

Handbook of Forensic Mental Health

Edited by
**Keith Soothill,
Paul Rogers and
Mairead Dolan**



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List of abbreviations

ABCS	Abel and Becker Cognition Scale
AC	approved clinician
ACCT	Assessment, Care in Custody and Teamwork
ACF	Assessment and Classification of Function
ACR	automatic conditional release
ADHD	attention deficit hyperactivity disorder
AMHP	approved mental health professional
APA	American Psychiatric Association
APD/ASPD	antisocial personality disorder
ASBO	antisocial behaviour order
ASMRO	Addressing Substance Misuse Related Offending (alcohol and drugs programme)
ASW	approved social worker
AUR	automatic unconditional release
BMA	British Medical Association
BME	black and minority ethnicity
BPRS	Brief Psychiatric Rating Scale
CALM	Controlling Anger and Learning to Manage it (anger management programme)
CAMHS	Child and Adolescent Mental Health Services
CAST-MR	Competence Assessment to Stand Trial – Mental Retardation
CBT	cognitive-behavioural therapy
CCTV	closed-circuit television
CD	conduct disorder
CDSR	Cochrane Database of Systematic Reviews
CDVP	Community Domestic Violence Programme
CFMHT	community forensic mental health team
CI	co-investigator
CJA	Criminal Justice Act
CJS	criminal justice system

CMHT	community mental health team
CPA	Care Programme Approach
CPS	Crown Prosecution Service
CRD	NHS Centre for Reviews and Dissemination
CSC	Cognitive Self Change Programme
CSIP	Care Services Improvement Partnership
CTO	compulsory treatment order
CV	curriculum vitae
DARE	Database of Abstracts of Reviews of Effectiveness
DBT	dialectical behaviour therapy
DCR	discretionary conditional release
DfES	Department for Education and Skills
DoH	Department of Health
DPSPD	dangerous people with severe personality disorder
DRAMS	Dynamic Risk Assessment and Management System
DRR	drug rehabilitation requirement
DSM	Diagnostic and Statistical Manual of Mental Disorder
DSPD	dangerous and severe personality disorder
ECHR	European Convention on Human Rights
ECT	electro-convulsive therapy
EPP	extended sentence for public protection
EPS	Emotional Problem Scale
FACTS	Forensic Adolescent Consultation and Treatment Service
FMH	forensic mental health
GAM	General Aggression Model
GAP	Group for the Advancement of Psychiatry
GEE	Generalised Estimating Equations
GOBP	General Offending Behaviour Programme
GP	general practitioner
HAC	Health Advisory Committee [for the Prison Service]
HAC	Home Affairs Committee
HASI	Hayes Ability Screening Index
HCR-20	Historical Clinical and Risk – 20 Items Violence Risk Assessment Scheme

HDC	home detention curfew
HMCIP	HM Chief Inspector of Prisons
HMPS	HM Prison Service
HO	Home Office
ICAP	Integrated Cognitive Antisocial Personality theory
ICD	International Classification of Diseases
ID	intellectual disability
IDAP	Integrated Domestic Abuse Programme
IMR	inmate medical record
IPCUs	intensive psychiatric care units
IPDE	International Personality Disorder Examination
IPP	imprisonment for public protection
IPT	Imaginal Provocation Test
IQ	intelligence quotient
LASCH	local authority secure children's home
MacVRAS	MacArthur Violence Risk Assessment Study
MAPPA	multi-agency public protection arrangements
MAPPP	multi-agency public protection panel
MASRAM	multi-agency sex offender risk assessment and management
MCMi	Millon Clinical Multi-Axial Inventory
MDO	mentally disordered offender
MDT	mode deactivation therapy
MHA 1983	Mental Health Act 1983
MHAC	Mental Health Act Commission
MHRT	Mental Health Review Tribunal
MHTR	mental health treatment requirement
MMPI	Minnesota Multiphasic Personality Inventory
MSEI	Multi-Dimensional Self-Esteem Inventory
MSI	Multiphasic Sex Inventory
MSP	Member of the Scottish Parliament
MTFC	multidimensional treatment foster care
Nacro	National Association for the Care and Resettlement of Offenders
NAO	National Audit Office
NAS	Novaco Anger Scale
NAW	National Assembly of Wales

NHS SMS	NHS Security Management Service
NHS	National Health Service
NICE	National Institute of Clinical Excellence
NIMHE	National Institute for Mental Health England
NMC	Nursing and Midwifery Council
NOMS	National Offender Management Service
NPD	National Probation Directorate
NPS	National Probation Service
NPSA	National Patient Safety Agency
NSCAG	National Specialist Commissioning Advisory Group
NSF	National Service Framework
NSIC	National Statistics Information Centre
NSPCC	National Society for the Prevention of Cruelty to Children
NTA	National Treatment Agency
OASys	Offender Assessment System
OBP	offender behaviour programme
ODEAT	OASys development, evaluation and analysis team
OGRS	Offender Group Reconviction Scale
OLR	order for life-long restriction
ONS	Office for National Statistics
OPD	operational psychodynamic diagnostics
OSAP	Offender Substance Abuse Programme
PACE	Police and Criminal Evidence Act 1984
PAI	Personality Assessment Inventory
PANSS	Positive and Negative Syndrome Scale
PCC	Powers of Criminal Courts (Sentencing) Act 2000
PCL	(Hare) Psychopathy Checklist
PCL-R	(Hare) Psychopathy Checklist – Revised
PCL:SV	(Hare) Psychopathy Checklist: Screening Version
PCT	primary care trust
PD	personality disorder
PDNOS	personality disorder not otherwise specified
PERI	psychiatric epidemiology research interview
PI	principal investigator
PICU	psychiatric intensive care unit
PPG	Penile Plethysmograph
PRISM	Programme for Individual Substance Misusers

PSA	Public service agreement
PSE	present state examination
PSR	pre-sentence report
PTSD	posttraumatic stress disorder
QACSO	questionnaire on attitudes consistent with sexual offences
RAO	risk assessment order
RAP	Resettlement and Aftercare Provision
RC	responsible clinician
RCP	Royal College of Psychiatrists
RCT	randomised controlled trial
REBT	Rational Emotive Behaviour Therapy
RM2000	Risk Matrix 2000
RMA	Risk Management Authority
RMO	responsible medical officer
RNR	Risk/Needs/Responsivity approach
RRASOR	Rapid Risk Assessment for Sex Offender Recidivism
RSO	registered sex offender
RSVP	Risk for Sexual Violence Protocol
SARA	Spousal Abuse Risk Assessment
SCAN	Schedule for Clinical Assessment in Neuropsychiatry
SCID	Structured Clinical Interview for DSM
SCT	Supervised Community Treatment
SGC	Sentencing Guidelines Council
SIDP	Structured Interview for DSM-IV (Personality)
SMI	severe mental illness
SMS	short message service
SNAP	Security Needs Assessment Profile
SOAD	second opinion appointed doctor
SOAP	Sex Offender Assessment Pack
SOGP	Sex Offender Group Programme
SORAG	Sex Offence Risk Appraisal Guide
SOTP	Sex Offender Treatment Programme
SPSI	Social Problem Solving Inventory
STC	secure training colleges
STEP	Sex Offender Treatment Evaluation Project
SUD	substance use disorder

SVR-20	Sexual Violence Risk-20
SWAP-200	Shedler-Westen Assessment Procedure-200
TASC	treatment for appropriate social control
TBS	Terbeschikkingstelling (Dutch system)
TC	therapeutic community
TCO	threat/control-override symptoms
TTD	transfer for treatment direction
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
VES	Victim Empathy Distortion Scale
ViSOR	Violent and Sex Offender Register
VRAG	Violence Risk Appraisal Guide
VRS	Violence Risk Scale
WAG	Welsh Assembly Government
WAO	Wales Audit Office
WARS	Ward Anger Rating Scale
WHO	World Health Organisation
YJB	Youth Justice Board
YJS	youth justice system
YOT	youth offending team

Notes on contributors

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Anthony Beech is a Professor of Criminological Psychology at the University of Birmingham, and a Fellow of the British Psychological Society. Over the last 15 years he has been involved in treatment evaluation and the development of systems to look at treatment need and treatment change in sex offenders. He has produced over 140 papers, chapters and other professional publications mainly on these topics and other related subjects.

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Conor Duggan is Professor of Forensic Mental Health at the University of Nottingham and Honorary Consultant Psychiatrist at a Medium Secure Unit. His research interests are treatment needs in personality disordered offenders,

their long-term course and the neuropsychological basis of psychopathy. He is especially interested in (a) how routine clinical services can directly inform the research agenda and (b) how forensic mental health relates to its satellite disciplines. He is Editor of the *Journal of Forensic Psychiatry and Psychology* and currently chairs a NICE Guideline Committee on the treatment of Antisocial Personality Disorder.

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Kevin Gournay CBE recently retired from the Institute of Psychiatry (King's College, University of London) where he held a chair for 11 years. He is a Chartered Psychologist and a Registered Nurse. He has carried out research on areas as diverse as CBT, violence, suicide, schizophrenia, medication, epidemiology and primary care and supervised several MRC research training fellows.

He is the author of 300 books, monographs, papers, chapters and major conference papers. His diverse interests include policy work for the Department of Health, chairing a NICE panel on the management of violence and being a member of the DSPD and mental health in prison expert groups. He has worked for the Joint Parliamentary Committee on Human Rights which examined deaths in custody. In retirement he continues in clinical practice as a CBT therapist and as an expert witness.

Nicola Gray holds a joint clinical-academic appointment at the School of Psychology, Cardiff University and the South Wales Forensic Mental Health Service at Caswell Clinic, where she works as a Professor in Psychology and a Consultant Clinical and Forensic Psychologist. Professor Gray has focused her research efforts on the field of risk assessment, and is currently investigating the effectiveness of risk assessment tools, such as the HCR-20, in specific clinical populations (such as people with personality disorder or learning disability). She is also pioneering research on measuring implicit attitudes and intentions to offence-related behaviours, using the Implicit Association Test (IAT).

John Gunn CBE is Emeritus Professor of Forensic Psychiatry at the Institute of Psychiatry, King's College London. He is the past chairman of the Faculty of Forensic Psychiatry in the Royal College of Psychiatrists, and is currently a member of the Parole Board for England and Wales. At the Institute of Psychiatry he developed a large postgraduate teaching centre for forensic psychiatry and together with Professor Pamela Taylor he edited a textbook of forensic psychiatry. His research has been concerned with prisons and special hospitals, epidemiology and the therapeutic community at Grendon prison. He co-edits *Criminal Behaviour and Mental Health*.

