

TRAINING IN FORENSIC PSYCHIATRY — AN ENGLISH PERSPECTIVE

CLIVE MEUX & TIM EXWORTHY

Summary

Forensic psychiatry is an important and expanding sub-specialty. This paper describes the experience required for adequate training in forensic psychiatry from an English perspective. The relevant clinical, theoretical and research issues in forensic psychiatry are described within the broader framework of medical and psychiatric training and the facilities required. International issues and higher qualifications in forensic psychiatry are discussed.

Keywords: forensic psychiatry, training, education, qualifications

INTRODUCTION

Forensic psychiatry is an expanding branch of psychiatry whose emphasis is primarily towards the prevention of victimisation caused by mental disorder, through appropriate assessment and treatment. It examines the causes and treatment of aggressive behaviour, offensive sexual behaviour and other destructive behaviours in mentally disordered people. It is also concerned with the psychological damage caused to victims of severe psychological stress and the relationships between being a victim and victimising others. The term "forensic" is defined as "pertaining to the courts of law" (Oxford English Dictionary, 1989). By its nature, it is intimately involved with mental health legislation, compulsory treatment and associated ethical issues. Society is often judged by the manner in which it treats its most deprived members. Mentally disturbed offenders are doubly stigmatised and the problems they raise can force a critical evaluation of the development of that society.

There has been a protracted debate as to whether forensic psychiatry should be a sub-specialty. Part of the argument is that if it is, general psychiatrists and their clinical colleagues will become progressively deskilled in the assessment and management of psychiatric patients presenting with significant behavioural disturbance or requiring compulsory treatment and supervision. However, such a process probably predates the advent of the formal sub-specialty of forensic psychiatry and has its roots in the pharmacological, legislative and social revolutions of the 1950s. The counter argument is that there is a recognised need to provide expertise for this most severely affected group of patients and ignoring its sub-specialty status does not remove that need. We would contend that specialists

can develop centres of excellence in their field and the research and developments so produced can help to alter practice and raise standards in the surrounding area. The Royal College of Psychiatrists (in the United Kingdom) formally recognises forensic psychiatry as a sub-specialty of psychiatry. Moreover, there is a continuing need for special circumscribed training and expertise in forensic psychiatry, not least because of public and governmental pressures following inevitable tragedies involving mentally disordered people. (Ritchie et al, 1994; Blom-Cooper et al, 1995)

Medical training is an area of immense importance. The training and education of staff is one of the principal ways of ensuring continuing high standards of treatment for the whole of the population, be it through hospital or community care or indeed through psychiatry. Medical education begins in medical school. All medical students in England have to complete a module in psychiatry and a number of these modules include some brief experience and education in forensic psychiatry. Although forensic psychiatry is only a small area of the knowledge medical students are expected to learn, we know of such exposure inspiring students to enter forensic psychiatry and going on to be consultants.

Training in forensic psychiatry can only be built on the solid foundations of a broad basic knowledge of the rest of medicine and psychiatry. With regard to psychiatry this would include a knowledge of adult psychiatry, child and adolescent psychiatry, drugs & alcohol misuse, learning disabilities and the psychiatry of old age. An individual's experience may also include research work. The psychiatric training should then be consolidated in a standard systematic manner, such as gaining membership to the Royal College of Psychiatrists, in the United Kingdom. This

is achieved by way of a two stage examination involving written, clinical and oral sections (Royal College of Psychiatrists, 1994). The first part is sat after approximately twelve months experience of psychiatry and the process is completed with Part II after a total of approximately three years training. Access to higher sub-specialty training (for example, in forensic psychiatry) can then occur and usually lasts a further three to four years prior to appointment as a consultant.

