numerous demands in their relationships with their patients for which they are poorly prepared" and "medical education consists largely of learning facts and being taught to act, with little time for students to pause and reflect".

From a psychiatric trainee's point of view, with examinations, research and other academic pursuits in mind, it is often difficult to see beyond the immediate necessity of developing diagnostic and other skills fitting the traditional medical model that makes up the mainstream of psychiatry. My worry is that this leaves trainees with little chance of developing an understanding of relationships which is surely necessary for every psychiatrist. The difficulty of the task is highlighted in the out-patient setting where there is little time and consequently a pressure towards the information gathering-diagnosis-action system.

Yet the out-patient setting is rich in phenomena that become more understandable by broadening one's approach to include psychodynamic ideas. Encouraging trainees to take the opportunity of exploring psychodynamic approaches to the doctor/patient relationship would, I believe, foster a deeper understanding and more flexible attitude. Time with patients need not be an inhibiting factor (as the book *Six Minutes for the Patient* [Balint & Norell, 1973] demonstrates). Prevailing ideology and one's own training requirements are.

Acknowledgements

Thanks to Drs K. Healey, N. Minto and S. Craske for their support, advice and encouragement.

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Innovations

Working with psychiatric problems in probation

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Recent public concern about prisoners with psychiatric disorder, the deliberations of the Department of Health and Home Office Review of Health and Social Services for Mentally Disordered Offenders (the Reed Review) and the allocation by HM Government of funds for magistrates' courts to pay for duty psychiatrist schemes like the experimental scheme at Clerkenwell Magistrates' Court (James & Hamilton, 1991) are raising the profile of the mentally disordered offender and focusing attention on a

https://doi.org/10.1192/pb.16.7.427 Published online by Cambridge University Press

group of people not only handicapped by mental disorder but also caught up in the criminal process. Probation officers have a key role in the care of many mentally disordered offenders and in the recent Home Office circular (1990) *Provision for Mentally Disordered Offenders* a reference is made to two courses for probation officers run by the Regional Staff Development Organisation for the Northern Region of the Probation Service. These courses are 'Working with High Risk Offenders' and 'Working with Psychiatric Problems in Probation'. The former is run by Professor Herschel Prins and the latter by me. Judged by the number of applications, these are the two most popular courses run by RSD, but, as part of the process of evolving training to local probation areas, RSD closed in November 1991 and it has now organised its last course 'Working with Psychiatric Problems in Probation'. This therefore seems an opportune time to describe the aims, format and evolution of the course and promote discussion concerning its implications for psychiatrists.

Aims

The aims of the course are to help probation officers gain a better understanding of their clients who have mental health problems, recognise when psychiatric intervention alongside probation supervision may be appropriate and assist them in working more closely with psychiatric services.

Format

It is a five day residential course which runs from Monday lunch-time to Friday lunch-time. The course tutor is assisted by three senior probation officers. The course participants are about 28 probation officers from the North of England and Northern Ireland. Each probation officer tutor has a group of nine, or at the most ten, probation officers. These 'base groups' are opportunities to discuss the course content in more detail, relate it to their own experience, and, if appropriate, support colleagues who for various reasons find the sessions on depression and suicide risk particularly demanding. Plenary sessions take a variety of forms. Several sessions employ an interactive teaching mode in which the knowledge and experience of the participants is used to build up a systematic approach to thinking about or tackling a particular area. Some sessions are more didactic with material presented by the tutor on overhead transparencies but with plenty of opportunity to discuss as the session goes along. One session involves role playing and there are other practically oriented sessions in which the members work together in smaller groups. There is one traditional 'slide show'.

Course content

A framework for understanding psychiatric disorder

This occupies the afternoon of the first day. The model derives from Fould's hierarchical approach to the classification of psychiatric disorder (Foulds & Bedford, 1975) which has been adapted for teaching purposes. Members are provided with an A3 sheet of paper on which is printed a blank pyramid with six layers. The tutor has the same pyramid on a white board or blackboard. Members are told that this pyramid is going to be used to classify psychiatric disorder and they are asked to suggest the names of particular psychiatric conditions. These are allocated to the appropriate layers of the pyramid:

Layer 1: Organic disorders
Layer 2: Non-affective psychoses
Layer 3: Affective psychoses
Layer 4: Neuroses
Layer 5: Personality abnormalities
Layer 6: Abnormal intelligence.

