

The Home Office Mental Health Unit

J. M. Potts

On 1 April the mental health section of the Home Office's C3 Division was renamed "Mental Health Unit", as part of a wider initiative to streamline the Department and give more meaningful titles to the various different areas of work. The responsibilities of our Unit remain the same, however. First, we deal with the cases of restricted patients under mental health legislation. As well as advising Ministers or taking decisions on their behalf about leave, transfers and discharge, the Unit also authorises the transfer of mentally disordered prisoners to hospital. This prison transfer work is focused in a separate section of the Unit which is able to provide a very rapid response to urgent requests for transfer warrants. The number of transfers has gone up from 337 in 1990 to over 700 in each of the last three years.

The Unit also has important responsibilities for advising Ministers on the development of policy and legislation, and for carrying out policy decisions. In this area we work very closely with other departments, especially the Department of Health. A major objective in recent years has been to promote local inter-agency working with mentally disordered offenders, notably through the funding of court assessment schemes and related initiatives. We are also represented on the new High Security Psychiatric Services Commissioning Board.

Members of the Unit are generalist administrators and have no clinical expertise. Our job is to take a broad view of public safety and to look at proposals for the rehabilitation of restricted patients in a constructively critical way. We are sensitive to the limits of our role, and would never interfere in judgements about, for example, the type of medication a patient should receive. But we might properly ask questions about a proposal which revealed there had been an important change in medication but did not explain why.

In particularly difficult cases we may ask the Home Secretary's Advisory Board on Restricted Patients (formerly "Aarvold Committee") for a view. Chaired by a circuit judge, the Board covers an impressive range of perspectives with two psychiatrists, a solicitor, a magistrate and senior figures from police, probation and social services. One Board member will interview the patient and members of the care team, and then report back

to the Board who will discuss the case before settling their advice to the Minister. In other cases the Unit may request an independent psychiatric report, for example for a tribunal hearing where the issues are contentious.

Apart from the section which deals with transfers from prison, the Unit is divided into a number of groups each of which deals with cases falling under particular letters of the alphabet. This means that cases stay with the same section as patients move from special hospitals into local catchment areas. To ensure that we are in touch with local and regional issues, each section leader ("grade 7", or, in old-fashioned terms "Principal") has responsibility for liaising with hospitals and other relevant interests in one or two particular regions.

In 1995, the Unit dealt with 265 proposals for transfer and discharge, provided 1200 statements to tribunals and considered an estimated 3000 leave requests. We have target times for each of these activities: three months for transfer and discharge, the statutory deadlines for tribunal statements, and two weeks for leave requests. These targets are regularly achieved in 80–90% of cases. The times for transfer and discharge proposals are counted from the point at which we have received all the necessary information supporting a proposal, since only then can we properly begin the process of submitting advice to the Minister of State, who decides such cases personally.

Our aim in the Unit is to be outward-looking, well-informed, and always ready to learn and improve our understanding and working methods. Members of the Unit from the most junior level upwards are encouraged to visit hospitals, to talk to the many professionals whom we welcome as visitors in the Unit, to participate in policy discussions and to attend seminars, some of which we organise ourselves. It is important that patients too should have the chance to ask about our role, and members of the Unit have visited a number of Patient Councils and less formal groups in the hospitals.

The Unit is currently engaged on a major project to review its risk assessment and management procedures, the training and guidance about risk available to staff, and information

flows between the Unit, hospitals and mental health review tribunals. In this we are being helped by a consultative group of professionals and others such as the Mental Health Act Commission. We hope the results will be of use to others working in this field as well as ourselves.

We do not always agree with responsible medical officers about risk in individual cases, but we like to feel that we are working to a common end and that any disagreements are based on mutual understanding and not on ignorance or cross purposes. Rigorous questioning and a constructive dialogue can only be of benefit all round in this area of high public expectations. Effective rehabilitation and good risk management go hand in hand; each promotes the other.

After nearly four years I shall shortly be moving on from this area of work. It has been the most fascinating and rewarding of all jobs I have had. The work done with mentally disordered offenders in hospitals and elsewhere seems to me to be one of the most worthwhile enterprises, in its alleviation of suffering and contribution to the well-being of society. As with many such worthwhile projects, its accomplishments are sometimes greatest in the most unpropitious of circumstances.

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So Young, So Sad, So Listen

By Philip Graham & Carol Hughes

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