Forensic Psychiatry in Britain

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This report provides an overview of the criminal forensic mental health system in Great Britain, that is England and Wales. The report is based on the author’s participant observation as a visiting consultant psychiatrist at a regional forensic facility in Manchester, England during early 1994. British law casts a net over a wider population of forensic patients than does U.S. law. There is a forensic care system in the British National Health Service that is parallel to and independent of the general psychiatric care system. The forensic system provides continuity of care from prison through maximum security hospitals to regional medium secure facilities, and finally, into the community. Community care is provided by psychiatrists and social workers and, if necessary, by psychiatric nurses. This system appears to provide effective treatment for persons with major mental disorders and histories of violence. Differences between Britain and the United States in philosophy of government, in law, and in forensic training and practice are discussed. The fundamental difference is a greater British belief in the capacity of government to act in the best interests of the individual. Current problems in the British health care system and plans to privatize some services are also discussed.

The purpose of this paper is to describe the British system for dealing with mentally disordered persons who commit criminal acts. In 1974, the British government officially recognized that services for the forensic patient population were grossly inadequate. At that time, services were limited to prison hospitals and maximum security forensic hospitals.

Beginning in 1980, the National Health Service developed an extensive network of regional secure units (RSUs) to provide hospital and community services for involuntary forensic patients. Some patients choose to continue in this system voluntarily. This system stands in marked contrast to the law and service system in most U.S. jurisdictions.

In the United States in 1993, 10 states had laws authorizing involuntary community treatment of persons found not guilty by reason of insanity or incompetent to stand trial. Experience in the United States and in Britain demonstrates that a system that authorizes discharge of patients from hospitals conditionally or under certain restrictions meets two goals: it provides least-restrictive-alternative treatment for patients and it reduces the risk of future violence against others to acceptably low levels.

**Method**

This is an impressionistic report based on two months’ (early 1994) participation
in and study of forensic system in England. I was based at Edenfield Centre, a RSU in Greater Manchester. Edenfield provides inpatient, outpatient, and community treatment for forensic patients. It is considered to be one of the best RSUs in Britain.

Facilities visited included RSUs in Liverpool, Birmingham, and Preston; the only secure forensic adolescent hospital in the U.K.; one maximum security or special hospital; three prisons; an entry level court with a “diversion scheme” (what would be called a court clinic in the United States); community clinics and residences; a day treatment program; and a probation office.

Participant-observation of diverse activities included clinical interviews with patients in the outpatient clinic, community residences, and patients’ apartments; academic and case conferences; policy planning meetings of RSU senior staff; medical students’ formal presentation of forensic psychiatric research projects; and working research meetings on evaluation of a court diversion project.

The following annual meetings were attended: the forensic section of the Royal College of Psychiatrists in Glasgow, the Institute for the Study and Treatment of Delinquency (in the Cholmondeley Room in the House of Lords), and the Medical/Legal Society of Manchester (held in much less grand surroundings).

**British Law**

**Criminal Law.** *Fitness to Plead* Before 1991, British law stated that anyone found not fit to plead, that is incompetent to stand trial, was subject to involuntary commitment to a mental hospital for an indefinite period. Therefore, defense counsel rarely raised the question, because the consequences of being found unfit were so problematic.

Under the 1991 revision of the criminal code, when a defendant is found unfit to plead, the court orders a trial based on the facts, not an automatic, indefinite commitment to a mental hospital. If the court finds that the defendant has committed a criminal act, the court may commit to hospital or release the person to the community subject to a restriction order. Either order may be for a limited or unlimited time.

**Criminal Responsibility** Before 1991, attorneys rarely raised the insanity defense. There were two reasons for this. First, the law permitted diversion of criminal defendants into the health care system without a finding of lack of responsibility; however, the disadvantage was that criminal charges remained open. Second, if the defense succeeded, the only disposition for an insane defendant was involuntary hospitalization without limit of time.

Since the 1991 act, the court has had some choice of disposition following a verdict of not guilty by reason of insanity. As with a finding of unfitness to plead, the court may commit to hospital for a limited time, or order the person released to the community subject to restrictions. As a result, defense attorneys now more frequently raise insanity as a defense to criminal charges.

