

The mentally ill in prison

DEAR SIRs

The recent case of a mentally ill remand prisoner found hanging in a cell at Brixton Prison draws our attention yet again to the mentally ill in our prisons. Following this case the coroner made five recommendations. One was that Brixton needs to review their allocation of prisoners requiring medical examination, a need highlighted by recent Home Office guidelines (Home Office Circular No. 66/90) in which they advise treatment of abnormal offenders be a priority area and that individual authorities audit their practice and ensure an adequate service is provided.

A study of the probation service has been carried out in Nottingham. A questionnaire, completed anonymously by 30 probation officers in the Nottingham area, focused on three main areas: the criteria used to select clients; the procedure for obtaining a report; and ways in which the present system could be improved.

The decision to refer for a psychiatric opinion was a difficult one for the majority (17 out of 30). The reasons for referral were: people are at risk because of client's abnormal behaviour (19 out of 30); client not fit to appear in court (18 out of 30), so the case could be adjourned awaiting a full psychiatric report (12 out of 30); to enable more appropriate treatment and care early on (22 out of 30); to obtain advice on disposal (9 out of 30).

There was general agreement on criteria for referral: nature of offence (14 out of 30); past psychiatric history (20 out of 30); abnormal behaviour (22 out of 30); intuition (18 out of 30). One out of 30 said they did not know what criteria to use for referral. Twenty-three out of 30 probation officers did not think that they were adequately trained to decide who to refer and 18 out of 30 did not know the procedure for obtaining a psychiatric opinion should one be needed.

Suggestions were made as to how the system could be improved, including a formalised education programme as part of the in-service training requirements and improved liaison between the legal system and psychiatric services.

This is a preliminary study and the low numbers involved must lead to cautious interpretation of the findings. However, the results highlight important deficiencies in training and in liaison between the courts and psychiatric services, and the need for a more comprehensive survey of the whole Probation Service. A more 'active' approach is needed on both sides for the mentally ill to be recognised as early as possible and removed from the criminal justice system.

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Adolescent psychiatry experience for psychiatry trainees

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Specialised services for children were not available until the early 1920s when the first clinic, the East London Child Guidance Clinic, was opened. Separate services for adolescents were established in the late 1940s. Slow expansion took place, with adolescent special out-patient clinics appearing in the late 1960s. There followed further expansion, with provision for day patients, links with hostels and approved schools.

More recently, the College (1983) has recommended a minimum of two consultants per 200,000 of the population. It also recommends (1990) that there should be a significant element of experience in child and adolescent psychiatry at registrar level, either part-time or whole-time. The 4½ to 5 years training scheme must include a placement (minimum of six months) in child and adolescent psychiatry or mental handicap and psychiatry of old age.

The above guidelines are in line with the recommendations of the NHS Health Advisory Service (1985) on services for disturbed adolescents, which proposes that all trainee psychiatrists should have a general introduction to child and adolescent psychiatry and that trainees in child and adolescent psychiatry should have adequate training in adolescent psychiatry.

Given the range of subspecialties available to the psychiatric trainee, one must consider the arguments for devoting a placement to adolescent psychiatry. Adolescent psychiatry is still not widely developed, and it is therefore important for its future that junior doctors are not only exposed to this option for their future career but also gather the understanding required to plead for adolescent needs within each psychiatric service. There are particular aspects of adolescent psychiatry that provide unique insights which can enhance future understanding of adult patients. Adolescents are at the stage of passing between childhood and adulthood and the problems they present may have origins in childhood, as in dealing with difficult behaviour following a disrupted family life-style, or be early expressions of illnesses that usually appear in adulthood (e.g. schizophrenia). Whatever the problem, there is always a tension between the adolescent's bid for independence and his/her rootedness within a family or substitute family.

In adolescent units, developmental issues of growth, sexual, intellectual, and family changes are not historical events, as they are for many adult psychiatric patients. They are visibly in the 'melting pot'. This provides opportunities for preventive work, allowing the trainee the opportunity to work with families, schools and other institutions, in often