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Kevin Howells is Professor of Forensic Clinical Psychology at the University of Nottingham and Head of the Peaks Academic and Research Unit at Rampton Hospital. The Peaks is a high secure facility for DSPD (Dangerous and Severe Personality Disorder) patients. He has worked as a clinician and academic in the UK and in Australia and is a visiting Professor at the Centre for Applied Psychological Research at the University of South Australia. He has research interests in anger and its links to violence, readiness for treatment and in cognitive-behavioural interventions for offenders.

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William R. Lindsay is a Consultant Forensic Clinical Psychologist at the State Hospital and NHS Tayside and is Chair of Learning Disabilities and Forensic Psychology at the University of Abertay, Dundee. He is a leading research and clinical authority on offenders with intellectual disability and publishes widely in the field. He also has major clinical and research interests in cognitive therapy with people with developmental disabilities.

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Paul Rogers became the first university appointed Professor in Forensic Nursing in 2004. Prior to that he worked in medium security in a range of roles, the last being Clinical Nurse Specialist in CBT, before embarking on his research career. He was the recipient of a Welsh Assembly PhD Fellowship in 1999 and an MRC post doctoral Fellowship in 2002. His research interests involve: symptoms and violence, risk assessment and prediction, CBT and posttraumatic stress disorder. He has published approximately 100 peer-reviewed professional papers and holds a range of advisory positions in England and Wales.

Jane Senior qualified as a mental health nurse in 1990 and has since worked in a variety of in-patient, community and high and medium secure services. She worked for the Prison Service in a young offenders' institution for four years during which time she completed a Master's degree in criminology. She has worked as a researcher full-time since 2000, completing a PhD examining the development of comprehensive mental healthcare systems in prisons. She currently works for the University of Manchester, managing both the Prison Health Research Network and the North West Forensic Academic Network.

Jenny Shaw is Professor of Forensic Psychiatry, University of Manchester and consultant forensic psychiatrist at Guild Lodge secure unit, Preston. She is assistant director of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness and her research interests include homicide, prison mental health and suicide in the criminal justice system.

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Keith Soothill is Emeritus Professor of Social Research in the Department of Applied Social Science, Lancaster University, UK and is now based in the Centre for Applied Statistics at Lancaster. He has recently been Chair of the Department of Health advisory committee for the Research and Development programme on Forensic Mental Health. His publications span the areas of crime and health. He has co-authored the book, *Making Sense of Criminology* (Polity Press) and the monograph, *Murder and serious sexual assault: What criminal histories can reveal about future serious offending* (Home Office), and co-edited, *Questioning Crime and Criminology* (Willan Publishing). His current research interests are in the areas of homicide, sex offending, and criminal careers.

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Preface and acknowledgements

Much has happened within the fields of forensic mental health and forensic psychiatry in recent years. While probing origins is rarely straightforward, there seems little doubt that the focus on forensic mental health in the United Kingdom has changed markedly over the past decade and a half. The killing of Jonathan Zito by Christopher Clunis – a patient with schizophrenia who had been discharged from hospital and who stabbed and killed Zito at a London Underground station on 17 December 1992 – symbolises part of that change.

The tragic event of Zito's killing became a signal crime¹ that helped to highlight similar incidents. These tragic and high-profile killings by people with mental illness were used to suggest that the community care model for mental health services had failed. Certainly there was a concern felt more centrally at governmental level whether the professionals involved with forensic mental health – in terms of both theory and practice – could adequately meet the challenge that the public was implicitly demanding: that of public protection.

There was, in fact, the launch of two trajectories. One, which is the main focus of this book, is the development of a knowledge base for forensic mental health. The other, which became a more explosive issue, was managing the moral panic that was developing around the topic of mentally ill persons being in the community. To some extent, the latter view was partially defused when Taylor and Gunn (1999) considered whether homicides by people with mental illness had, indeed, become more frequent as psychiatric services had changed. They persuasively argued that there was little fluctuation in the numbers of people with a mental illness committing criminal homicide over the 38 years studied and, in fact, noted a 3 per cent annual decline in their contribution to the official statistics. While they suggested that 'there appears to be some case for specially focused improvement of services for people with a personality disorder and/or substance misuse', their main conclusion was that 'there is no evidence that it is anything but stigmatising to claim that their living in the community is a dangerous experiment that should be reversed'. While this message proved reassuring for professionals actively involved in forensic mental health, the politicians, who were, in turn, heavily influenced by the media, would not be so readily persuaded by rational argument. The counter argument was that you are much more likely to be killed while crossing a road by a speeding motorist than by a lion roaming the streets, but if you had a choice which would you prefer to meet on your next shopping trip! Whatever one's views of the contentious programme developed by the Home Office around the neologism, DSPD (dangerous and severe personality disorder), one can see its introduction as another staging post in managing the political and moral panic that both developed and was partly orchestrated by the media and campaigners following the killing of Jonathan Zito.

In contrast, the 'knowledge' trajectory has had a less public journey. It is not totally distinct from the other more public trajectory – so, for instance, the DSPD programme is underpinned by a million pound evaluation study which should eventually add to the growing knowledge base on this rare but most dangerous of society's deviants. Another manifestation of this new thirst for knowledge was the establishment of the National Programme on Forensic Mental Health R&D. Following David Farrington, one of the editors (Keith Soothill) became Chair of the Advisory Committee in 2003. In the course of its 'life', the National Programme has funded 79 projects, numerous research fellowships, sponsored conferences and commissioned expert papers. Additionally there were unmeasured processes which are hard to capture, but include assisting researchers and clinicians to advertise events and offering ethical and methodological advice on an as needed basis. The funding from the R&D Forensic Mental Health initiative provided a form of 'protected status' that everyone knew would end at some point. However, when the new Department of Health strategy *Best Research for Best Health* was issued in 2006, it was decided without consultation that the Programme would cease commissioning with immediate effect and close in March 2007. In the event the administration of the programme finally ended in June 2007 which coincided with the end of the lease to house the administrative office in Liverpool. Sadly, the future of this very important area of research activity is still not clear now that forensic mental health researchers have to compete with the more publicly attractive health areas such as childcare and cancer services.

As editors, we are immensely grateful to the contributors to this book, and we are delighted that such an array of talent agreed to come on board. They have accepted with apparent good humour our various chivvying for chapters. They accepted the suggestions – not sure about the humour as we were not there when they received the e-mails! – for changes and revisions. Anyway, it all came good in the end. But many of the contributors have done much more. They have agreed to comment on other chapters providing helpful and supportive messages. There have also been others and we wish to thank Ian Baguley, Clair Chilvers, Derek Perkins and Joanne Wood in particular.

Finally, our thanks to Brian Willan and his colleagues at Willan Publishing. They must be the best publishers to work with, knowing how to support and what to advise. It is important to note that as much as we have tried to cover all that is relevant to England, Scotland, Wales and Northern Ireland, there will be times where this cannot be possible. To compare and contrast each policy, legal system and healthcare system and then apply this to local practices would have been an impossible task. Nonetheless, we hope that the crux of the messages contained within each chapter are more than generalisable to all. Hopefully, we will have readers who will think the project was all worthwhile.

The Editors
March 2008

Note

- 1 Innes (2004: 17) argues that 'the concept of signal crimes focuses upon the processes of social reaction through which a criminal event comes to be defined as a problem and is thereby imbued with meaning for a public audience'.

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Setting the Scene – The Administrative and Social Framework

Keith Soothill

Understanding forensic mental health is a complex task. Indeed, what is forensic mental health is contentious. In Chapter 1 Paul Rogers and Keith Soothill insist on the need to recognise and embrace the fact that the boundaries of the subject area are 'fuzzy'. Furthermore, what complicates the picture is that the area is dynamic. Certainly there have been massive changes over the past decade and a half. Soothill and Rogers capture part of this in recognising that there are now a variety of professional voices involved. No longer is it the preserve of the discipline of forensic psychiatry. Forensic psychology, mental health nursing, social work and occupational therapy are professions that have become more closely involved in the forensic field. Now interdisciplinary working is a critical issue. Also, users are increasingly attempting to have a more credible voice. There has been a greater investment in research in recent years, but Soothill and Rogers are cautious about the current situation. They suggest that there is a dearth of thinking about this very important area of research activity. The very maintenance and development of forensic mental health is at risk.

In Chapter 2 Lindsay Thomson makes a very important contribution in reminding us that in the United Kingdom there is not one forensic mental health system, but four. The four systems reflect the countries that make up the UK – England, Northern Ireland, Scotland and Wales. Rarely have the intricacies of the similarities and the differences between the four systems been so carefully detailed. Practitioners need to know the administrative and legal frameworks within which they are working. Thomson points out that we are at a very interesting stage in the development of forensic mental health services in the UK. Will the effects of devolved power lead to more differences in the care and management of mentally disordered offenders? Astutely, Thomson notes that this could create an opportunity for naturalistic experiments comparing system effects for the issues posed by mentally disordered offenders are similar throughout the UK, assuming that our populations are the same.

In Chapter 3 David Forshaw provides a very readable account of the origins and early development of forensic mental health. Here he captures how closely the development of the field has been entwined with the development of the discipline of psychiatry. He captures its origins within the broader historical context. However, while there are underlying historical forces at play, it is fascinating how the growth of mental health legislation is so often the response to very dramatic and unusual events. Moral outcries and moral panics are not phenomena unique to the late twentieth and early twenty-first centuries. How does all this relate to the present? The present is often shaped by being trapped by the past and trying to overthrow those trappings. Without historical knowledge it is impossible to know what is new. After all, Clement Attlee, the British Prime Minister after the Second World War, maintained in a speech in 1950 that 'I think the British have the distinction above all other nations of being able to put new wine into old bottles without bursting them'. Of course, there is never a definitive history and the way that other disciplines have become increasingly embroiled in forensic work is perhaps another history that still needs to be told.

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Understanding forensic mental health and the variety of professional voices

Paul Rogers and Keith Soothill

Introduction

The aim of this chapter is not to rehearse or summarise all the issues that will be presented in this book, but to try to set the scene by painting with a broad brush. What is forensic mental health? Where is it 'done'? When is it done? By whom is it done and onto whom? And finally, and most crucially, how can we develop an understanding of the issues?