Diminished responsibility is used as a defense only in murder cases. A plea or a finding at trial of lesser responsibility reduces the crime of murder to manslaughter.
ter. After a manslaughter conviction, the court has a wide range of sentencing options: prison, hospital, or probation. Conviction for murder carries a mandatory life sentence.

This system has resulted in defense attorneys putting heavy pressure on psychiatrists who evaluate murder defendants. Attorneys press for a finding of diminished responsibility. Not infrequently, forensic psychiatrists are opposed to a mandatory life sentence for a particular defendant. The psychiatrists’ beliefs and the defense attorney pressure may combine to create a severe ethical dilemma for the forensic psychiatrist who believes that the defendant is responsible.

Social critics in Great Britain note that the law on mandatory life sentence for murder has worked to the disadvantage of women charged with killing their abusive partners.6

British law recognizes provocation or self-defense as a defense in assault or homicide cases only when the crime follows immediately on the alleged provocation. Therefore, women face a cruel choice. If the woman goes to trial and argues diminished responsibility, and the argument fails, she faces mandatory life in prison. The alternative is to plead guilty to manslaughter, typically resulting in a sentence of several years in prison.

Finally, as in the United States, a criminal may be placed on probation with psychiatric treatment as a condition. As in this country, such a person cannot be treated involuntarily. If the probationer refuses treatment then he or she is returned to the criminal justice system for disposition.

In 1994, an unmedicated schizophrenic randomly pushed a newly married man under a subway train. Following this highly publicized killing, there has been growing pressure to medicate some civil patients involuntarily.

**Mental Health Law.** Definitions The Mental Health Act of 19837 governs psychiatric practice for persons with mental illness, mental impairment, psychopathic disorder, “and any other disorder or disability of mind.” The act explicitly excludes persons whose sole problems are “promiscuity or other immoral conduct, sexual deviancy or dependence on drugs or alcohol (Ch. 20, 1).”7

Mental illness is not further defined. Mental impairment refers to low intelligence and impaired social function “associated with abnormally aggressive or seriously irresponsible conduct. (Ch. 20, 1(2)).”7 Psychopathic disorder means “a persistent disorder or disability of mind . . . which results in abnormally aggressive or seriously irresponsible conduct (Ch. 20, 1(2)).”7

In practice, the legal category of psychopathic disorder may refer to a variety of clinically recognized personality disorders. Patients in special hospitals with psychopathic disorders often have antisocial, borderline, paranoid and/or narcissistic DSM-III-R diagnosed personality disorders.8 Many have committed sexual offenses. Women averaged 3.7 axis II diagnoses. Drug and alcohol abuse were common in men and women. Over half of the sample had lifetime axis I disorders and/or psychiatric hospitalization. One quarter had had electroconvulsive therapy.

There is dispute about whether the
legal category “psychopathic disorder” refers to any medically recognizable group of diagnoses, how these disorders should be categorized and described, and whether they should be incarcerated in prisons or special hospitals, or whether involuntary treatment under the present law makes any sense.

Civil Commitment A physician may initiate commitment of a person who is “suffering from a mental disorder which in the interests of his own health or safety or with a view to the protection of other persons, warrants his detention in hospital . . . (Ch. 20, 2(2a)).”

The law authorizes commitment for 28 days for evaluation and for six months for treatment. Further six months commitment for treatment of mental illness is authorized if the patient’s condition “makes it appropriate.”

An additional requirement for commitment for a person who has a psychopathic disorder or mental impairment is that treatment “is likely to alleviate or prevent deterioration . . . and is necessary for health or safety of the patient or for the protection of others.”

The committed patient may be involuntarily medicated for as long as three months. Thereafter, a patient whom the doctor considers to be refusing medication rationally is entitled to refuse. A patient whom the doctor and one consulting physician consider to be refusing irrationally and in need of medication may be involuntarily medicated. The consultant must consult two people who know the patient—a nurse and a nonphysician—before rendering an opinion on competency to refuse medication.

