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Training matters

Training aspects of the Birmingham court diversion scheme

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Recent developments in the criminal justice system (Home Office, 1990) have highlighted the need to divert the mentally disordered offender away from custody whenever practical. To this end a number of pilot schemes have been developed within the National Health Service. The West Midlands Regional Forensic Service, together with the West Midlands Probation Service Court Liaison Team recently initiated a project based in the Central Police "lock up" in Birmingham. This scheme differs from others in that defendants are screened prior to their appearance before the court (James & Hamilton, 1991; Joseph & Potter, 1990).

The mechanism of referral is that all prisoners held in overnight custody are screened, by reference to the charge sheets and records of previous convictions, by one of two forensic community psychiatric nurses (FCPNs) who have a half-time commitment to the scheme. They look for any unusual aspects of the offence, multiple drug or alcohol related offences or any previous psychiatric disposals. In addition, the custody officer or probation officers may make referrals in the case of a prisoner whose demeanour has caused them concern.

All such defendants are screened by the FCPNs by way of a brief, unstructured interview. Particular attention is paid to the possibility of a serious mental illness, the potential for deliberate self-harm and whether or not the defendant is a substance misuser.

Possible recommendations to the court which can be made by the FCPNs are, depending upon the nature of the offence and defendant, a remand for a psychiatric report either on bail or in custody, or informal admission to the local psychiatric hospital or out-patient attendance there following contact with the responsible consultant (if he or she is agreeable to accepting a direct referral). In such cases, if the offence is of a trivial nature, the Crown Prosecution Service may agree to discontinue proceedings.

If any other course, such as compulsory admission, needs to be considered, the FCPNs ask for an immediate forensic psychiatric assessment. This is carried out by a senior registrar in forensic psychiatry. The assessment differs from a standard forensic assessment in three important respects.

First, sources of information are relatively few. The assessment occurs at the pre-hearing stage and therefore the only available accounts of the offence are the charge sheet and that of the defendant, the latter often being unreliable. It is unusual to have a relative available to interview but, in the case of a recidivist the probation service may have prior knowledge of the defendant.

In addition the environment available for interview is less than desirable, bearing more resemblance to a casualty department than a psychiatric out-patient unit. Competition with hard-pressed duty solicitors for interview space is sometimes fierce and the custody area generates much noise. Defendants are seen while in custody shortly before appearing in court and are often more anxious and less co-operative than might otherwise be the case.

Finally, the time available is usually very brief. As well as assessing the patient there is a need to liaise with local services and, where compulsory admission is being considered, an approved social worker and second medical opinion will often be required. This latter may involve inconveniencing colleagues if they have prior commitments, since the last court sitting is in the early hours of the afternoon.

As a result, unless the defendant is well-known to psychiatric services, an exhaustive psychiatric assessment is not possible. In essence, the assessment is usually of whether or not the defendant fits the criteria for mental disorder laid down in the Mental Health Act 1983, and is not about making a definitive psychiatric formulation. Compulsory admission occurs almost invariably under the provisions of either Section 2 or rarely, Section 35.

Perhaps surprisingly, the doctor is not often called upon to give oral evidence. When this does happen it can be a particularly anxiety-provoking experience, since judgements are often based on incomplete information without the luxury of adequate time.

The scheme provides the psychiatric higher trainee with opportunities to develop negotiation skills with colleagues in a variety of disciplines. As might be expected, over-burdened local services are often initially sceptical about admitting patients to their few beds (especially since this group will often require intensive nursing input) when the staff have not had an opportunity to make a complete community assessment and information concerning prior history is sketchy. Having said this, we have found that the offender is often well known to local services, which may clarify the potential benefits accruing from admission.

In addition, there is a need to develop the ability to give a concise account of the patient's mental state and suggestions concerning disposal to solicitors either while pursuing them down corridors or in whispered communications in the magistrates' court between cases. Whether there are other settings in which this skill can be utilised is, however, debatable! On the other hand, we have found that participation in the scheme has been rewarding, both personally and professionally. The police officers and officers of the court with whom we have had dealings have been unfailingly helpful. All have appeared to be very receptive to the scheme and concerned that it should succeed.

The defendants who are seen are frequently charged with minor crimes and display symptoms of florid psychosis. Without psychiatric diversion the court has no options other than to return the person into the community or to remand him or her into custody. Given the time limitations of the court, unless psychiatric services are available *in situ*, the possibility of organising an urgent psychiatric opinion for the court would be almost non-existent.

As a training opportunity we believe the scheme is unusual, in that it teaches one to make rapid assessments which are sufficiently coherent so as to stand up to scrutiny by lawyers. In addition, the opportunity of diverting the mentally ill from custody towards appropriate psychiatric treatment is one we have found to be satisfying, in spite of any *angst* involved in the proceedings.

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A review of training in neuropsychiatry

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The boundary between neurology and psychiatry has never been sharply defined. It remains the case that a number of conditions (e.g. epilepsy, head-injury sequelae, dementia, and conversion hysteria) are seen by both neurologists and psychiatrists (Reynolds & Trimble, 1989). Few neurologists would dispute that there may be a marked psychiatric element to the presentation of multiple sclerosis, and it has long been noticed that even unmedicated chronic schizophrenic patients sometimes exhibit abnormalities of movement and so-called "soft" neurological signs such as dysgraphia and clumsiness (Lishman, 1988). These and other conditions may all on occasion present to the neuropsychiatrist.

Neuropsychiatry has re-emerged in recent years as an apparently new speciality. Present post-graduate training in the UK is such that practising neuropsychiatrists may well never have held a neuropsychiatry training post, but instead cobbled together their own scheme of training through neurology, neurosurgery and psychiatry posts. Some may have held neuropsychiatry posts overseas. It would seem self-evident that some formal training in neuropsychiatry might be of benefit to the vast majority of practising psychiatrists, and essential to the neuropsychiatrist.

With this in mind, we attempted to establish how much neuropsychiatric training is available to