They are also encouraged to mention particular symptoms of which they have heard and a separate list is made of these. Each condition or symptom is explained as it arises.

The last part of the session is a videotaped interview with a patient used to promote discussion about psychiatric symptoms, signs and diagnosis. At the end of the session the members are given a printed version of the pyramid on which each layer is labelled, the differences between adjacent layers are identified and some 'normal' experiences are appropriately positioned outside the pyramid. The base group held after dinner on the first evening is partly an opportunity for members to get to know each other within smaller groups and partly an opportunity to consider the application of the framework to help understanding of current and previous clients.

The twelve faces of depression

Eleven vignettes are presented representing different presentations of depression which has reached the level of causing significant suffering or impairment of functioning. These not only provide the opportunity to familiarise the members with concepts such as 'biological symptoms' and 'endogenous depression' which they encounter in psychiatric reports but they also give an opportunity to show the range of physical and psychological treatments which may be employed. A blank 12th face is used to raise the question of the status of normal human misery and the issue of different classifications which may identify different numbers or types of depression.

Assessing suicide risk – how to do it

In this session, participants are introduced to six questions which have to be answered in the course of

https://doi.org/10.1192/pb.16.7.427 Published online by Cambridge University Press

assessing suicide risk (motive, risk of suicide, risk of repetition, underlying psychiatric disorder, etc). Their approach to each question is built up on the white board and when it is as near complete as they can achieve a complete list of the relevant elements is revealed on an overhead transparency.

Assessing suicide risk – doing it

This is a role play occupying most of the afternoon. Members are divided into groups of three. In the course of the afternoon they take it in turns to play the part of the probation officer, client and the observer in three suicide risk situations. Two are set in a probation office and one relates to a prisoner remanded in custody. When the members return to the plenary session the observers present, for each of the three cases in turn, the factors which were taken into account when assessing suicide risk and they discuss their assessment of the degree of risk. Every member has experience of each of the three cases either having played the role of the probation officer, the client or having been the observer. This session finishes with a videotape of a real parasuicide assessment. Following this session they go immediately into a short base group.

The Mental Health Act and Code of Practice

Overhead transparencies are used to introduce the definitions of mental disorder in Part I of the Mental Health Act 1983 and the provisions for compulsory admission and treatment in Part II and III.

Psychiatric evidence in court

Mental health legislation leads naturally to consideration of the place of psychiatric evidence in court proceedings. This session starts with the issues of fitness to be interviewed and detained; fitness to plead; 'psychiatric defences' (insanity, diminished responsibility, automatism, lack of specific intent); possible medical recommendation in relation to sentencing or as alternatives to sentencing (Hall Williams, 1980). In dealing with the practicalities of courts obtaining psychiatric evidence, the roles are described of the Crown Prosecution Service, Prison Medical Service, the Clerk to the Justices and defence solicitors. Related issues include impartiality, confidentiality and punctuality. This session always leads to discussion about the relationship between psychiatrists and probation officers at the pre-sentencing stage. There are recurring and predictable themes in the discussion which forms part of this session. Some relate to the area of personality disorder. Why do psychiatrists diagnose personality disorder, declare it untreatable and leave the probation officer to get on with looking after the patient? If people with personality disorders are dangerous, why are they not all admitted to hospital? The other theme concerns relationships with psychiatrists. What can the probation officer do about psychiatrists who always recommend probation with a condition of psychiatric treatment with disregard to the sentencing criteria for probation, the nature of the offence, the lack of success of previous probation orders, the dangerousness of the patient and the views of the probation service? What can the probation officer do about the psychiatrist who refuses to discuss the patient at the stage when both are preparing reports for use at sentencing?