What is forensic mental health?

Semantics is often an appropriate start to a project. But probing the meaning of words can also be offputting. Establishing precise definitions can be tedious and, like medieval philosophers seeking the 'philosopher's stone' by which they could turn base metal into gold, the task may be impossible to accomplish. Interestingly when one of us went to a meeting recently, the person chairing the group started with the line 'We really don't want to be too definitive about this definition lark!' Our aim is a rather different one. From the outset we are trying to establish the boundaries of the domain of forensic mental health. Again there are difficulties, for the boundaries are not clear. However, our message is a clear one. We need both to recognise and embrace the fact that the boundaries of our subject area are 'fuzzy'.

Recognising 'fuzziness' takes the pressure off. What is regarded as the domain of forensic mental health in one historical era may be different from that of another era. There will also be differences between individual professions, different services and different countries in terms of what they see as the boundaries of forensic mental health. In short, there are no absolutes that we must seek.

'Forensic mental health' would not be a term in general use 40 years ago and there are still those around who are reluctant to embrace it. Up until recently, forensic psychiatry was the dominant term with multi-professional staff working in forensic psychiatric units or services. The term, forensic mental health,

reflects the movement away from services which are determined by a medical/illness model and towards a health/prevention model.

Mullen (2000: 307) defines forensic mental health as:

... an area of specialisation that, in the criminal sphere, involves the assessment and treatment of those who are both mentally disordered and whose behaviour has led, or could lead, to offending.

We would like to extend this to also include offenders who are not currently mentally disordered but have the propensity to be so. Thus forensic mental health takes a preventative approach to both offending and mental ill health.

Where is forensic mental health done?

Forensic mental health can occur anywhere within health and is not the sole bastion of what we would traditionally consider forensic mental health clinicians. If we concentrate on offenders, then mental health issues are abundant in police stations, prisons, probation services, psychiatric hospitals and back in the community. Patients who offend and who have mental health problems come into contact with all aspects of health and public service. The police custody sergeant is as concerned with deaths in custody as the ward manager in a high-security hospital. The probation officer is just as concerned with understanding how a person's mental disorder is linked to their offending as a social worker who is working with a family where domestic violence occurs, initiated by someone with mental health problems. The simple answer to 'where' does forensic mental health occur is that it is everywhere. Furthermore, the greater the understanding that non-forensic mental health clinicians have about the potential for offending among those with mental disorder, the greater the possibility of early detection where problems may be developing. This is crucial and a consideration for the future if we wish to try and divert people from the laborious and lengthy 'offender pathways' that currently exist. Investment in prevention and diversion at the earliest possible point must be the goals of all health and public service employees and organisations. Why wait until sentencing to determine if a person is mentally ill when it can be done at the point of arrest? Why wait to intervene after an offence has occurred, when crisis resolution and home treatment could have stopped the offending in the first place? Put simply, the need for forensic mental health and the fact that it is becoming a growth industry must be viewed as a failure in the other sections of health. Surely the goal of health services should be to prevent offending at all costs?

Who does forensic mental health?

Forensic mental health covers a wide plethora of professions if we agree that the focus of such work is the reduction of offending in those with mental health problems or mental health problems in those who have offended. This forensic mental health industry is ever-expanding. Generally speaking, there are the five

main professions: forensic psychiatry, forensic psychology, mental health nursing, social work and occupational therapy. It is questionable as to whether mental health nursing, social work and occupational therapy have a claim to a 'forensic' label.

Forensic psychiatry

Forensic psychiatry is 'that part of psychiatry which deals with patients and problems at the interface of the legal and psychiatric systems' (Gunn 2004: S1). Furthermore, Gunn argued that 'such a definition implies a speciality that does not travel easily, and the practice of forensic psychiatry does vary considerably from one country to another'. Gunn (2004: S1) also defined forensic psychiatry in this paper as 'the prevention, amelioration, and treatment of victimization that is associated with mental disease'. Here lies the problem: many people can have differing views about what forensic psychiatry is or isn't. Put simply, forensic means legal and therefore forensic psychiatry can cover a plethora of people who have come into contact with the legal system and have a mental disorder.

Mullen (2000) argues that simplistic definitions of forensic psychiatry based upon literal meanings to acting exclusively as handmaidens to the court are constraining. Mullen suggests that defining forensic psychiatry in terms of the assessment and treatment of the mentally abnormal offender delineates an area of concern that could potentially engulf much of mental health.

Forensic psychology

Forensic psychology is defined as being:

... devoted to psychological aspects of legal processes in courts. The term is also often used to refer to investigative and criminological psychology: applying psychological theory to criminal investigation, understanding psychological problems associated with criminal behaviour, and the treatment of criminals. (British Psychological Society 2007)

Both forensic psychiatry and forensic psychology have one unique aspect which helps with the forensic 'identity' that the other professions of nursing, social work and occupational therapy do not: that of specialised and recognised training.

Forensic mental health nursing

It has been argued that there is no such thing as a forensic mental health nurse. Whyte (1997, 2000) has consistently argued that forensic mental health nursing is exactly the same as mental health nursing. Quite simply, Whyte has a very strong case as there is no separate forensic training, and all nurses working in forensic mental health are mental health nurses working with a population that is 'forensic'. Collins (2000: 39) states that:

There has always been substantial debate surrounding the 'forensic nurse' ever since the term came into regular use ... criticisms of the role range from 'glorified custodians' to a homogeneous group who strut around swinging a capacious bunch of keys, in a quest for domination of those under their care.

Many dispute these arguments and desperately try to make a case that forensic mental health nursing is a separate discrete branch of mental health nursing (Kettles and Woods 2006; Kettles and Robinson 2000). However, the evidence for a forensic nursing as a separate specialism is currently a weak one. There is a lack of high quality and meaningful studies which demonstrate what it is that 'forensic' mental health nurses do. Undoubtedly, the debate will surely go on for a long time and it is appropriate that the topic should remain on the agenda.

Forensic social work

Forensic social work has the same 'problem' as nursing when attempting to identify itself as a discrete speciality: there is no 'forensic training' or forensic registration. Thus definition proves difficult. Interestingly, the British Association of Social Workers has a 'Forensic Social Work' special interest group. Consequently, the role is an extension of the general social work role, only again with a forensic population.

Forensic occupational therapists

Again forensic occupational therapy has no direct forensic route or registration. Little is known about the role, although recently a book by Couldrick and Alred (2003) entitled *Forensic Occupational Therapy* has been published.

Service users

Service user involvement has slowly gathered pace in forensic mental health (Faulkner and Morris 2003), though, much slower than in non-forensic mental health settings. But this is not all. Over the past 20 years, there has been an increasing insistence that service users should have a voice about mental health services. The barrier of recognising that the service user has a role to play has probably been broken, but the nature and the strength of that particular voice is still being questioned and negotiated. Some units insist on having a service user on interview panels for new staff while others will not hear of it. The challenge when recognising the contributions that service users can make is to ensure that tokenism isn't at play. Coffey (2006: 82) conducted a literature review of research into service users' views in forensic mental health and noted many problems with the quality of the research to date.

Studies focussing upon diagnostic groups (Ryan *et al.* 2002; Sainsbury *et al.* 2004) or location, for instance medium secure services (Morrison *et al.* 1996) and community (Gerber *et al.* 2003), did not present sufficient detail to determine similarities and differences between groups and settings. Given the particular needs of women (Byrt, Lomas, Gardiner and Lewis 2001) and the over-representation and treatment of black and ethnic minority groups (Bennett Inquiry, 2003; Lelliot, Audini and Duffett 2001) it is noteworthy that few studies have investigated these experiences.

Clearly, forensic mental health has a long way to go before truly understanding and incorporating the service user's experiences and insights into ensuring high-quality service delivery. Coffey (2006) concluded in his review that:

Forensic mental health researchers have not yet accessed views of services in a sustained, systematic, and critical fashion or in a way that represents the multiple perspectives of service users.

Interdisciplinary working

The killing of Jonathan Zito by Christopher Clunis has gone a long way to focus the mind on some of the problems within forensic mental health. The later inquiry team indicated that the case was a 'catalogue of failure and missed opportunity', finding that 'the more disturbed Christopher Clunis became, the less effective was the care he received'. The inquiry team expressed concern at the lack of the prompt response by the police, but also criticised doctors, psychiatric nurses and social workers for failing to assess Christopher Clunis's history of violence and for failing to work closely together (Court 1994).

The Clunis case highlighted what many in forensic mental health already knew. New territorial battles surrounding professional power were emerging in the forensic mental health field. One scratch under the surface and the true interprofessional problems floated to the top. The problem has been eased somewhat through *Agenda for Change*, where all professions except psychiatry have been rewarded on the same salary scheme based upon the importance of their work and not their professional tribe; however, it must be said that, despite this rather expensive governmental reform of pay scales, it is probably only time until the new, forced larger and 'non-psychiatry tribe' begin asking why psychiatry is allowed to be paid upon professional status when everyone else has given up their roots. Soothill *et al.* (1995: 3) proclaimed that 'how they all work together – or fail to do so – will be one of the critical questions in the coming decade or so.' It is not an exaggeration to say that the issue remains a central question of healthcare generally and no doubt will continue to ebb or even eat away within forensic mental health.

Why do we have forensic mental health?

Writing a quarter of a century ago, Soothill *et al.* (1981: 33) note that 'some of the greatest dilemmas in the management of deviants have recently been raised at the interface of the two control systems – issues of liberty and confinement, ethics and efficacy of the psychiatric treatment of offenders and so on.' The picture remains the same and perhaps will always be so.

The devil is in the detail! And the 'why' is the \$64,000 question. Scott (1975) suggested that 'detaining custodial institutions have two aims: one therapeutic; and the other custodial'. Forensic mental health has two obvious roles: the need to treat people who are mentally unwell and the need to protect society. Undoubtedly this is a balancing act where these two roles can conflict with each other causing forensic mental health clinicians and services to come into conflict with politicians who then intervene. However, politicians cannot get this balance right either. This is evidenced by the political pendulum surrounding two inquiries into Ashworth Hospital in the 1990s. The first Ashworth Hospital

inquiry (Blom-Cooper *et al.* 1992) considered the hospital as being an abusive, authoritarian institution (Beales 2004: 270) resulting in a politically driven, vast liberalisation of the hospital regime. However, did the liberalisation go too far? Only seven years later a second Ashworth Hospital inquiry occurred (Fallon *et al.* 1999). Fallon investigated and confirmed complaints of patients trading in pornographic material, a young child visiting convicted dangerous paedophiles and being 'groomed' for abuse, patients running ward businesses, misuse of drugs and alcohol and gross lapses in security. This led to the Tilt Report (Tilt *et al.* 2000) which investigated all three English Special Hospitals and recommended greater levels of security, calling for patients' telephone calls to be recorded, random searches of patient quarters and improvements to perimeter and internal security systems. Thus, since 1992, we have come full circle, where the emphasis is now back on security. It could be argued that we are so focused on getting the balance right between a secure environment with a caring environment that the primary issue of how we get people better through an effective environment gets lost in the fallout.

