et al., 2010).

The concept of quality of life has only recently received attention within (long-term) forensic psychiatric care. Some authors stress that in a high secure context, with long-term involuntary liberty deprivation, aspects like autonomy, lack of freedom, sense of control, restriction of movement and constraint of sexual relations will diverge and influence the well-being of patients (Coid, 1993; Mercier & King, 1994). Empirical research in this area has, however, so far been single-centered, decreasing the generalizability of the findings (Swinton, Carlisle, & Oliver, 2001; Van Nieuwenhuizen, Schene, & Koeter, 2002; Saloppé & Pham, 2006). Besides, the instruments used in these studies to assess quality of life are either based on general society or psychiatric patients, ignoring the restrictive context of (long-term) forensic psychiatric care and its' influence on quality of life (Van Nieuwenhuizen & Nijman, 2009; Swinton, Oliver, & Carlisle, 1999; Walker & Gudjohnson, 2000). Therefore, the conceptualization of quality of life, based on perceptions of patients in long-term forensic psychiatric care, differs from that required for use in (forensic) psychiatric studies (Vorstenbosch et al., 2010).

Systematic comparative research on long-term forensic psychiatric care has been sparse. Apart from the studies already mentioned and some EU research projects on marginally related subjects, few international studies have been conducted in this area. There is a substantial lack of knowledge and international cooperation is needed to deepen the understanding of 'best practice' in long-term forensic psychiatry and to address the current lack of indicators to describe and standardize the most basic data in the field e.g. service provision, outcomes and/or prevalence in Europe (Dressing & Salize, 2004; Marušič & Kamin, 2005; Becker & Kilian, 2006; Gordon & Lindqvist, 2007; Salize & Dressing, 2007; WHO, 2008).

Although some research has been conducted to identify factors associated with a long duration of stay, a detailed analysis of the current long-term forensic psychiatric patient population (including comparison with the characteristics of other forensic patients and offenders), determining long-term forensic psychiatric care, treatment pathways and specific long-term needs, is lacking. This Action aims to fill this gap, increase the knowledge on important aspects of long-term forensic psychiatric care and, support the innovation of the services currently provided.