Working with psychiatric services and other agencies – members' contributions

Prior to the course, members are identified who may already have some particular experience of working with the psychiatric services and to these are added any others who respond to a call at the beginning of the course to talk for a few minutes about their own experience of working with the psychiatric services. The course usually includes a probation officer attached to a Regional Secure Unit, there is usually someone with experience of the M62 Forensic Psychiatry Club and there is usually someone from Leeds with experience of a regular liaison meeting between a consultant psychiatrist and local probation officers. By this stage in the course the tutors direct discussion away from complaints about lack of cooperation with psychiatric services or about psychiatrists who do not value probation officers as professional colleagues and the emphasis shifts to looking at different ways of working with the psychiatric services and improving relationships.

Good practice

Working in groups the members have the task of drawing up good practice guidelines for working with psychiatric services prior to conviction, following conviction and on termination of the order in a specimen case where there is a probation order with a condition of psychiatric treatment. The case is summarised in a Social Enquiry Report and psychiatrist's report. Groups get together in a plenary session and the various suggestions are synthesized and distilled into one set of good practice guidelines. These are typed and duplicated before the course finishes so that members can take away their own set of guidelines. A base group follows this session and is mainly concerned with consolidating members' ideas about how they will work more closely and more effectively with psychiatric services when they get back to their local probation offices.

Drug treatment in psychiatry

This is an introduction to psychotropic and related drugs with particular reference to side effects which

https://doi.org/10.1192/pb.16.7.427 Published online by Cambridge University Press

might be observed by or reported to probation officers. The session inevitably covers other treatments such as ECT and psychotherapy. It was introduced by request after the first two years of the course but not all participants find it useful. It is particularly valued by hostel staff.

Alcohol and drugs

This session, mainly aided by slides, covers concepts common to alcohol and drug misuse, epidemiology, aetiology and treatment.

Problems and strategies

Members are asked to bring with them to the course details of a particular case which has a psychiatric element. They spend the first 15 minutes working on their own completing a questionnaire about the case. Members then form into groups of three, read through each other's questionnaires and ask questions about the cases so that at the end of 30 minutes, they have a good grasp of the difficulties in each case. For the first ten minutes they draw up strategies for each case with the assistance of a list of sources of help (e.g. the client, clients' families, individual colleagues, senior probation officer, other agencies, etc.).

Inter-agency schemes

This session, at the last course, was contributed by one of the members who has been seconded for six months to establish an Inter-Agency Assessment Panel (Hajioff, 1989). Discussion of this was linked to discussion of court duty psychiatrist schemes (James & Hamilton, 1991).

Unfinished business

A short session is reserved at the end to discuss additional topics raised by members during the week and not already covered in the course.

The course closes with a final base group and feedback session followed by lunch.

Evolution

The first course in 1986 was attended by a number of probation officers who had already been on alcohol and drug courses, so the 'Alcohol and Drugs' session was optional. Then, at the suggestion of the members, it was made a 'compulsory' element. The position now is that most probation officers are experienced in the alcohol and drug field to an extent which makes it difficult to provide anything extra for them within a single session and if the course was being run again, this session would probably be dropped.

Sex offending has been and gone. It was introduced when probation officers thought that psychiatrists knew more about the subject than they did. In some ways the position is now reversed and this session has been dropped.

Implications

It is not suggested that psychiatrists up and down the country should replicate this course but it may give some ideas to those who are called upon by their local probation services to assist them in training. Such opportunities should be seized. Not only have 150 probation officers throughout the North of England and Northern Ireland been equipped to work more effectively, I hope, with psychiatric services, but each year I have learnt something new from the probation officers, and this has enhanced my practice of psychiatry.

Acknowledgements

I am grateful to Bill Bayley and George Best of RSD for persuading me to run the first course in 1986; the assistance of my probation officer tutors has been invaluable – Ann Barker, Chris Challenger, Hana Knotek, Jean Merchant, Michael Rourke, Peter Sugden, Lesley Thompson, Tony Walker, and John Wright; most of all I am thankful to have had such stimulating and receptive course members.

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