Persons Involved in Criminal Proceedings or Under Sentence Criminal defendants are subject to psychiatric evaluation by order of magistrate’s or crown court, analogous to the U.S. district and superior courts. A crown court may also order involuntary treatment for defendants charged with imprisonable offenses, but only after receipt of a physician’s statement in writing that hospitalization is necessary. The judge may so order sua sponte or after a motion by prosecution (“the crown”) or the defense. Judicial- or crown-ordered evaluations are turned over to the defense. Defense-ordered evaluations may be suppressed at the defense’s discretion. However, the crown may call a defense psychiatrist to testify after a report is suppressed.

In contrast to the United States, there is no required statutory question to be answered. The pre-trial evaluations do not necessarily focus on fitness to plead or on criminal responsibility. The purpose of the exam may be simply to assist the court in understanding and disposing of the case.

All homicide cases receive a psychiatric evaluation. Men are usually remanded to a prison hospital or special hospital for psychiatric evaluation. Women are usually released on bail and evaluated as outpatients.

A crown court judge may order a convicted defendant for psychiatric evaluation and treatment for six months. This requires a statement from two doctors that such treatment is appropriate and that a bed is available. This hospital order may be extended repeatedly, ending when the patient is clinically ready for discharge.
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The crown court may add a restriction order for these hospitalized patients. A restriction order states that the restricted patient may not be discharged or transferred from hospital without permission of either the Home Secretary or a Mental Health Tribunal. The physician does not have the power to discharge a restricted patient. A restriction order may be made for a specified period, or for an unlimited period when public safety is at issue.

The Home Secretary administers the criminal justice system of the United Kingdom. Within the secretariat is an office of 30 civil servants, none of whom is a mental health professional. They receive regular reports from the responsible consultant and social worker assigned to each restricted patient.

After a careful review, the Home Office, not the psychiatrist, decides whether to discharge a patient from hospital or to end a restriction order. In doubtful cases, the Home Office obtains outside, independent assessment.

The definition of hospital discharge means discharge to the community. RSU staff may write for grounds privileges without consulting the home office. Some RSUs have open grounds.

A patient may appeal a restriction order or any civil commitment to a three-person tribunal. One member of the tribunal is always a crown court judge or judge of equivalent standing; one is a psychiatrist, and one is a layperson. When a tribunal orders discharge, neither the clinician nor the Home Office has a right of appeal.

The forensic psychiatrists in Britain say this is a good system. They are not critical of the Home Office. Home Office decisions reflect the views of the community on the balance between individual liberty and public order. Forensic psychiatrists criticize the occasional Home Office decision that appears to be made on political grounds.

A restricted patient may be unconditionally discharged from the hospital and from the restriction order. However when a restricted patient is discharged, the restriction order usually continues in effect. The restricted patient is under the supervision of a responsible medical officer and social worker or probation officer, must live in an agreed-upon residence, take medication, and follow such other conditions as may be ordered.

The Health Care System

Under the National Health System (NHS) everyone has access to a general practitioner. Access to specialty health care is available on referral from the general practitioner. There is a small private-practice medical system outside the NHS. It is similar to U.S. private health care.

Deinstitutionalization has occurred in Britain much as in the United States. General hospitals have open psychiatric wards. General psychiatrists and community psychiatric nurses (CPNs) render outpatient care. CPNs work in community clinics and they make home visits to impaired patients. Psychologists provide some psychotherapy. This may be cognitive, short-term, or group therapy. There is very little long-term individual psychotherapy in the NHS, and psychiatrists almost never provide any.

Patients with chronic mental disorder who are unable to work are supported by
the government. There is much more public housing (council housing) in Britain than in the United States. There are also community residences with varying levels of staffing for chronic patients. Housing for chronic patients is relatively easy to arrange. Some newly developed residential facilities are jointly staffed by the probation and the forensic service.

**Forensic Psychiatry** The training of forensic psychiatrists is far more extensive in the United Kingdom than in the United States. Forensic psychiatrists have seven or eight years of postgraduate training. This includes one or two years of general medicine, three years of general psychiatry, followed by at least three years of forensic psychiatry. Core forensic psychiatry residency training occurs in the RSUs, special hospitals, and prison hospitals. Elective training may involve specialized substance abuse services, neuropsychiatry, adolescent or child forensic psychiatry, geriatrics, or a university-affiliated research placement. Completion of this training is a requirement for employment by the NHS as a consultant, that is senior forensic psychiatrist.