Forensic mental health is undoubtedly a political imperative. Nothing causes a press and societal outcry quite as much as a stranger-homicide committed by a 'madman', as rare as these are. However, the role of social policeman does not sit easy with clinicians, who at the end of the day are primarily concerned with the care and treatment of those who are not well. The question as to what responsibility forensic mental health should take in managing societal dangerousness is one that will continue. The dispute between the Home Secretary and the then President of the Royal College of Psychiatrists about whether psychiatrists should be preventively detaining untreatable psychopaths under the Mental Health Act clearly illustrates the problem when a Home Office Minister said: 'Don't expect the public to pay your salary if you don't protect the public' (Sen *et al.* 2007: 340).

Political influence over or interference with forensic mental health will cause concern to many clinicians, especially when it is related to issues of dangerousness. Exworthy and Gunn (2003) observed this when commenting on the Tilt Report (Tilt *et al.* 2000: 470):

The emphasis throughout the report on the more tangible aspects of security such as high walls and better locks, and the virtual absence of consideration of the less overt contribution of relational security, fits in with the official preoccupation with 'dangerousness' in recent years.

Exworthy and Gunn (2003: 470) go on to state that:

... recent evidence of the greater prominence of public protection within the mental health service provision is seen in initiatives such as the creation of a new 'condition' – dangerous severe personality disorder (DSPD) – which requires a new form of service provision and could permit preventive detention.

The tension between public protection and the treatment of mentally disordered offenders is pivotal. Certainly one of the reasons why we have forensic mental

health is to balance the needs of treating those with mental disorder who have offended in as humane a manner as possible, while at the same time meeting society's need for safety. The problem of the processes by which this is achieved is one that will probably never be resolved for all patients, in all environments at all times.

However, as discussed in Chapter 21, the tendency to separate the functions of patient care and society's need for safety as two separate processes suggests that these processes are not related. However, they are: in fact, the more intensive the care and treatment of a patient, the more secure a person becomes.

Clearly the issue of why we do what we do is an important one concerning medical ethics, underpinned by human rights. Adherence to medical ethics is of great concern to all forensic mental health clinicians. Sen and colleagues (2007: 340) provide a very good illustration of the problems of applying the 'four principles plus scope' approach which should underpin medical ethics. This approach provides clinicians with what is stated as a 'simple, accessible and culturally neutral framework for dealing with this difficult and confusing area of medicine' (Sen *et al.* 2007: 340). These 'four principles plus scope' approach are: respect for autonomy, beneficence, non-maleficence and justice, coupled with their scope of application. Sen and colleagues (2007: 340) report that:

The practice of forensic psychiatry illustrates some of these difficulties. It includes all aspects of the care and treatment of offenders with mental disorders or patients posing similar problems of antisocial behaviour. Because the patients are offenders and are in hospital for treatment, both for their own benefit and to reduce risk to society, the forensic psychiatrist thus has an ethical obligation towards both the patient and to the wider society. This would also include addressing the interests of the patients on the same ward and staff working on the ward, who might be at risk from the patient.

Sen and colleagues (2007: 341) conclude that the two cases that they present:

... highlight some ethical dilemmas common in forensic clinical practice. We would also argue that, although the four-principles approach may work well in the context of traditional dyadic doctor-patient relationships, it has limitations in the forensic domain: firstly, because the principles are often in conflict with one another; secondly, because the forensic psychiatrist may have duties to third parties other than the patient, which are not covered by the four-principles approach; and, lastly, because forensic practice requires special attention to justice.

Research in forensic mental health

The foregoing has to a large degree emphasised that working in forensic mental health is in many ways different. Within the house of academia this difference is appreciated insofar that forensic work in psychiatry and psychology demands specialised and recognised training. Other disciplines involved in forensic work

also recognise difference but one of degree rather than of kind. Their emphasis is more in pointing to similarities and continuities between the demands of forensic work and the application of their skills in other contexts. The tension between what is different about forensic mental health and what is similar to other areas needs to be confronted in understanding the one remaining voice which is often neglected – namely the voice of the researcher into forensic mental health.

Constructing a knowledge base is the prerequisite to establishing a discipline or even a subdiscipline. The same questions posed at the beginning of this chapter – namely, what is forensic mental health, where is it ‘done’, when is it done, by whom is it done and, most crucially, why do we have it? – can again be posed in relation to research into forensic mental health.

Again the boundaries are elastic, for forensic mental health research can cover everything which is embraced by the term, ‘forensic mental health’. We have already stressed that the practice of forensic work can vary in terms of both time and place. However, similar research questions tend to emerge and these can be posed as questions about *process* and questions about *outcome*. ‘Process’ essentially refers to the practice of forensic mental health – how do practitioners go about their work, what are the decision points in the process and questions of fairness and justice need to be addressed. ‘Outcome’, in contrast, is concerned with results and whether an intervention, for example, makes a difference. ‘Outcome’ is much more about effectiveness, while ‘process’ is much more about equity. But these, of course, are not the only types of questions that need to be addressed. There are also very basic issues, such as a description of the type of persons who enter the system. What are their characteristics and so on? Epidemiologists have the skills to design this kind of research and to interpret the results.

Research in its various guises should feature in all the diverse activities which comprise the field of forensic mental health. While all activity can be usefully monitored to ensure that standards are being maintained, research has a different purpose. Its task is to aid understanding.

Sadly, when entrenched views are resistant to challenge, research is regarded as a dangerous interloper. Sometimes research is only embraced if it comes up with treasured preconceptions and is quickly dismissed if its insights are unexpected or unwanted. However, ultimately, researchers are essentially the custodians and arbiters of the knowledge base. So who are they?

Pinning down who the researchers are is more hazardous than it may at first appear. In the forensic mental health field there are those who do nothing else but engage in research. But, in a comparatively small subdiscipline, such persons are few and far between. Mostly, researchers are practitioners and/or teachers who seem to find it increasingly difficult to fit in the demands of research with all their other commitments, usually declaring ‘the beast of bureaucracy’ as the main enemy. Further, different funding models within the field can sometimes disadvantage the furtherance of research. And yet, interestingly, research in forensic mental health has increased hugely over the past 30 or so years. There are now specialist journals, such as the *Journal of Forensic Psychiatry and Psychology*, *Criminal Behaviour and Mental Health* and *Personality and Mental Health*, where research findings can be published.

In the 1960s there were just three or four talented male psychiatrists who represented the research interest of what was then the narrower field of forensic psychiatry. This has markedly changed. Different disciplines have declared an interest and the gender balance of the researchers has dramatically shifted.

A recent study (Soothill *et al.* submitted) has probed the gender, ages and professional groupings of this emerging research community. Curiously, the killing of Jonathan Zito mentioned earlier can be regarded as the catalyst for this recent development in forensic mental health research. The public outcry orchestrated by the media and a public campaign by his widow, Jayne Zito, helped to maintain interest in the case. The tragic event was not a solitary incident, but became a signal crime that helped to highlight similar incidents (see this volume, Preface note 1). These tragic and high-profile killings by people with mental illness were used to suggest that the community care model for mental health services had failed. This concern developed into something of a moral panic about the safety of the community. In fact, Taylor and Gunn (1999) considered whether such homicides had, indeed, become more frequent as psychiatric services had changed. Extracting data from the Criminal Statistics for England and Wales between 1957 and 1995 and subjecting the material to trend analysis, they argued that there was little fluctuation in the numbers of people with a mental illness committing criminal homicide over the 38 years studied and, in fact, noted a 3 per cent annual decline in their contribution to the official statistics. While they suggested that 'there appears to be some case for specially focused improvement of services for people with a personality disorder and/or substance misuse', their main conclusion was that 'there is no evidence that it is anything but stigmatising to claim that their living in the community is a dangerous experiment that should be reversed'. Nevertheless, despite this robust defence of the community care model, the public mood had certainly shifted. The corollary was a concern felt more centrally at governmental level whether the professionals involved with forensic mental health could adequately meet the challenge that the public was implicitly demanding. Hence, the moral panic was also accompanied by a more measured concern about the validity of the knowledge base that underpinned the professional response.

The NHS Forensic Mental Health Programme over a twelve-year period (1996–2007 inclusive) had as its aim the development of the research base of forensic mental health. The programme essentially had two phases. The first phase (1996–99) of the national programme was originally formed under the auspices of the High Secure Psychiatric Services Commissioning Board and was operating in a context whereby the need for an improved academic base in the special hospitals was explicitly recognised. This interim period ended as planned after three years when the Programme became one of the NHS National Research Programmes in April 1999 within the remit of the R&D Board. A new advisory committee was established revisiting the objectives. The stated objectives of the new Programme closely mirrored the original objectives: dealing with potential or actual mentally disordered offenders, looking at the life course of these individuals, dealing with a range of settings in the NHS and CJS, service-led research, development of an evidence base for NHS and CJS services, development of research and a research culture, and influencing other funding bodies.

A substantial priority-setting exercise was undertaken with a wide range of stakeholders; expert papers were commissioned to provide overviews of key research areas and identify key research gaps and these, together with consideration of national priorities, played a stronger role in embedding forensic mental health research in the priorities and practice of the wider NHS. However, there was recognition that there should in addition be a role for responsive or investigator-led research in this area. In short, the research opportunities were opened to a much wider pool of potential researchers – but the situation whereby all the academics except one were funded by the NHS at the local level remained. Nevertheless, the development of research capacity remained a key priority.

The funding from the R&D forensic mental health initiative provided a form of ‘protected status’ that everyone knew would end at some point. However, when the new Department of Health strategy, *Best Research for Best Health*, was issued in 2006, it was decided without consultation that the Programme would cease commissioning with immediate effect and close in March 2007. In the event the administration of the Programme finally ended in June 2007.