SPECIALIST TRAINING

In England and particularly at the Institute of Psychiatry in London there is a long history of organised training in psychiatry and forensic psychiatry. The practical experience gained suggests that higher specialist training in forensic psychiatry should be as follows:

CLINICAL

Significant experience of clinical work needs to be acquired from working in settings of minimal, medium and maximum security, as well as out-patient settings such as community hostels and out-patient clinics (which would include the follow up of patients subject to statutory supervision due to the nature of their potential risk to others). Professional contact with remanded (awaiting trial) and sentenced prisoners, either in the criminal courts (which can involve writing psychiatric reports as well as giving oral evidence in court) or at penal establishments is also required. In addition, the forensic psychiatrist is expected to be able to work with the statutorily appointed independent inspectors of psychiatric services as well as appear before the independent legal appeals body that monitors the compulsory detention of patients (respectively, the Mental Health Act Commission and the Mental Health Review Tribunal, in England and Wales). To add further breadth to the training some experience of clinical work in the following areas is recommended: psychiatric assessment services in the lower criminal courts (so called court diversion schemes, as described by Exworthy & Parrott, (1993)), the civil courts, forensic units for those with learning difficulties or for adolescents, specialist penal establishments (for young persons, life sentenced prisoners, vulnerable prisoners, high security or females) and with victim services. Experience of out of hours and emergency duties and of relevant management and administrative issues, including budgetary measures, is important.

Such a variety of venues provides a broad experience of clinical work for the trainee forensic psychiatrist. Not only does it provide exposure to both criminal and civil law but it also delivers practical experience of the various presentations and treatment approaches to the different

diagnostic groups within the generic term "mental disorder", for example schizophrenia, manic depressive disorder and personality disorders. Another important aspect is the acquisition of an understanding of multi disciplinary working and its application to forensic psychiatric patients.

Forensic psychotherapy is also a very important subject to be covered in training. Issues concerning transference and especially countertransference are often well to the fore in therapeutic relationships with forensic psychiatric patients. At an individual level, knowledge of psychotherapeutic principles can assist in the formulation of an understanding of a particular offence or behaviour and thence help in quantifying the risk that that person poses. Experience with specific psychotherapeutic techniques, such as cognitive behavioural models, is required in the treatment of, for example, psychosexual disorders. On a broader plane, forensic psychotherapy has much to offer in interpreting the dynamics within a ward, unit or institution, or in providing support for staff managing a difficult or disturbed patient. The importance of having ready access to appropriate supervision in all these cases cannot be overemphasised. A part time training course in forensic psychotherapy, as described by Cordess et al (1994), is offered by the Portman Clinic in London. The need for specific texts in forensic psychotherapy has been recognised and appropriate work is underway in England.

Although a detailed knowledge of one's own mental health legislation (for example, the Mental Health Act, 1983, in England and Wales) and related codes of practice (for example, Department of Health and Welsh Office, 1993) is vital, exposure, such as by visits, to different legislative and cultural systems can be a valuable experience and learning opportunity for the trainee forensic psychiatrist.

THEORETICAL

The practical side of training needs to be underpinned by a sound theoretical base and this should be provided by a detailed academic programme. Such a programme should include both clinical, psychotherapy and didactic seminars as well as research seminars and journal clubs with senior staff present. A visits programme to gain an understanding of the role of organisations such as governmental bodies, for example the Home Office in England, judicial bodies, such as the Parole Board in England, other hospitals, and also police establishments and therapeutic facilities in penal establishments (for example Grendon prison in England (Gunn et al, 1978)). An increased theoretical understanding of forensic psychiatry is also facilitated by attendance at national and international conferences.

RESEARCH

Dedicated time for trainees to plan, conduct and communicate the outcome of a research project is required by the Royal College of Psychiatrists (1995), in the United Kingdom, as part of their accreditation of training programmes. Research must be encouraged and trainees may be part of a large study in the centre where they work or they may pursue a smaller project on their own. Whichever option is followed the same fundamental requirements of a stimulating environment with access to specialist (e.g. statistical) advice and regular academic supervision are needed. While the outcome of such research is frequently measured in terms of published papers in the scientific journals, it is also possible for the research to be registered for a post-graduate degree. Trainee forensic psychiatrists exposed to research may pursue an academic career becoming a lecturer and then senior lecturer (or even professor). Alternatively, even those who return to full time clinical work will take with them an interest in academic work and teaching which will become incorporated into the philosophy of their practice and so will encourage and stimulate future trainees and other developments. Certainly, a study (Knesper, 1978) of large mental institutions has demonstrated that the quality and quantity of recruitment is improved by academic linkages.