The prestige hierarchy among psychiatrists in the United Kingdom contrasts dramatically with that in the United States. Psychiatrists in the public sector are more highly regarded than those in the private sector, and forensic psychiatrists are at least as highly regarded as general psychiatrists. Thus, consultant forensic psychiatrists working for the NHS in RSUs are at or near the top of the psychiatric hierarchy in the United Kingdom.

NHS forensic psychiatric services are organized separately from and parallel to general psychiatric services. Prison hospital services are run by the prison system, but most NHS forensic psychiatrists have good working relationships with prison medical services. Special hospitals and RSUs form one integrated forensic care system for restricted patients. There are now approximately 650 RSU beds nationally serving 55 million people.

A consultant based at an RSU will initially evaluate a remanded patient. This may occur in the community, police custody, local hospital, prison, or special hospital. The consultant will become the responsible medical officer if the patient is transferred to an RSU, and continue as responsible medical officer if and when the patient is discharged to the community. The continuity of care for restricted patients is impressive. When the restriction order is lifted, some patients request to continue as voluntary patients rather than be discharged to general psychiatric care.

RSUs are secure hospitals, typically with between 20 and 60 beds. At Edenfield, all wards are locked. The building is entered through a trap of double locked doors. On entering the building each staff person is issued a key, which must be attached to his or her person by a heavy cord or chain. On leaving, the key must be surrendered.

A psychiatric consultant will typically be responsible for a 15-bed ward and a community psychiatry service. On most services, a senior registrar (chief resident) in forensic psychiatry and a general psychiatry registrar are also present.

The ward is staffed by a multidisciplinary team. The CPN and community so-
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cial worker participate actively at ward rounds. This promotes continuity of care.

Patients may be admitted either for evaluation and court reports, or for treatment. Median length of stay is approximately nine months, and most patients are discharged within two years. An RSU will admit forensic patients direct from prison, from special hospital, from community forensic services, and rarely from community psychiatric care.

General hospitals at times try to transfer difficult-to-manage patients to RSUs. RSUs differ in their response to apparently comparable cases. If they have a bed open, some RSUs will accept patients who appear to need RSU security. Other RSUs have a higher threshold for admission, offering consultation and training to the referring service rather than admission.

Forensic service patients are typically men, diagnosed with either schizophrenia or with psychopathic disorder. Afro-Caribbean men are overrepresented. The few women are typically diagnosed as depressed, schizophrenic, or borderline.

Treatment is similar to U.S. treatment, except that there is very little long-term individual psychotherapy. Any long-term individual therapy is likely to be cognitive or behavioral. The forensic service has virtually no in-house capacity for psycho-dynamic psychotherapy. In selected cases, an RSU may contract with an outside therapist to provide this treatment. RSU psychologists provide almost all the psychotherapy to forensic patients. Nurses often provide long-term counseling in their role as key workers for patients.

Antipsychotic medications are prescribed in much larger doses than in the United States, and intramuscular (i.m.) medications are commonly used. A dosage of 60 to 100 mg per week i.m. of Hal-dol is not uncommon. Chlorpromazine and amitriptyline are also widely prescribed.

Physical restraint as we know it in the United States is not used. Instead, nursing staff are trained to use akido-derived techniques of passive physical control. Three trained staff can subdue and control any violent patient. Each of the patient’s wrists are “locked” in extreme flexion by a staff person. If necessary, the patient’s head is held down by a third staff person. The patient is walked slowly to a quiet area. If the patient tries to struggle, staff can inflict pain by increasing the degree of wrist flexion. Staff report that this technique works well when applied by trained staff. I had a personal demonstration of locks. To struggle hurts.

The system places a value on minimal use of restraint and seclusion. One RSU, Reaside, has a policy of no seclusion. Staff provide one-on-one special nursing as needed. They have done so for as long as a year before giving up and transferring the patient back to a special hospital. A Royal College of Psychiatry working group is currently developing a position paper on seclusion. This will state that seclusion should be an unusual event.

Restricted patients are discharged from RSUs to the community when treatment is successful and the Home Office approves. By statute, every discharged, restricted patient must be followed by a community social worker and a responsi-
ble medical officer. These two professionals meet regularly with the patient and with each other, as well as with other involved caregivers. Additionally, many patients, especially those with a psychotic disorder, are followed by a CPN as well.

