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Personal columns

A plea against over specialisation in forensic psychiatry

ERIC F. MENDELSON, Consultant Forensic Psychiatrist, Knowle Hospital, Fareham, Hampshire PO17 5NA

The optimal system for delivering forensic psychiatric care has yet to be established. At an early stage, Gunn (1977) drew attention to the differing models of a 'parallel' service and an 'integrated' approach. Only with the integrated system do forensic patients pass to ordinary NHS facilities when they no longer require security or other specialist expertise. The debate can be extended into whether forensic services should be provided by regional units, by district services, or by a mixture of both. Indeed, the Royal College of Psychiatrists (1988) recognised that in addition to a regional service led by a fully trained forensic psychiatrist, secure care can be provided at a district level by consultants who have sufficient training to hold posts with a special responsibility. Furthermore, managers are understandably keen for as much as possible to be provided by their own district services.

Potential advantages of district based services

If all patient needs could be met locally, in close proximity to their families and homes, this must be desirable. Secondly, accessibility to forensic psychiatrists should be increased if their numbers were enlarged for each district to have its own; yet this assumes that training could be rapidly expanded to ensure that posts will only go to those appropriately trained.

Likely problems of local small secure units

Regrettably, providing an adequate service within each district will be fraught with problems. Some of these are listed below.

Systems of local secure units are likely to require a much greater overall provision with lower occupancy rates. There tends to be a marked fluctuation within a district of referrals to secure care. Even from year to year, needs could be a fraction of an estimate and yet the following year be wildly beyond the provision. But over a region the random fluctuation of the small numbers from each district tends to even out. Moreover, a regional service allows more opportunities for balancing needs across a wider pool when emergencies arise. A clinical crisis can easily overwhelm a small unit.

If each district has its own forensic psychiatrist, there will obviously be a tendency for him or her to be referred all forensic cases. Indeed, psychiatrists (and no doubt other disciplines too) might find the opportunity to off-load their difficult cases onto another service irresistibly tempting! The more a district forensic service is used so more cases will be labelled as 'forensic' and ordinary services will be less and less inclined to become involved. Furthermore, this stigmatisation could easily extend until general psychiatric wards automatically reject such cases and increasingly lose their former skills at managing difficult patients. But if, as with just a regional secure unit, each ward looks after its small share of reasonably problematic patients then confidence and skills are maintained. This avoids much unnecessary duplication of services, as it would not take long for local forensic services to become fully parallel in nature, having to care for the 'forensic' patients through all the stages of rehabilitation.

Partly as a corollary to the above, patients are likely to stay longer in more expensive care. In addition, not only would ordinary wards be less willing to take them but the secure unit staff would understandably wish to see the patients complete their treatment. Undoubtedly, staff do get attached to patients and fear that others may not have the same commitment to provide what they perceive as the necessary care. Also, as in any service, a need is felt to keep occupancy up, so that at best there may be less pressure from within to move much needed patients onto the care of others.

The smaller the unit the greater the risks of idiosyncratic practice. Within the NHS we all rely on comparing our skills and performance with colleagues. Generally this checks unusual procedures and fosters a continuing education through clinical training and academic meetings. If we are relatively isolated we may be unduly biased by our experiences and not have sufficient opportunity to discuss difficult issues with colleagues.

Paradoxically, small units might struggle with difficult cases too long! Staff can become over-involved in certain situations. Referring difficult cases on to more secure or more appropriate resources may be felt as a failure, particularly as in small units this need

is only likely to occur infrequently and there will be less ongoing interaction with the Special Hospitals.

Small units will provide less opportunities for training, audit and research. A sufficiently large pool of staff is needed to easily allow individuals to be seconded or sent on training. Also a larger unit can provide more in the way of in-house training. Research must be an integral role of developing forensic services. Larger units should be able to call on a wider range of expertise and likewise find it easier to establish the critical mass of interested personnel to maintain the necessary enthusiasm and productivity in both research and audit.

Smaller secure units are likely to be more vulnerable to the vagaries of staff personalities. Clashes between staff can be more problematic, as emotional issues are less easily circumvented and have a more adverse influence on those within a more compressed environment.

District units usually require only one consultant. But single consultants are generally not recommended. Like other grades of staff, consultants benefit from peer support. Furthermore in larger units medical cover is more easily facilitated and there is much less need for external medical locums, who can be unsatisfactory.

Even in large and attractive centres, which provide good internal promotion prospects, there can be difficulties in recruiting sufficient staff. Finding adequate numbers of professionals of an appropriate calibre will be particularly challenging for many locally based units. These units are also likely to be perceived as having less status than any regional counterpart.

