2. Diversion from the criminal justice system:
   a depends upon good inter-agency working
   b is available everywhere as a comprehensive service
   c can involve mental health care professionals from different disciplines
   d is available through one of several specialised bail hostels throughout the country
   e prevents imprisonment of offenders with mental disorders.

3. Current mental health legislation may:
   a allow the detention of offenders with mental disorder under civil sections
   b provide for compulsory treatment of prisoners with mental disorder serving a sentence
   c facilitate the transfer to hospital of prisoners awaiting trial or sentencing suffering from psychopathic disorder
   d permit a restriction order to be imposed by the court which limits the powers of the RMO
   e provide for residence in hospital as a condition of bail.

4. Psychiatric court reports:
   a are always requested by the defendant's solicitor
   b must specify the nature of the disorder where a hospital order is recommended
   c should avoid quoting word-for-word from the relevant legislation
   d should never contain clinical information
   e are confidential medical documents.

5. In prison:
   a there are relatively few individuals with mental disorder
   b psychotropic medication may not be routinely administered without consent
   c individuals with mental disorder will always be placed in a hospital wing
   d suicide prevention policies are similar to those that exist in the health service
   e those deemed at risk of self-harm may be placed in strip cells.

MCQ answers

1	2	3	4	5
a F	a T	a T	a F	a F
b F	b F	b F	b T	b T
c F	c T	c F	c F	c F
d T	d F	d T	d F	d F
e T	e F	e F	e F	e T

Commentary

Tim Exworthy

Dr Humphreys is right to emphasise that the majority of offenders with mental disorder have not committed serious offences (conversely, a number of general psychiatric patients are admitted to hospital after incidents in the community which, in different circumstances, might have attracted official attention) and that the principles of treatment and management are the same as for patients in general psychiatry. However, psychiatric assessment of more serious offending does call for careful consideration of additional issues, such as 'psychiatric defences' to criminal charges (including fitness to plead, insanity, automatisms, and in cases of charges of murder, diminished responsibility) and the role of security in their management.

The need for the appropriate degree of security during the admission of some patients is addressed in the guiding principles of the Code of Practice to the Mental Health Act 1983 (Department of Health & Welsh Office, 1999). This states that people to

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https://doi.org/10.1192/apt.6.1.30 Published online by Cambridge University Press

whom the Act applies should "be given any necessary treatment or care in the least controlled and segregated facilities compatible with ensuring their own health or safety or the safety of other people". The Code goes on to state that those subject to criminal proceedings "have the same right to psychiatric assessment and treatment as other citizens". As Dr Humphreys has illustrated, the 1983 Mental Health Act provides many opportunities when offenders with mental disorder can be removed from the criminal justice system and transferred across to the health and social services systems – and these were restated in the Government document that emphasised that the official policy was for the treatment of offenders with mental disorder to take place in the health system (Home Office, 1990). This circular also drew attention to the development of psychiatric assessment schemes based in the magistrates' courts. Many models have now evolved to meet the needs of the local agencies, but their common purpose is early intervention during the remand period to ensure that appropriate care and treatment are provided to those requiring it. Evaluation of these schemes clearly demonstrates that not only can significant reductions in the time spent on remand be achieved, but a wider impact on the processing of all defendants referred to the scheme is discernible (Exworthy & Parrott, 1997). It is also becoming increasingly apparent that non-psychiatric venues such as police stations, magistrates' courts and prisons are important places for the identification of 'new' cases of psychiatric illness – either those presenting for the first time or those reappearing after time out of supervision. The psychiatric system is responding with the development of schemes at these points to detect people with psychiatric disorders and to expedite them through, and if necessary out of, the criminal justice system. These schemes work most effectively when there is at least a degree of integration between the facilities concerned (Banerjee *et al*, 1995; Murray *et al*, 1997).

Mental health care in prisons has been part of a recent review (Department of Health, 1999*a*). Among the recommendations made were calls for the care of mentally ill prisoners to be developed in line with National Health Service mental health policy and national service frameworks, and for better identification of mental health needs at reception into prison. Overall, offenders with mental disorder should receive the same level of community care within prison as they would in the wider community. This could be achieved through operating the Care Programme Approach within prisons, developing mental health outreach work on prison wings and including prisons in local service arrangements between health authorities and trusts. While these changes will improve the delivery and quality of mental health care, if compulsory treatment is required, there is still the need to transfer the person to hospital under the relevant provisions of the Mental Health Act. This avoids potential conflicts between care and custody in the prison environment.