While the Programme had many initiatives, including the commissioning of expert papers and appointing research fellowships, an analysis of the principal investigators (PIs) and the co-investigators (CIs) of the 79 projects commissioned by the Programme provides a useful profile of the persons who have been recently contributing to the knowledge base of forensic mental health. Certainly, of course, there will be others who are involved in forensic mental health research who did not apply for funding from this programme; they may have secured funding elsewhere or the focus of the programme may not have attracted them. Nevertheless, there were 213 different persons (127 males and 86 females) who were involved as either PIs or CIs (or both) and these investigators must be regarded as pivotal to the continued development of FMH research in the UK. Of these, there were 20 persons involved in the 12-year ‘life’ of the Programme as either a PI or a CI (or both), while 37 were involved as PIs only and the remaining 156 as CIs only. In short, these are the ones who have had a successful experience in applying for funding and who, thus, can be considered as providing the backbone of an active research community.

Table 1.1 shows the age and gender profile – as at 31 December 2007 – of all those who have been successful applicants in the search for project funding from this source. Of course, not all those who have had interests in the past will continue to have the same interests. Some may have moved from a research interest to a more mainstream teaching role or have become engrossed in practice that does not leave time for research. Others may have retired while, sadly, some will have died. Nevertheless, for any active research community, the remaining persons are likely to be pivotal players. These are the ones who have had a successful experience in applying for funding; in brief, these are the ones that might perhaps be regarded as the backbone of a research community in forensic mental health.

Table 1.1 The ages of all those who have been successfully involved as applicants in the FMH programme as principal investigators or co-investigators (or both) – a ‘virtual research community’ on 31 December 2007

Age	Male		Female		Total	
	No.	%	No.	%	No.	%
25–29	3	2.4	6	7.0	9	4.2
30–34	1	0.8	8	9.3	9	4.2
35–39	9	7.1	9	10.5	18	8.5
40–44	18	14.2	21	24.4	39	18.3
45–49	26	20.5	17	19.8	43	20.2
50–54	27	21.3	7	8.1	34	16.0
55–59	22	17.3	12	14.0	34	16.0
60–64	9	7.1	4	4.7	13	6.1
65+	6	4.7	–	–	6	2.8
No information	6	4.7	2	2.3	8	3.8
Total	127	100.0	86	100.0	213	100.0

Table 1.1 indicates that these ‘players’ are quite evenly divided in the four age groups between 40 and 59 years. The females, on average, are younger than the males with the peak age group for the males being 50–54 years (21.3 per cent) and for the females being 40–44 years (20.2 per cent). This difference will largely reflect the greater preponderance of females among co-investigators while the more responsible position of principal investigator will tend to be held by older persons and these older persons are more likely to be males. Whether this is a generational effect – that is, whether there will be a higher proportion of older females becoming PIs in the next decade or so – is a moot point and cannot be answered by this data.

Moving on to the professional groupings of these successful applicants, Table 1.2 highlights how psychiatrists in general – and male psychiatrists in particular – dominate as recipients of the awards for project grants. Just over one-third of the grants were awarded to psychiatrists (in fact, one-quarter of the grants were awarded to *male* psychiatrists), while psychologists secured one-quarter of the grants with female psychologists outperforming their male counterparts.

Among the other professional groupings around one in ten grants were awarded to nurses with a similar proportion to social scientists. Male nurses seem to be considerably more successful than female nurses (but this may simply reflect that more male nurses apply than female ones), while among the other professional groupings of the ‘Other’ category, the gender balance is more evenly divided.

Table 1.2 Professional backgrounds of all those who have been successfully involved as applicants in the FMH programme as principal investigators or co-investigators (or both)

Professional background	Male		Female		Total	
	No.	%	No.	%	No.	%
Psychiatrist	56	44.1	21	24.4	77	36.2
Psychologist	25	19.7	28	32.6	53	24.9
Other:						
Nurse	15	11.8	5	5.8	20	9.4
Social scientist	12	9.4	13	15.1	25	11.7
Health research	7	5.5	8	9.3	15	7.0
Medical/geneticist	4	3.1	4	4.7	8	3.8
Statistician	3	2.4	5	5.8	8	3.8
User	1	0.8	–	–	1	0.5
No information	4	3.1	2	2.3	6	2.8
Total	127	100.0	86	100.0	213	100.0

So what do the two tables really mean? We can perhaps say with some confidence that the forensic mental health research community is looking more buoyant than it has done so for decades. Instead of perhaps three or four figures that dominated the meagre field of forensic mental health research in the 1960s, there are now many 'players' in the field. Instead of just a few male psychiatrists, females and other professional groupings now play a very significant part. Also the age distribution looks healthy and there is no imminent 'retirement problem' with a particular peak in an older age group. There is much that is very encouraging. However, there are also issues to confront.

Seen from the various standpoints of the interest groups involved in forensic mental health research, there are a variety of perspectives to consider. Certainly psychiatry no longer has an almost monopolistic position in pursuing research in this area. There are several other professional groups involved. Nevertheless, with the funding emerging from the FMH R&D initiative, psychiatrists retain a somewhat dominant position. Psychiatrists are more likely to get awards and very much more likely to be given further awards than the other professional groupings. In contrast, psychologists, the next major group involved in forensic research, while nowadays having a massive presence in this area, seem to do less well proportionately in obtaining grants than psychiatrists. Perhaps psychiatrists do, indeed, produce better proposals and focus on topics that are more

likely to be welcomed by the advisory committee of the Programme or perhaps the committee is, albeit unconsciously, biased towards accepting proposals from psychiatrists. This study certainly does not reveal the answers but raises the questions. One possibility is that nursing tends to focus on trying to understand the patient experience through qualitative methodologies, while psychiatry and psychology are more experienced through their training programmes in measuring outcomes. In a forensic world where we don't really have a strong evidence base as to what works, then the latter will probably always take precedence.

Additionally, the success of psychiatrists compared with psychologists can be linked with the gender issue. Females have a presence in the forensic field which would have been quite unimaginable even a couple of decades ago and yet some familiar patterns seem to continue. Females still tend to do less well proportionately and are more likely to be in the role of co-investigators rather than principal investigators. In terms of females being more likely to be co-investigators than principal investigators, there is an age question also to consider. Females involved in research in this study tend to be younger than the males, so perhaps it is a generational issue. Thus, perhaps the next generation of females will produce more principal investigators as the females gain more experience. Females are probably emerging more slowly from the handmaiden or deferential role than some might expect. However, it will also probably remain the case that females are more likely to move out of research and into caring roles to a much greater extent than males, and so it remains another moot point whether the next generation of females in their 40s will be sufficiently evident to produce research proposals as principal investigators.

The other professional groupings categorised as 'Other' in this study are too different to be considered as a coherent group. There is little doubt that their presence is nowadays evident in ways that – like females – would have been unimaginable even a decade ago. However, again like females, it is not too clear how the research base of these disparate professional groups will grow; there are, indeed, dangers that their research bases will wither rather than grow if there are inclement conditions. Now we must consider the more structural issues that are likely to affect all members of the forensic mental health community, although the issues will affect some more than others. Structurally there are issues that may produce a troubling tension and indicate the fragility of the FMH research community.

Firstly, there is the inexorable move in most areas of research to a concentration of resources to fewer locations. The work of the FMH initiative has demonstrated that the developing talent is widely distributed. While there has been some concentration of resources in places such as the Institute of Psychiatry, London and the University of Manchester, the diversity of the successful applications is what has been most noteworthy. If there is an attempt to concentrate resources, then this diversity – which can be regarded as a strength – will be lost.

The link between practice and research needs to be considered. In brief, while a concentration of resources may be commendable in theoretical subjects that are divorced from practice or where there is very expensive apparatus to purchase, it has much less rationale when research is trying to inform practice and

to maintain high standards within practice. It may be trite to say that a greater concentration of resources within, say, London and Manchester may not help the maintenance and development of national standards, but there are other structural issues at stake.

Once one takes forensic work as covering activity beyond the special hospitals where there is a concentration of personnel, then the issue of numbers becomes much more paramount. Thankfully, in dealing with mentally disordered offenders, the numbers are comparatively few in relation to the general population. The large samples beloved of many funding bodies are simply not available to the forensic researcher. Of course, to build up numbers, cooperation between institutions who house researchers will become increasingly important. However, this requirement needs a national network rather than a concentration of researchers within just a few institutions. However, it is not the experience of this R&D programme that institutions, mostly universities, have been particularly helpful in attempting to nurture the long-term future of forensic work. The resources provided by the programme have rarely been integrated into a long-term plan for research at the local or regional level.

There are certainly some very highly committed, overworked but very focused individuals whom this recent programme of research has clearly identified. The hinterland is also much richer with talent than perhaps many might have expected. However, the verdict must be that the forensic mental health research community is currently very fragile. The Department of Health R&D FMH initiative certainly provided scope for research which seems to have been used fruitfully, but could also have provided a basis for thinking about the future development of forensic mental health research. Sadly, it is thinking about the future of this very important area of research activity which currently seems remarkably lacking. Constructive thinking about what is required is certainly needed. However, the aim of this book is more modest. It is to review the knowledge base of this fuzzy area called 'forensic mental health', to explain the administrative contours and the legal framework. Without an understanding of the issues and an appreciation of the variety of professional voices involved, the maintenance and development of forensic mental health will not happen.

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The forensic mental health system in the United Kingdom

Lindsay Thomson

Introduction

Contrary to the title of this chapter, there is not one system of forensic mental health within the United Kingdom, rather there are four reflecting the countries that make up the UK – England, Northern Ireland, Scotland and Wales. To understand these systems it is necessary to have some knowledge of the geographical, socio-economic and political landscape of each country. Having set the scene, this chapter describes the system within each in terms of mental health policy, legislation, forensic mental health services within the National Health Service and the criminal justice system, and mechanisms to ensure public safety. Tables are used throughout to provide an at-a-glance comparison of the four systems. Detailed descriptions of specific components can be found in later chapters.

Setting the scene

Socio-economic background

The geographical and socio-demographic characteristics of each country within the United Kingdom are described in Table 2.1 with basic data on rates of mental disorder and crime. While the latter uses a similar methodology for data collection in each country, there may still be cultural variations in the reporting of crime to the police. This may be particularly true in Northern Ireland where the police have traditionally been associated with one side of the religious-political divide. Caution must be exercised in comparing rates of mental disorder between Northern Ireland and the rest of the UK. The Northern Ireland study employed a different methodology with different time periods and created a prevalence hierarchy using primary diagnosis alone. Rates of psychoses were, however, similar throughout the UK.