Many patients are placed in hostels initially, and later graduate to council flats (apartments). CPNs are responsible for psychiatric care of the patients whom they follow. A CPN caseload will consist largely or almost entirely of patients who receive i.m. medication. CPNs know their patients well. They spend as much as an hour per visit. They discuss the patient’s health and concerns, as well as giving medication. The CPN may take the patient for a meal as part of social rehabilitation.

One RSU has a program in which CPNs and patients go off for several days on camping trips or “outward bound” trips together. Evenings at the “pub” drinking together are an accepted part of these trips.

Community social workers serve a role that parallels and overlaps that of the CPN to a considerable extent. The social worker is responsible for insuring that the patient’s civil rights are maintained and that he or she receives the various necessary entitlements—disability payments and housing primarily. The social worker will also meet with the family to discuss the patient’s current social adjustment and relationships.

By law, CPNs and social workers must make home visits to restricted patients. Initially, these occur weekly, or more often if there is a crisis. The visits taper off over time, but must occur at least every three months for any restricted patients. A CPN will typically have a caseload of 30 patients.

The patient will return to the RSU monthly to see the psychiatrist. The psychiatrist will spend up to an hour with the patient, inquiring into the patient’s situation, monitoring the patient’s mental status, and prescribing medication. Forensic patients who are not restricted receive similar but discretionary services.

Patients who relapse in the community can be rehospitalized at the RSU, either voluntarily or involuntarily. CPNs and social workers have considerable responsibility and autonomy in management of restricted patients. De facto, they decide to rehospitalize patients. The psychiatrist will review this decision only after the patient has returned to hospital.

Follow-Up Data. One recent study compared patients who were discharged unconditionally from special hospital with those discharged on restriction. Restricted patients did significantly better. They rarely reoffend—only five percent of restricted patients with psychotic disorders reoffended in a three-year period. Approximately 25 percent of psychopathic patients on restriction reoffended seriously.

There are no systematic data on follow-up studies of patients discharged from RSUs. Anecdotal reports suggest that serious violence is even more rare in this population than in the patients discharged from special hospitals.

Current Developments

A conservative government under Margaret Thatcher set in motion dramatic
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changes in the health care system. The government created an option for private inpatient psychiatric service within the health care system. In practice this looks remarkably like the Clinton administration’s 1994 proposal for managed competition in the United States.

The NHS is a single-payer/single-provider system. It is being supplanted by a system in which the government gives money for health services to regional purchasing authorities. These purchasing authorities are empowered to contract with whom they choose for medical services for their region. There are now private psychiatric hospitals that offer RSU-type services to regions in which the existing RSU is almost always full.

In response to the creation of purchasing authorities, some health care institutions are reorganizing as provider trusts, which are legal entities. For example an RSU, a general hospital, and a chain of private community residences may each bid for a contract with the purchasing authority to provide services for the region. RSUs must now think about marketing and cost control for the first time. This has not been easy.

In 1992, the British government published an extensive report on health and social service needs of mentally disordered offenders. The Reed Report served not only as a review, but also as a policy directive for the development of forensic services. It calls for high-quality, individual treatment plans for offenders, and for increased interagency collaboration between the prison medical service, the NHS forensic service, the police, probation officials, and community care agencies. The needs of offenders with learning disabilities or more pervasive developmental disabilities were specifically addressed.

Problems

There is a chronic national shortage of regional secure beds in Britain. A recent survey found that on the particular day, 100 percent of the 650 RSU beds were occupied; there were no available RSU beds in the entire country. The NHS plans to build an additional 1,000 RSU beds over the next few years.

The RSU bed shortage is a result of several interrelated factors. First, the NHS is closing most long-stay, traditional mental hospitals. Chronic patients are sitting up in the RSUs because they have nowhere else to go.

Second, patients who no longer need the security of an RSU are difficult to place in community psychiatric beds. General hospital psychiatric units resist taking forensic patients in transfer because of their discomfort and inexperience with forensic patients.

This is one symptom of a more general problem of poor collaboration between the general psychiatric care system and the forensic system. No regional authority has the power to transfer patients from the forensic system to the general system. The strength of the separate forensic care system is that it does its work well. The weakness is its isolation from the general psychiatric system.

