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Editorial

Psychiatric Assessment at the Magistrates' Court

Early intervention is needed in the remand process

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Until relatively recently, the traditional focus for the assessment of mentally disordered defendants facing criminal charges was the remand prison. In contrast, in the US, the practice of providing psychiatric assessment at court has grown steadily in popularity from humble beginnings in Baltimore in 1917, until the present when most major metropolitan areas have a court-based psychiatric assessment scheme (Keilitz, 1989).

The practice of prison-based assessment in England was pioneered by such notable figures as Hamblin-Smith, who, nevertheless, lamented the lack of court-based services in Birmingham (Bowden, 1990). Although disquiet had been expressed over remanding the mentally disordered into prison simply for psychiatric assessment (Gibbens *et al*, 1977), little was done until the issue was highlighted following the widespread distribution of Home Office Circular 66/90 (Home Office, 1990). This outlined the various mechanisms for the diversion of the mentally disordered from the criminal justice system and provided the impetus for the fledging court-based psychiatric assessment schemes.

Psychiatry at court

The idea of court-based psychiatric assessment is simple and effective. By intervening early in the remand process, delays which are inherent in assessment at the remand prison are avoided. These delays are particularly iniquitous because they are influenced by psychiatric factors, such as waiting for the psychiatrist to visit the prison, rather than anything due to the severity of the alleged offence (Dell *et al*, 1991). One inner-London scheme found that the time spent on remand reduced from an average of 50 days to 6 days (Joseph & Potter, 1993).

Psychiatric assessment at court has other advantages: more information is available to the psychiatrist, there is greater liaison with other professionals (e.g. solicitors and probation officers) and, in particular, there is an opportunity to discuss the possibility of discontinuing the case as set out in the Code for Crown Prosecutors issued under the Prosecution of Offences Act 1985. The discontinuance of a criminal case on public interest grounds is rarely, if ever, recommended by prison-based psychiatrists, yet it is of particular value when a defendant, who has been charged with a minor offence, is clearly mentally ill, probably unfit to plead and in need of hospital admission.

A recent survey of consultant psychiatrists in England and Wales (Gunn & Joseph, 1993) has revealed widespread dissatisfaction with the remand to hospital provisions of section 35 of the Mental Health Act 1983, which cannot be relied upon to ensure early diversion from custody.

Diversion from custody

Since those early days of the first court schemes, there has been a dramatic upsurge in interest in the concept of 'diversion from custody', with the term itself achieving jargon status, and worthy organisations jumping on the bandwagon in order to make their own particular point. Money has been made available by both the Department of Health and the Home Office to encourage the setting up of diversion schemes, while the Mental Health Foundation has run a series of regional conferences to promote a sharing of ideas about diversion. There have been numerous publications attesting to the merits of court schemes (James & Hamilton, 1991; Holloway & Shaw, 1992; Joseph & Potter, 1993), a pilot study in three areas of England undertaken by NACRO, and one study commissioned by the Department of Health which has shown the widespread emergence of diversion schemes, especially in inner-city areas, with 48 schemes identified and a further 34 under development (Blumenthal & Wessely, 1992). However, only a minority of purchasing authorities developed a policy on diversion, and Blumenthal & Wessely were concerned that the current schemes were over-dependent on key people. The lack of a contractual basis to these schemes does not necessarily mean that they are likely to fail; for example, most prison and police station assessments are carried out on an informal basis by those psychiatrists in a given catchment area who express an interest and each visit attracts an extra-contractual payment.

Court-based diversion schemes have flourished because, at the time of their inception, the regular reports of prison suicide, overcrowding and riots emphasised their importance. Stinging criticisms were made by the Chief Inspector of Prisons (*Report of HM Chief Inspector of Prisons*, 1989), as he catalogued the misery and squalor of prisons around the country. Questions were asked of the calibre and experience of many of the applicants for jobs in the prison medical service (Bluglass, 1990), and an inquiry, chaired by Lord Justice Woolf, set up after the riot at Strangeways Prison proposed far reaching changes (Home Office, 1991). All this proved too much of a cumulative embarrassment to the Home Office, leading to a radical change in the atmosphere of some prisons, perhaps nowhere more so than at Brixton Prison, where the contrast between the chaos of the notorious, now closed, F Wing and the current hospital regime is striking. A more humane phase in the approach to mentally disordered and other offenders had been entered, and this was given impetus by the Reed report (Department of Health and Home Office, 1992), which stressed the need for early diversion from custody and the establishment of court-based psychiatric schemes to aid this process. The Reed report recommended early diversion at all phases of the criminal process, namely the police station, the magistrates' court and the prison, although the promised funding to allow an increase in the numbers of medium-secure beds has not been forthcoming.

At one level, psychiatric assessment at the magistrates' court is simply an effective way of providing a service to mentally disordered defendants and the courts. However, it is underpinned by certain attitudes which raise ethical and jurisprudential issues, such as the presumption that prison is the wrong place for the treatment of the mentally ill offender. This was not the view of the late Peter Scott who wrote:

> "The prison medical service should merge with the National Health Service, and the forensic psychiatrists, instead of running esoteric little units in the Health Service, should treat patients in prison thus bringing a benevolent medical influence within the reach of any prisoner needing it . . ." (Scott, 1974)

This approach is favoured by the Chief Inspector of Prisons, Judge Tumim, who advocates the extension of the Mental Health Act 1983 to prison hospitals. Surely the consequence of such a step would be that courts would sentence the mentally disordered offender to prison in order to receive treatment which is unavailable elsewhere. The distinction between punishment and treatment will be blurred further and courts may be tempted to pass exemplary sentences using treatment as an excuse for prolonged incarceration.