Table 2.1 The United Kingdom

Country	England	Wales	Northern Ireland	Scotland
Geographical area	130,395 km ²	20,600 km ²	14,139 km ²	49,000 km ²
Population ^a	49,138,831	2,903,085	1,685,267	5,062,011
Ethnicity ^a – white	87%	96%	> 99%	98%
Unemployment rates (2002)	5.1%	6%	6.3%	6.8%
Rates of mental disorder/ 1000 adults ^b (16–74 years)	5	5	> 14 years ^c 6	5
Probable psychoses*	165	190	97*	141
Neuroses**	72	93	14*	84
Alcohol dependence***	36	23	3	60
Drug dependence*				
Legal system	Common law	Common law	Common law	Common and civil law
Age of criminal responsibility (years)	10	10	10	8
Recorded crime rates/ 10,000 (2005–06)	1040 ^d	870 ^d	731 ^e	1,964 ^f
Prison population/ 100,000 (2002) ^g	139 with Wales	139 with England	62	126

* in past year ** in past week *** in past 6 months

^a Office for National Statistics (2002)

^b Office for National Statistics (2001)

^c McConnell *et al.* (2002)

^d Walker *et al.* (2006)

^e Police Service of Northern Ireland (2006)

^f Scottish Executive (2006a)

^g Home Office (2003a)

Political systems

The UK is a political union of four countries with a constitutional monarchy. The House of Commons is the supreme legislative body consisting of 646 elected members of the Westminster Parliament. Its second chamber, the House of Lords, has a review and amendment function for proposed legislation and is made up of non-elected members. All legislation relevant to England is made at Westminster. A proposal to create regional government in England is no longer active following an unsuccessful referendum in the North East in 2004 although

there is an elected mayor and assembly in London. Devolved government exists in varying forms in Northern Ireland, Scotland and Wales.

The Northern Ireland Assembly provides devolved government for that country under the terms of the Good Friday Agreement 1998. It has 108 members and powers to legislate on transferred matters such as education, health or transport. Areas such as criminal justice are reserved to the Westminster Parliament or exempted, for example defence. Acts of the Assembly are subject to judicial review if they exceed the competencies of the Assembly, discriminate on religious or political grounds, or violate European law or the European Convention on Human Rights. The Assembly sat between December 1999 and October 2002 when the Ulster Unionist Party walked out after an investigation into an alleged IRA spy ring led to no convictions. The Assembly recommenced in May 2007.

The Act of Union 1707 united Scotland with England and Wales. The Scotland Act 1998 established a Scottish Parliament and a Scottish Executive which has both governmental and civil service functions. The Act followed a referendum of the Scottish people in 1997. The Scottish, or Holyrood, Parliament has 129 Members of the Scottish Parliament (MSPs). It can legislate on all matters such as health, criminal justice or education, except for those powers specifically reserved to the Westminster Parliament, such as defence, energy or social security. It has tax-raising powers.

The National Assembly for Wales was set up following a referendum of the people of Wales in 1997 and the Government of Wales Act 1998. It has 60 Assembly Members and has powers to create secondary legislation to amend primary legislation passed by Westminster. The Government of Wales Act 2006 gave powers to legislate in devolved fields but members of the Westminster Parliament have powers to veto Assembly laws or measures. It is important to note that matters relating to health have been devolved to the Welsh Assembly but the criminal justice system in Wales remains the responsibility of the United Kingdom Parliament through the Home Office and the new Ministry of Justice. This can cause logistical difficulties when England launches a joint Department of Health/Home Office or Ministry of Justice initiative (e.g. devolving the delivery of prisoner healthcare from the Prison estate to the NHS). Wales is bound by the criminal justice aspect of the Home Office's remit but not bound by the Department of Health's remit. Attempting to disentangle which part of an initiative or guidance belongs to which body is difficult and, generally speaking, uncertainty prevails. This means that much of the criminal justice data relevant to Wales are published as joint English and Welsh statistics.

Legal systems

There are three distinct legal systems within the UK and the court structure of each is set out in Figures 2.1–2.3. English law is relevant to both England and Wales and is based on common-law principles as is the law of Northern Ireland; in contrast, Scots law is a system based on both common law and civil-law principles. Common-law draws from precedents set by previous judgments whereas civil law interprets legal principles.

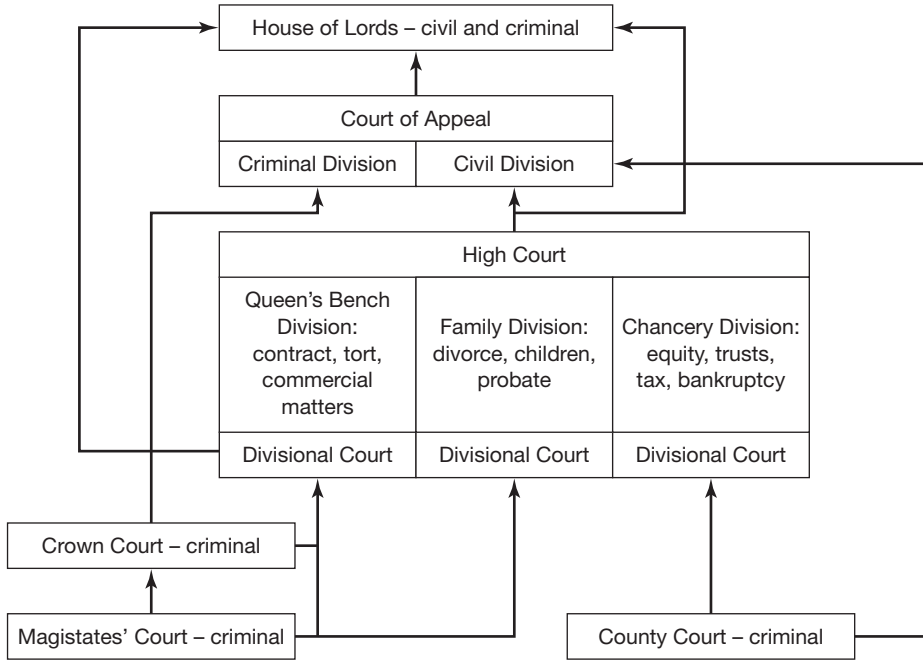


Figure 2.1 Court structure: England and Wales

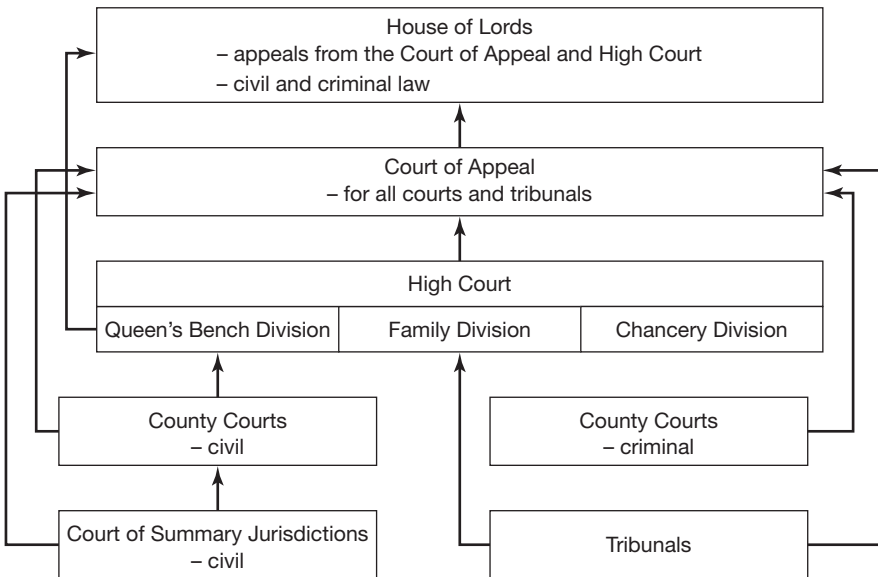


Figure 2.2 Court structure: Northern Ireland

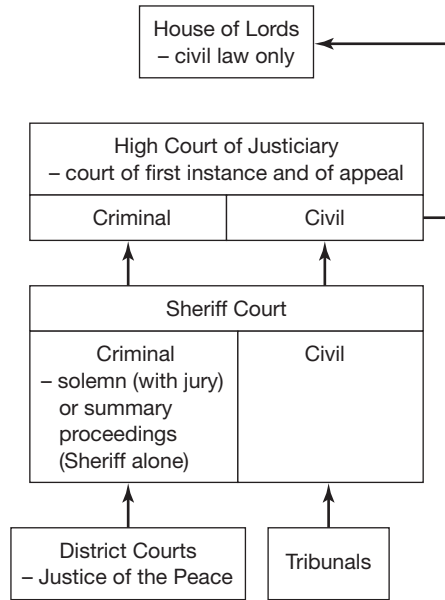


Figure 2.3 Court structure: Scotland

Components of forensic mental health systems

Policy framework

England

The Department of Health published the *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services* in 1992 (Department of Health and Home Office 1992 – Reed Report). It set out five guiding principles for the care and treatment of mentally disordered offenders:

- with regard to quality of care and proper attention to the needs of individuals;
- as far as possible in the community rather than institutional settings;
- under conditions of no greater security than is justified by the degree of danger they present to themselves or to others;
- in such a way as to maximise rehabilitation and their chances of sustaining an independent life;
- as near as possible to their own homes or families if they have them.

The National Framework for Mental Health (Department of Health 1999) defined national standards and service models for promoting mental health and treating mental illness, put in place underpinning programmes to support local delivery and established milestones and a specific group of high-level performance indicators against which progress within agreed timescales would be measured.

Wales

The *Welsh Revised Adult Mental Health National Service Framework* (Welsh Assembly Government 2005) sets out eight key actions involving:

- social inclusion, health promotion and tackling stigma; service user and carer empowerment; promotion of opportunities for a normal pattern of daily life;
- providing equitable and accessible services;
- commissioning effective, comprehensive and responsive services;
- delivering effective, comprehensive and responsive services;
- effective client assessment and care pathways; and
- ensuring a well staffed, skilled and supported workforce.