Third, it is now Home Office policy that anyone serving a sentence who requires hospital treatment for a mental disorder should be transferred from prison to
a secure hospital or an RSU. These mentally disordered offenders cannot be released before their earliest prison release date. If hospital treatment is effective and the patient improves clinically, the prison is often reluctant to accept the person back.

Lastly, privatization is both an opportunity and a potential problem. At this early stage, the problems of transforming an RSU from a public institution on a fixed budget to one whose budget depends on marketing loom large. The advantages are less apparent.

**Comment**

The law in Great Britain authorizes involuntary treatment for more people than does the law in the United States. This reflects a fundamental difference in the role of government in the two countries. British law reflects the belief that government and its agents can be trusted to exercise a benign influence on the lives of its citizens. The British see less need than Americans do to protect citizens from intrusive acts of government.

Examples abound—in Britain a person is mentally ill if a psychiatrist says so. Neither law nor regulations define mental illness. Psychopathic disorder is defined so broadly that it describes a substantial minority of the population.

Civil commitment is appropriate for persons who need treatment; there is no limitation based on danger to self or others. Psychiatrists’ opinions control. The patient’s opinion, even if competent, does not. Similarly, psychiatrists may medicate an involuntary patient for three months, regardless of the patient’s competency or wishes.

Criminal defendants may be tried whether or not they can assist counsel. Psychiatrists may report to a judge before a criminal trial on anything they can learn about the defendant from him or her or anyone else.

In the United States, we are more skeptical. We believe the government’s authority to deprive a person of liberty, either criminally or civilly, should be hedged around with clear rules and restrictions. It should not be left to the discretion of judges or medical doctors.¹⁵

The strengths of the British system include the extensive training of forensic psychiatrists and the range of specialized forensic services available to restricted patients. There is continuity of care and continuity of caregiver in the person of the responsible medical officer. Few if any states in the United States provide the range and quality of services provided in the best RSUs in Britain.

The British system offers an implicit social contract to restricted patients. The government set limits on the patient’s freedom. In return for accepting these, the patient receives quality service in the least restrictive setting. Many restricted patients have stable, long-term relationships with caring professionals. Not infrequently, patients ask to continue in treatment when restriction is ended. Occasional patients have been known to reoffend in order to reestablish themselves as patients of the forensic system.

There are marked differences between the United States and Great Britain in how psychiatrists and CPNs conduct their relationships with patients. In Britain the underlying treatment model is medical,
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not psychotherapeutic. The professionals inquire into their patients’ symptoms and lives much as a concerned primary care physician in the United States might inquire.

One consequence of the medical model is that clinicians and patients were happy to have me observe ongoing, long-term treatment. That would be inconceivable for ongoing, long-term psychotherapy in the United States.

Several consultants remarked to me that they shared personal information with their patients as a way of establishing rapport. One described a unique ability to establish relationships with difficult patients who came from a particularly tough, chronically depressed area. Success came after he told several of these patients he had grown up in their community. Another consultant displayed some personal mementos in her office. She described these as “good icebreakers.”

Some CPNs and patients may have relationships that we would call boundary violations. Social drinking on the therapeutic camping trip is a good example.

CPNs are tolerant of their patients’ drinking. In my experience in the United States, community mental health professionals generally believe that patients should not drink at all.

Forensic consultants and CPNs all told me that they liked their patients. From my observations, they did. Their implicit model of care is one in which the professional is friendly, concerned, and professional rather than neutral and distant.

The American model of the patient-psychiatrist relationship owes more to psychotherapy. Psychotherapy, even supportive therapy, has technical demands beyond those of the doctor-patient relationship. Psychotherapy requires a continuous process of monitoring the effect of the therapist on the patient. There are strictures on personal disclosure and on boundary violations of any kind.

I suspect that fewer practitioners are able to meet the requirements of good practice in the psychotherapy model than in the medical model. The British model requires a combination of good professional training and adequate capacities for human relationships rather than more arcane skills and training. At present the system attracts and holds highly trained, caring men and women. They deliver apparently effective services to a group of patients whom we see as problematic and difficult in the extreme.

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References