If a district-based policy is chosen, there will be less scope for competition to encourage efficient and quality care. A district service will effectively have a monopoly and moreover it will require a great deal of financial support from its parental authority, both to cover clinically quiet periods, when resources are not being fully used, and also to cover the many expensive contingencies that can arise in these units.

Secure units have to be of a certain size in order to provide an adequate range of therapeutic, educational, occupational and leisure activities. It is impractical to do this on a small scale. Thus providing each district with its own forensic services is likely to be considerably more expensive and difficult than with a more centralised service. It might be argued that the extra resources are more desperately required elsewhere.

But each district is likely to require an intensive or special care ward (Faulk, 1985). Services must be sufficiently centralised to allow this to occur. Districts which devolve the provision of psychiatric care to community patch units are unlikely to maintain the large core of staff and expertise necessary to keep intensive care wards running. General psychiatrists should have direct access to such facilities; if it is not possible for them to continue the management of their cases in intensive care then they should take over as soon as possible. And successful intensive care wards should enable an early return from medium security and, hopefully, by facilitating early treatment may prevent some from requiring greater security.

There needs to be a regional secure unit or, if not, some comparably well resourced centre, capable of providing a full range of back-up facilities, with a good consultancy service and the capability of admitting cases quickly before too many problems ensue locally and staff morale is compromised. This should ensure that catchment area services remain willing to take on 'forensic cases'.

In caring for these patients it seems advantageous to increase accountability. This can be effectively achieved through contracting. And to be most effective it should be done at both levels: district to regional services and regional services to Special Hospitals. So far our experience in Wessex has been very encouraging. Our contracts with districts enable us to surcharge them if local services fail to take back their cases. In the majority of instances the threat alone is sufficient to expedite the necessary transfers. Yet we are still aware of the importance of preserving our good relations with local teams.

There is also a strong case for the Prison Medical Service to have statutory standards to set the relevant health authorities, so that if their request for assessment and treatment is not dealt within a certain time limit they have the right to sanctions – say, using an alternative provider but levy the charge to the patient's health authority!

Finally, in the process of ensuring that patients are treated as locally as possible, regional secure units could be developed to take many more of the cases which are currently in maximum security. This should bring about a more expeditious return to catchment area services. Many patients are at their most dangerous at the beginning of their admission, but with treatment soon settle and then security needs become less. Therefore, if greater security could be provided in part of the regional units then perhaps many more not need to be sent to special hospitals at all.

The other side of court diversion schemes

Keeping those with major mental disorder out of prison should always be an important priority. But the current diversion initiatives seem to fall into two types. Firstly, there are schemes which aim to expedite psychiatric assessment and these must be advantageous if they lead to the swift transfer of the mentally ill into more appropriate facilities. James &

Hamilton (1991) have demonstrated that providing their local Inner London magistrate courts with sessions from two psychiatrists brought about an impressive reduction in the length of custodial remands. Yet the problems of the overwhelmed psychiatric services of Inner London are fortunately not universal. As Gibbens *et al* (1977) showed, practice was different in an area like Wessex, and concluded that services "... were better organized to deal with these problems smoothly, economically and efficiently". Unfortunately the Peterborough scheme (reported in a Home Office Circular, 1990) will probably not attract the glamour of other initiatives; yet it seems particulary worthy. The scheme minimises some of the potential problems by using the local duty psychiatrist.

Secondly, there are the new developments of the multidisciplinary assessment-panel court diversion schemes, which have been spawned from the North West Hertfordshire Assessment Panel Scheme (it is described in a Home Office Circular, 1990). By their very nature they are likely to engender a secondary development towards 'district based community forensic services'. The schemes also seem to prolong the time taken for assessment but at the theoretical advantage of providing a wider view of the client's 'needs'. Many hope that the latter will better address the wants of the inadequate offender. But it is not clear whether this will provide an enduring benefit over the considerable existing skills and facilities of the probation service. Indeed, the assessment panels will have similar implications to ordinary probation officers for those with social problems as will apply to general psychiatric services for those with diagnosed mental disorder.

But are we proceeding too far down the road of specialisation?

The following comments mostly concern both types of scheme and are put forward in an attempt to balance some of the current zeal towards specialisation. Although these assertations have yet to be scientifically tested, they are all based on clinical experience and I hope have considerable face validity.

Likely problems with court diversion schemes

If specialist staff operate these initiatives then this will induce a labelling process. The patients will be regarded as requiring specialist expertise, and probably specialist resources too, and are then likely to be disfavoured, perhaps even rejected, by ordinary facilities.