Northern Ireland

Since 2003 Northern Ireland has been engaged in the Bamford Review of Mental Health and Disability. Its report on forensic services (Bamford Review 2006) makes detailed recommendations for the development of forensic mental health and learning disability services in Northern Ireland. It acknowledges that levels of mental disorder in people subject to the criminal justice system are high, that current services are inadequate and that equivalence of access for this population to services should be a fundamental aim. It recognises that the majority of people with mental disorder pose no increased risk of harm to others but that for those who do, there must be adequate services to identify, assess and manage such individuals in both the health and criminal justice systems.

The principles for forensic services in Northern Ireland are:

- People who are in police stations, on bail, attending court, in prison, on probation or otherwise subject to the criminal justice system must have equity of access to and provision of the full range of statutory mental health and learning disability services (principle of equivalence).
- There should be joint cooperative planning between the criminal justice agencies and the health and personal social services and joint delivery of services in order to best meet the needs of service users and carers.

Mentally disordered offenders and others with similar needs should receive treatment, care and support for their mental disorder that is:

- as far as possible in the community rather than inpatient settings;
- under conditions of security and restriction no greater than as are justified by the degree of danger they present to themselves or others; and
- open, accountable and subject to external review.

Scotland

The primary policy document of the Scottish Executive is *Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland* (The MDO Policy). (Scottish Office 1999). It describes mentally disordered offenders as those who

are 'considered to suffer from a mental disorder as defined in [Scottish mental health legislation], whether or not they are, or may be, managed under its provisions and come to the attention of the criminal justice system'. It adopted the Reed guiding principles set out previously for the care and treatment of mentally disordered offenders.

The MDO Policy, which was complementary to the *Framework for Mental Health Services in Scotland* (Scottish Office 1997), tasked Health Boards with the organisation of a range of inpatient facilities and community services. The policy highlighted the concept of the 'managed clinical network' to ensure a formal relationship between the components of a service based on standards of service, quality assurance and seamless provision of care. The Forensic Mental Health Services Managed Care Network was established in 2003 to provide a strategic overview and direction for the planning and development of specialist services. It has produced a number of policy and working documents which resulted in a New National Policy for Forensic Mental Health Services (Scottish Executive 2006b). This provides policy on care standards, resolving clinical conflicts and security liaison and gives guidance on levels of security, services for women and services for people with learning disability. It recognises areas of further work on the development of services for people with personality disorder, risk management strategies and in teaching, training and research.

Mental health legislation

Mental health legislation is a necessary component of all forensic mental health systems to allow the care and treatment of patients unwilling or unable to accept this on a voluntary basis, or to allow diversion from the criminal justice to the mental health system. Tables 2.2–2.5 set out the relevant Acts and basic definitions used within mental health legislation throughout the UK, and the civil provisions for each country. Legislation for mentally disordered offenders is described below under the criminal justice system. The relevant provisions of the Mental Health Act 2007 are described within the text in each section or table and Chapters 11 and 12 contain further information.

Mental Health Act 2007 – England and Wales

The Mental Health Act 2007 received royal assent in July 2007. This was the government's third attempt to revise mental health legislation in England and Wales and it again met with stern opposition. The 2007 Act amends rather than replaces the Mental Health Act 1983. The part of this Act referring specifically to mentally disordered offenders is subject to little change, other than the abolition of time-limited restriction orders, although the broader definition of mental disorder may affect any detention. The Act introduces the concept of treatment availability to replace the concept of 'treatability' – that the detained patient will be stabilised or improved by the treatment. Community treatment orders are introduced and a wider range of professionals are able to undertake specific roles within the Act. For the first time, England and Wales will each have its own Code of Practice to the Act.

Table 2.2 Mental Health Legislation: Definitions and Exclusion Criteria

Definition Legislation	England and Wales Mental Health Act 1983	Northern Ireland Mental Health (NI) Order 1986	Scotland Mental Health (Care and Treatment) (Scotland) Act 2003
Mental disorder	Mental disorder means mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind	Mental disorder means mental illness, mental handicap and any other disorder or disability of mind	Mental disorder means mental illness, personality disorder or learning disability however caused or manifested
Mental illness	Mental illness is not defined	Mental illness means a state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of other persons	Mental illness is not defined
Mental impairment	Mental impairment means a state of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned	-	-
Severe mental impairment	Severe mental impairment means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned	Severe mental impairment means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned	-

Table 2.2 (continued)

Definition Legislation	England and Wales Mental Health Act 1983	Northern Ireland Mental Health (NI) Order 1986	Scotland Mental Health (Care and Treatment) (Scotland) Act 2003
Psychopathic disorder	Psychopathic disorder means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned	–	–
Mental handicap	–	Mental handicap means a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning	–
Severe mental handicap	–	Severe mental handicap means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning	–
Exclusions	Persons suffering from mental disorder by reason only of promiscuity or other immoral conduct, sexual deviancy, or dependence on alcohol or drugs, are excluded	Persons suffering from mental disorder by reason only of personality disorder, promiscuity, or other immoral conduct, sexual deviancy or dependence on alcohol or drugs, are excluded from detention on these grounds alone	A person is not mentally disordered by reason only of any of the following: sexual orientation; sexual deviancy; transsexualism; transvestism; dependence on, or use of, alcohol or drugs; behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person; or acting as no prudent person would act

Interestingly a caveat exists whereby any power of Welsh ministers to make regulations or an order regarding mental health legislation is exercisable by statutory instrument but must be approved by resolution of the National Assembly for Wales. Thus a potential for conflict between England and Wales on legislative powers could arise, thereby causing further confusion relating to the England/Wales relationship.

Under the Mental Health Act 2007 when enacted, mental disorder means 'any disorder or disability of the mind'. A person cannot be treated as mentally disordered by reason of learning disability unless they exhibit abnormally aggressive or seriously irresponsible behaviour. Learning disability is defined as 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning'. Dependence on alcohol or drugs are the only exclusion criteria.

Forensic mental health services

Between the mid-nineteenth century and the late-twentieth century, the high security special hospitals in England and the State Hospital in Scotland were the sole providers of specialist hospital in-patient services for offender patients. It was with the publication of the Glancy (Department of Health and Social Security 1974) and Butler (Department of Health and Social Security 1975) Reports, however, that the basis of our current forensic mental health systems was developed with a system of regional secure units in England and Wales.

There are two essential components to successful forensic mental health services: firstly, there should be a range of services from the community to high security, incorporating services to the criminal justice system; and secondly, there should be strong links between forensic services and general adult psychiatry, learning disability, psychotherapy, and child and adolescent psychiatry. These assist in the identification of patients and their throughput between services and levels of security as appropriate. Security can itself be considered as a therapeutic component and the principles of assessment and management are common to each level.

High-security psychiatric hospitals

There are four high-security psychiatric hospitals in the United Kingdom which care for people with dangerous, violent or criminal propensities under civil mental health legislation or legislation for mentally disordered offenders. Table 2.6 summarises the roles of the four high-security hospitals. Patients from Northern Ireland in need of high security go to the State Hospital in Scotland, and Welsh patients go to English high-security hospitals, particularly Ashworth.

Table 2.3 England and Wales – Mental Health Act 1983: Part II Compulsory Admission and Detention (NB. The Mental Health Act 2007 for England and Wales will introduce a broader definition of mental disorder when enacted.)

Purpose	Section	Grounds for Detention	Duration	Signatories/applicant	Appeal
Admission for assessment	2	Mental disorder Patient's health or safety / protection of others Requires hospitalisation	28 days	Two doctors (one approved)/ nearest relative or approved social worker applies	Mental Health Review Tribunal – application by patient
Admission for treatment	3	Mental illness, (severe) mental impairment and psychopathic disorder makes hospital treatment appropriate – if psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent deterioration of his condition Necessary for patient's health or safety or for protection of others and it cannot be provided unless detained	6 months	Two doctors (one approved)/nearest relative or approved social worker applies	Mental Health Review Tribunal – application by patient, nearest relative or by hospital managers
Emergency admission	4	Mental disorder Patient's health or safety, or protection of others Requires urgent hospitalisation	72 hours	One doctor /application by nearest relative or approved social worker	None
Emergency detention of patient in hospital	5(2)	Liable to be detained in hospital in pursuance of an application for admission for assessment	72 hours	Doctor in charge or nominated deputy/ same	None

Table 2.3 (continued)

Purpose	Section	Grounds for Detention	Duration	Signatories/applicant	Appeal
Nurses' holding power	5(4)	Mental disorder Patient's health or safety / protection of others Requires immediate restraint from leaving hospital Not practicable to obtain doctor immediately for s. 5(2)	6 hours	Nurse of the prescribed class / none	None

Detention can proceed from s. 4 or s. 5(2) → s. 2 → s. 3 or commence with s. 2 or s. 3. Detention can be terminated at any stage by the responsible medical officer or by the Mental Health Review Tribunal.

Note
The Mental Health Act 2007 introduces supervised community treatment (ss. 17A–G). The necessary pre-conditions of making a community treatment order are that:

- (a) the patient is suffering from mental disorder (any disorder or disability of mind) of a nature or degree which makes it appropriate for him to receive medical treatment;
- (b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;
- (c) subject to his being liable to be recalled, such treatment can be provided without his continuing to be detained in a hospital;
- (d) it is necessary that the responsible clinician should be able to exercise the power to recall the patient to hospital (the Bill said necessary for the patient's health or safety or for the protection of others – the Act simply says necessary).
- (e) appropriate medical treatment is available for him.

Source: Thomson (2004).

Table 2.4 Northern Ireland – Mental Health (Northern Ireland) Order 1986: Part II Compulsory Admission

Purpose	Article	Grounds for Detention	Duration	Signatories/applicant	Appeal
Admission for assessment	4	Mental disorder Requires hospitalisation Substantial likelihood of serious physical harm to self or others	7 days with possible extension to 14 days	One doctor/nearest relative or approved social worker	Mental Health Review Tribunal
Assessment of patients already in hospital	7(2)	Mental disorder Requires ongoing hospitalisation Substantial likelihood of serious physical harm to self or others	48 hours	Hospital doctor	None
Nurses' holding power	7(3)	Mental disorder Requires application for assessment Not practicable to secure immediate attendance of doctor	6 hours	Nurse of the prescribed class	None
Detention for treatment	12	Mental illness or severe mental impairment Requires hospitalisation Substantial likelihood of serious physical harm to self or others	6 months, renewable for a further 6 months and subsequently yearly	One doctor approved by the Commission/nearest relative or approved social worker	Mental Health Review Tribunal

'Detention can proceed from Art. 7(3) if required → Art. 7(2) if required → Art. 4 → Art. 12. Detention can be terminated at any stage by the Responsible Medical Officer, the Responsible Board, the nearest relative (if not opposed by the RMO); or by the Mental Health Review Tribunal following an appeal.'