Even in the health system, the balance between care and containment is difficult to achieve and the difficulties are probably most starkly illustrated in the maximum secure (special) hospitals. These hospitals, of which there are three in England and one in Scotland, together house approximately 1700 patients. The phrase 'grave and immediate danger' is often used as a shorthand description of the characteristics of special hospital patients, and this is illustrated by factors such as: the patient's history of physical aggression, both in the past and during the index offence; the use of weapons; harm to and/or continuing interest in the victim(s) or potential victims; and the risk of determined absconding. These types of patients may be clinically characterised by chronic histories of multiple psychosocial difficulties to a severe degree. Two recent official inquiries at one maximum secure hospital have highlighted how serious, deep-rooted problems can take hold in such institutions (Department of Health, 1992, 1999*b*). The simplistic approach is to call for an end to the large forensic institutions, but seemingly with little consideration as to how or where their patients would be treated.

At the next step down in the security hierarchy are the medium secure units providing a more localised service, often with a number of units serving a particular region. The level of security is less than in the special hospitals, but more than in locked wards. However, it does not necessarily follow that the index offences of those admitted are always less serious compared with those residing in special hospitals. There has been concern that medium secure units have had to restrict themselves to the "assessment and treatment of mentally ill remand prisoners following serious offences" because of the relative scarcity of such beds (Murray, 1996). Other types of patients are less well-catered for and a call has been made for hundreds of extra beds at medium and low levels of security (Reed, 1997; Exworthy, 1998).

Once discharged from medium secure units, patients may be either followed up by the forensic service or integrated back into the general psychiatry service. Snowden (1995) has listed the main factors suggesting the need for a community forensic psychiatric follow-up. By virtue of being detained in a secure facility, all patients benefit from various statutory requirements, other initiatives requiring needs assessments and the provision of services following discharge. Many patients need assertive community supervision on a long-term basis and, if

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subject to a restriction order (conditional discharge from hospital under section 41, Mental Health Act), there is also a requirement for regular reporting to the Mental Health Unit at the Home Office. Research has shown an association between psychotic symptoms and violence (Swanson *et al*, 1996; Taylor *et al*, 1998) and the risk of re-offending continues into the long term (Buchanan, 1998).

Offenders with mental disorders may be processed through many different institutions, within both the criminal justice system and the health system, during the same period of detention, which may last several years. This can serve to complicate their management, but successful care and rehabilitation back to the community is dependent on the co-ordinated input from many agencies and voluntary organisations working together in a 'joined-up' way.

References

Banerjee, S., O'Neill-Byrne, K., Exworthy, T., *et al* (1995) The Belmarsh Scheme. A prospective study of the transfer of mentally disordered remand prisoners from prison to psychiatric units. *British Journal of Psychiatry*, **166**, 802–805.

Buchanan, A. (1998) Criminal conviction after discharge from special (high security) hospital. Incidence in the first 10 years. *British Journal of Psychiatry*, **172**, 472–476.

Department of Health (1992) *Report of the Committee of Inquiry into Complaints about Ashworth Hospital*. Cm 2028-1-2. London: HMSO.

—— (1999*a*) *The Future Organisation of Prison Health Care. Report by Joint Prison Service and National Health Service Executive Working Group*. London: Department of Health.

—— (1999*b*) *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Hospital*. London: Stationery Office.

—— & Welsh Office (1999) *Code of Practice Mental Health Act 1983*. London: Stationery Office.

Exworthy, T. (1998) Institutions and services in forensic psychiatry. *Journal of Forensic Psychiatry*, **9**, 395–412.

—— & Parrott, J. (1997) Comparative evaluation of a diversion from custody scheme. *Journal of Forensic Psychiatry*, **8**, 406–416.

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

Murray, K. (1996) The use of beds in NHS medium secure units in England. *Journal of Forensic Psychiatry*, **7**, 504–524.

——, Akinkunmi, A., Lock, M., *et al* (1997) The Bentham Unit: a pilot remand and assessment service for male mentally disordered remand prisoners. I: Clinical activity in the first year, and related ethical, practical and funding issues. *British Journal of Psychiatry*, **170**, 456–461.

Reed, J. (1997) The need for longer-term psychiatric care in medium or low security. *Criminal Behaviour and Mental Health*, **7**, 201–212.

Snowden, P. (1995) Facilities and treatment. In *Seminars in Practical Forensic Psychiatry* (eds D. Chiswick & R. Cope), pp. 164–209. London: Gaskell.

Swanson, J., Borum, R., Swartz, M., *et al* (1996) Psychotic symptoms and disorders and the risk of violent behaviour in the community. *Criminal Behaviour and Mental Health*, **6**, 309–329.

Taylor, P. J., Leese, M., Williams, D., *et al* (1998) Mental disorder and violence. A special (high security) hospital study. *British Journal of Psychiatry*, **172**, 218–226.

https://doi.org/10.1192/apt.6.1.30 Published online by Cambridge University Press