Indeed, conclusions reached by an 'assessment panel' may not be shared by the catchment area psychiatrist, or team. There is also the risk of obstinacy. Those who are expected to deliver the care may not take kindly to being denuded of their assessment role. Under such circumstances it would be understandable if they search for reasons to disagree. This could prejudice both the management of the patients and future liaison. Furthermore, it is common for patients to profess compliance at the precourt stage, but subsequently, when a harsh penalty has been avoided, withdraw their willingness so preventing progress. A therapeutic alliance is much easier to maintain if it is initially forged by the treating psychiatrist. Also there will be less commitment to deliver the care than if the treating staff had identified the problems themselves, rather than had them thrust upon them! For example, with cases admitted through the assessment of a third party, staff may not persevere to persuade patients to stay or accept treatment as hard as if the admission had been sought by their own trusted consultant.

At worst, such schemes could be a facade which poorly masks the lack of underlying resources. Cases may only be temporarily diverted to hospital or community treatment. If there is not the enthusiasm and resources to engage them in treatment they will quickly lapse and no doubt evade the necessary care for some time. Yet the courts, with all their powers to highlight deficiencies, will not then have the same opportunity for direct contact with the local psychiatrist and may remain ignorant of the limitations of the relevant service. Unfortunately, the existence of local specialist teams is likely to engender a sense of inadequacy among other psychiatrists, who may then avoid these cases all the more!

It is also possible that an enthusiastic assessment panel might conclude incorrectly and effectively deprive a patient of an opinion from a fully trained forensic psychiatrist which may have otherwise been sought. Again, in a world of limited resources, assessment panels or other elaborate diversion schemes seem expensive both in staff expertise and time. Both are precious and desperately needed in managing those offenders who are already identified as mentally disordered! It remains a losing battle to keep good staff working in stressful in-patient units, helping the most disturbed and distressed. Community work is seen as offering independence, freedom from the pressures of working closely with colleagues, and unfortunately it even attracts more status and glory than the less noticed but essential hospital work.

Managers are likely to be very keen on these schemes as it can appear that something dramatic is being done. Indeed they are likely to feel that allocating relatively meagre additional resources, as compared to the much greater sums needed to maintain the underlying services, will be a good buy! However, tackling all the demands of the inadequate offender should be seen as a new development. Unfortunately it already appears that these developments are distracting health care managers away

from the current inadequacies of the services caring for those with major mental disorder.

Conclusion

In the rush to adopt new fashions of practice it would be a pity if we lost the virtues of the past, particularly as not all areas may have problems in ensuring the assessment of offenders. Much more could be done to enable existing services to function better. Indeed unless resources are boundless the only pragmatic policy seems to be to foster a truly integrative service. Wherever possible assessment and treatment should be undertaken by the catchment area services. The costs of establishing parallel services to usurp these duties will be considerable. But if only some of the additional resources could be used to foster a greater interest in forensic psychiatry by all clinicians then the pool of potential workers would be enormous. This brief could easily be taken on by the regional forensic units. Interdisciplinary liaison can be improved by instigating informal and informative meetings, held on a regular basis and ideally occurring across a region. And with the help of academic departments in general psychiatry it should not be difficult to establish a culture in which forensic matters are held in high regard. One of our aims should be to make assessments of inmates as palatable as domiciliary visits to those in the community.

With so many experimental developments proceeding, it should be a priority to maintain an adequate control. Perhaps this could be akin to a 'reservation park', where *general* psychiatrists could be encouraged to practise the range of their skills, with assistance, as necessary, by *fully trained* specialist experts. I only wish that such a control could be in my own region!

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A gravid glimpse at rapport

GRAINNE NEILSON, Psychiatric Registrar, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH

As a psychiatric trainee I have often been intrigued by the respect that is accorded to pregnant women, deservingly or not, by the general public. People give up their seats on crowded trains and buses, they open doors, refuse to allow any heavy lifting and generally pamper the pregnant woman. As the months pass and the woman is transformed into a potential mother, attitudes towards her adjust, and she begins to be viewed in a different light. Certainly such was the case for me during my pregnancy and it was fascinating to observe the way in which the doctor-patient relationship changed as a result of my pregnant state.

I am employed at a large inner city psychiatric hospital which has many long-stay patients as well as those who are acutely psychiatrically unwell. Many of the older, chronically psychotic female long-stay patients (who ordinarily sit about the hospital grounds smoking and shouting abusive comments at