Source: Thomson (2004).

Table 2.5 Scotland – Mental Health (Care and Treatment) (Scotland) Act 2003

Purpose	Section	Grounds	Duration	Signatories/consent	Revocation/appeal	Treatment
Emergency detention	36(1)	It is likely that the patient has a mental disorder Significantly impaired ability to make decisions about provision of medical treatment because of mental disorder likely Significant risk to patient's health, safety or welfare; or to the safety of others Necessary as a matter of urgency to detain patient in hospital to determine what medical treatment requires to be provided Undesirable delay in making arrangements for a short-term detention certificate	72 hours	One fully registered doctor/mental health officer if practicable	By an approved medical practitioner No appeal	Nil Urgent – section 243
Short-term detention in hospital	44(1)	It is likely that the patient has a mental disorder Patient has significantly impaired ability to make decisions about provision of medical treatment because of mental disorder Necessary to detain the patient in hospital to determine what medical treatment should be given, or to give medical treatment. Significant risk to patient's health, safety or welfare of patient; or to the safety of others The granting of a short-term detention certificate is necessary	28 days	Approved medical practitioner / mental health officer Must consult named person if practicable	The responsible medical officer (RMO) or Mental Welfare Commission can revoke the certificate The patient can appeal to the Mental Health Tribunal for Scotland	Authorised

Table 2.5 (continued)

Purpose	Section	Grounds	Duration	Signatories/consent	Revocation/appeal	Treatment
Short-term detention: extension certificate	47(1)	<p>Patient is detained under short-term detention certificate</p> <p>Patient has a mental disorder</p> <p>Patient has significantly impaired ability to make decisions about provision of medical treatment because of mental disorder</p> <p>Necessary to detain the patient in hospital to determine what medical treatment should be given, or to give medical treatment</p> <p>Significant risk to patient's health, safety or welfare of patient; or to the safety of others</p> <p>An application should be made for a compulsory treatment order because of a change in the patient's mental health</p> <p>Not reasonably practicable to apply for CTO before expiry of short term detention certificate</p>	<p>3 working days from end of short-term detention certificate (excludes Saturday, Sunday or Bank Holidays)</p>	<p>Approved medical practitioner/ mental officer if possible</p>	<p>The RMO or Mental Welfare Commission can revoke the certificate</p> <p>The patient can appeal to the Mental Health Tribunal</p>	<p>Authorised</p>
Extension of short-term detention pending determination of application by the Tribunal	68	<p>Patient detained under short-term detention certificate or an extension certificate</p> <p>Application for compulsory treatment order has been made</p> <p>Determination of application is pending</p>	<p>5 working days</p>	<p>Automatic if grounds are satisfied</p>	<p>By RMO</p> <p>No appeal</p>	<p>Authorised</p>

Table 2.5 (continued)

Purpose	Section	Grounds	Duration	Signatories/consent	Revocation/appeal	Treatment
Compulsory Treatment Order (CTO)	64(4)	<p>Patient has a mental disorder</p> <p>Patient has significantly impaired ability to make decisions about provision of medical treatment because of mental disorder</p> <p>Significant risk to patient's health, safety or welfare; or to the safety of others without such medical treatment</p> <p>Medical treatment likely to prevent mental disorder worsening; or alleviate symptoms or effects of disorder; and such treatment is available</p> <p>The making of a compulsory treatment order is necessary</p>	<p>6 months</p> <p>Renewable for a further 6 months and subsequently yearly</p> <p>The care plan measures can be varied by application to the Tribunal</p>	<p>2 doctors (1 approved); application including proposed care plan by mental health officer;</p> <p>Mental Health Tribunal approval</p>	<p>Can be revoked by RMO or the Mental Welfare Commission</p> <p>To Mental Health Tribunal 3 months after making a CTO or once during each period of renewal</p>	<p>Measures authorised by Tribunal</p>
Interim Compulsory Treatment Order	65	<p>As for CTO except the making of an interim CTO is necessary</p>	<p>28 days</p> <p>Maximum of 56 days in total for all interim measures</p>	<p>Determined by the Mental Health Tribunal for Scotland pending its determination of a CTO</p>	<p>Can be revoked by RMO, the Mental Welfare Commission, or automatically on granting of compulsory treatment order</p>	<p>Measures authorised by Tribunal</p>

Table 2.5 (continued)

Purpose	Section	Grounds	Duration	Signatories/consent	Revocation/appeal	Treatment
Nurses power to detain pending medical examination	299	Patient has a mental disorder Necessary for the protection of the patient's health, safety or welfare; or the safety of others that the patient be immediately restrained from leaving the hospital Not practicable to secure immediate medical examination Necessary to carry out a medical examination to determine if an emergency detention or short-term detention certificate is warranted	2 hours and can be extended by 1 hour if the doctor arrives after the expiry of the first hour of the holding period	Nurse of the prescribed class – usually registered mental nurse	No revocation No appeal	Nil

Detention can proceed from an emergency certificate to a short-term certificate to a compulsory treatment order. Alternatively, a short-term detention certificate can be granted immediately by an approved doctor with the consent of an MHO (preferred route). In a non-urgent situation an application can be made directly for a compulsory treatment order. An emergency or short-term detention cannot be re-applied immediately. Tribunal decisions can be appealed to the Sheriff Principal. Appeals against the decisions of the Sheriff Principal are made to the Court of Session.

Table 2.6 High security psychiatric hospitals within the United Kingdom

Hospital (founded)	Ashworth (1990): Moss Side 1913 and Park Lane 1974 combined	Broadmoor (1863)	Rampton (1914)	The State Hospital (1948)
Location	Maghull	Crowthorne	Retford	Lanarkshire
Areas of responsibility	England and Wales Mental illness and personality disorder	England and Wales Mental illness and personality disorder DSPD* unit – The Paddock	England and Wales Mental illness, personality disorder and learning disability DSPD* unit – the Peaks National Female High Security Service National High Security Service of the Deaf	Scotland and Northern Ireland Mental illness and learning disability
Beds	275	326	370	250
Management	MerseyCare NHS Trust	West London Mental Health NHS Trust	Nottinghamshire Healthcare NHS Trust	The State Hospitals Board for Scotland

* DSPD – dangerous and severe personality disorder

Studies of referrals to high-security psychiatric care have shown that patients who were admitted had a more serious mental disorder and index offence than those rejected (Berry *et al.* 2003; Pimm *et al.* 2004). Differences in views between referring and accepting teams were found in less than a tenth of cases (Sayal and Maden 2002).

The population of the high-security hospitals has been extensively described (Maden *et al.* 1993; Thomson *et al.* 1997; Taylor *et al.* 1998). A typical patient is a male in his thirties with schizophrenia and a history of antisocial behaviour and/or substance abuse. Adverse events in childhood and poor physical health are common. A number of major differences were found in a comparison of the English and Scottish high-security hospitals research cohorts (Taylor and Thomson, personal communication): primary diagnosis of schizophrenia 55 per cent v. 70 per cent; primary diagnosis of personality disorder 24 per cent v. 3 per cent; co-morbid schizophrenia and personality disorder 18 per cent v. 33 per cent; ethnicity non-caucasian 26 per cent v. 1 per cent; history of substance abuse 10 per cent v. 41 per cent; and a median length of stay 6 v. 3 years. The proportion of patients in both groups with learning disability (10 per cent v.

9 per cent) was similar as were the histories of violent and sexual offending with over a quarter of patients admitted following a homicide, and the median age of first admission to high-security care 29 and 30 years. There were more women in the English cohort (17 per cent v. 11 per cent). Between 30 to 50 per cent of patients in both settings were said not to require high security psychiatric care. Since these findings were made endeavours have been made to relocate patients in England to lower security by the use of ring-fenced funding and in Scotland there has been the development of some medium-secure provision and the introduction of appeals against excessive security under the Mental Health (Care and Treatment) (Scotland) Act 2003.

In each setting the patient's management is organised by a multidisciplinary team comprising psychiatric, nursing, social work, psychology, occupational therapy and security staff. Regular case conferences are held and reviews of detention carried out or formal reports on restricted patients prepared. Patients receive a restriction order because of the nature of their index offence, previous behaviour and potential risk to the public. The progress of these patients is monitored by governmental departments. Treatment plans are developed at case conferences and aim: to improve the patient's mental state, physical health, social functioning, self-care and self-esteem; to reduce aggressive or challenging behaviour; to promote the use of coping techniques; to encourage community links; and to establish ongoing analysis of risk following each intervention.

Outcome studies of patients transferred from high security found a recidivism rate of 34 per cent and 31 per cent in England/Wales and Scotland respectively, and a violent recidivism rate of 15 per cent and 19 per cent after ten years (Buchanan 1998; Thomson 2005).

Medium-secure psychiatric care

The development of medium-secure psychiatric provision in the UK began in England and Wales following publication of the Butler Report in 1975 (Department of Health and Social Security 1975). It demonstrated the need for step-down secure psychiatric facilities from high security and for regionally based secure provision. Medium-secure units provide more than just an inpatient service for mentally disordered offenders. They are a focal point for the provision of forensic services to the community and to criminal justice services, for the training of forensic mental health staff and for research.

Scotland opened its first medium-secure unit in Edinburgh in 2001 (Nelson 2003). The Orchard Clinic provides treatment for 50 mentally disordered offenders or others requiring similar services. A 74-bed medium-secure unit, Rowanbank, opened in Glasgow in August 2007. A further unit of 30 beds covering the north of Scotland is planned for Tayside. The Shannon Clinic opened in 2005 and is the medium-secure facility for Northern Ireland with 34 beds.

A study of referrals to 34 medium-secure care units found that assessment of need for medium security was associated with symptoms of acute schizophrenia, non-compliance with treatment, a history of sexually inappropriate behaviour, current issues of self-harm, a serious index offence and a history of recent or multiple custodial sentences (Melzer *et al.* 2004a). Just under a fifth of those assessed in prison were not admitted, and just under a quarter of those