A second issue underpinning diversion from custody concerns the ethics of discontinuing a criminal case. From a pragmatic point of view, the success of diversion at the magistrates' court is dependent, at times, on the discontinuance of criminal cases in order to facilitate admission to hospital under civil provisions of the Mental Health Act 1983, because of the failings of the criminal provisions of the Act as they apply to the lower court. This has caused concerns about whether mentally ill offenders should be held responsible for their actions (Prins, 1992). Others go further and positively encourage the prosecution of in-patients (Smith & Donovan, 1990). The issue of responsibility is closely linked to the perception of society, personified by the victim of the crime itself, of the culpability of the offender who might be seen to be evading justice.

Breaking the cycle

Placing diversion from custody in its historical context shows that there is a cyclical pattern to the care and management of this disadvantaged group of society, and a tendency to reinvent the wheel (Allderidge, 1979). It is only to be expected that, as a liberal and humanising approach is adopted, the clouds of a punitive backlash are already forming on the horizon. Psychiatric assessment at the magistrates' court is just one of a number of factors which have influenced the balance between care and custody. On the care side, improvements to the prison system, the Criminal Justice Act 1991 (prior to its hasty amendments) and the policy of care in the community, rather than its implementation, have all helped to foster a caring, non-institutional approach to the mentally disordered, whether or not they are offenders. The Royal Commission, set up in the wake of much publicised miscarriages of justice, examined the rights of suspects in criminal proceedings (Royal Commission, 1993). However the backlash is coming in the shape of disproportionate concerns about the dangerousness of recently discharged psychiatric patients, the public perception that people can do anything and not get sent to prison (or if they go to prison it is now a soft option) and the increasing emphasis on the infringement of the 'rights' of the victim rather than the alleged offender.

The success and continuance of psychiatric assessment schemes at the magistrates' court does

not depend simply on contractual arrangements between purchasers and providers, but will ultimately depend on wider public attitudes which will determine, through government, the balance which is struck between care and custody, leading to the allocation of resources to this group of patients. Without recognition that diversion from custody requires increased funding of both community and hospital care, the schemes will crumble. As Rollin (1993) 'wipes the tears from his ageing eyes', I am sure that he would agree that a simple return to institutional care is not the answer and that the only way forward is to resist the forced polarisation between hospital and community, victim and perpetrator, bad or mad, treatment or punishment, which results in policy lurching from one extreme to the other, while the continual victim, the mentally disordered offender, is caught in a locked revolving door.

References

ALLDERIDGE, P. (1979) Hospitals, madhouses and asylums: cycles in the care of the insane. *British Journal of Psychiatry*, **134**, 321–324.

BLUGLASS, R. (1990) Recruitment and training of prison doctors. *British Medical Journal*, **301**, 249–250.

BLUMENTHAL, S. & WESSELY, S. (1992) National survey of current arrangements for diversion from custody in England and Wales. *British Medical Journal*, **305**, 1322–1325.

BOWDEN, P. (1990) Pioneers in forensic psychiatry. Maurice Hamblin Smith: the psychoanalytic panacea. *Journal of Forensic Psychiatry*, **1**, 103–113.

DELL, S., GROUNDS, A., JAMES, K., *et al* (1991) *Mentally Disordered Remanded Prisoners*. Unpublished report to the Home Office.

DEPARTMENT OF HEALTH AND HOME OFFICE (1992) *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services* (Reed report). London: HMSO.

GIBBENS, T., SOOTHILL, K. & POPE, P. (1977) *Medical remands in the criminal court*. Maudsley Monograph No. 25. Oxford: Oxford University Press.

GUNN, J. & JOSEPH, P. (1993) Remands to hospital for psychiatric reports: a study of psychiatrists' attitudes to section 35 of the Mental Health Act 1983. *Psychiatric Bulletin*, **17**, 197–199.

HOLLOWAY, J. & SHAW, J. (1992) Providing a forensic psychiatry service to a Magistrates' court. *Journal of Forensic Psychiatry*, **3**, 153–159.

HOME OFFICE (1990) *Provision for Mentally Disordered Offenders*. Circular 66/90. London: Home Office.

—— (1991) *Prison Disturbances April 1990: Report of an Inquiry*. Cm 1456. London: HMSO.

JAMES, D. & HAMILTON, L. (1991) The Clerkenwell scheme: assessing efficiency and cost of a psychiatric liaison service to a Magistrates' court. *British Journal of Psychiatry*, **303**, 282–285.

JOSEPH, P. & POTTER, M. (1993) Diversion from custody. I: psychiatric assessment at the Magistrates' court. II: effect on hospital and prison resources. *British Journal of Psychiatry*, **162**, 325–334.

KEILITZ, I. (1989) Mental health services to the courts: a system isolated from judicial administration. In *Criminal Court Consultation* (eds R. Rosner & R. Harmon). New York: Plenum Press.

PRINS, H. (1992) The diversion of the mentally disordered: some problems for criminal justice, penology and health care. *Journal of Forensic Psychiatry*, **3**, 431–443.

REPORT OF H. M. CHIEF INSPECTOR OF PRISONS (1989) London: HMSO.

ROLLIN, H. (1993) Community care: Italy's 'U' turn. *Psychiatric Bulletin*, **17**, 494–495.

ROYAL COMMISSION (1993) *The Royal Commission on Criminal Justice Report*, Cm 2263. London: HMSO.

SCOTT, P. (1974) Solution to the problem of the dangerous offender. *British Medical Journal*, **4**, 640–641.

SMITH, J. & DONOVAN, M. (1990) The prosecution of psychiatric inpatients. *Journal of Forensic Psychiatry*, **1**, 379–383.

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