SUPPORT FACILITIES

Adequate support facilities are required if the training is to be fulfilling and effective. At a personal level trainees should have their own office or work space where they can work privately and store their papers, computer and other belongings and also have access to adequate secretarial support. The trainee should have regular dedicated supervision with their trainer (i.e. separate from a review of ward or patient matters) and have regular appraisals of their work performance. Their consultant trainer should be accredited as such in forensic psychiatry. It is necessary to have access to a well stocked library with high quality forensic psychiatry textbooks (e.g. Gunn & Taylor (1993), Bluglass & Bowden (1990), Chiswick & Cope (1995) and Faulk (1994)) and international forensic psychiatry journals (e.g. "Criminal Behaviour and Mental Health" and "The Journal of Forensic Psychiatry"). The library should also have facilities that provide for easy retrieval of information, for example, literature searches and should hold appropriate reading lists for trainees. Modern teaching aids should also be available.

Having acquired a theoretical knowledge and a practical experience of the subject the specialist in forensic psychiatry should then possess an understanding of:

- the history and development of forensic psychiatry,

- the range of forensic psychiatric services available,
- the treatment approaches in forensic psychiatry,
- specific mental disorders and forensic psychiatry, for example antisocial personality disorder, treatment resistant schizophrenia, morbid jealousy,
- specific groups (such as the elderly or females) and forensic psychiatry,
- psychopathology in victims and services for them,
- mental health legislation and law as applied to forensic psychiatry,
- human rights, ethical issues and codes in forensic psychiatry,
- criminological issues, including ethnicity and causes of crime,
- dangerousness and risk - assessment and management,
- offending behaviour - violent, non-violent and sexual ,
- relevant research issues and methods and clinical audit in forensic psychiatry.

In the United Kingdom all higher training in psychiatry is monitored and accredited by the Royal College of Psychiatrists who inspect the quality of training in all centres on a regular basis. The College has published guidance on the issues relevant to higher training (Royal College of Psychiatrists, 1995).

In due course the trainees become trainers and so the cycle of education is perpetuated. Continuing professional development is gaining an increasingly high profile and the disciplines learnt and developed through a period of research can be invaluable in this regard. In the UK the Royal College of Psychiatrists is now formalising arrangements for continuing professional development to help all consultants keep abreast of changes and innovations in psychiatry (Tait, 1994).

GAINING EXPERIENCE

Obviously the number of psychiatrists in specialist forensic training is likely to be small but exposure to forensic psychiatry for the generalist doctor is very important, be they general psychiatrist, prison medical officer, general practitioner or forensic medical examiner (formerly police surgeon). While the training for these groups would not have the depth as for the specialist trainee and so they could not substitute for a forensic psychiatrist, nevertheless, other groups of doctors do have regular contact with mentally disturbed people who have committed some sort of offence and so require training experience. Not infrequently they will be required to make their assessment before a referral to a forensic psychiatrist is made. Thus the importance of a degree of understanding of the principles of forensic psychiatry cannot be overstated.

For the generalist trainee the programme should be individually tailored to take into account the specific requirements of that person or group of people, as well as the previous experience and skills already possessed. An example is the proposed changes to training for prison medical officers in England and Wales. A Report from the Royal Colleges of Physicians, General Practitioners and Psychiatrists (1992) on the training and education of doctors working in prisons recommended a new educational programme there. The Health Care Service for Prisoners plans to implement three types of courses for doctors. All doctors new to working in prisons will undertake a four week induction course to orientate them with regard to prison management, medicolegal and ethical work, primary care in prison and psychiatry as it pertains to prison. There will also be an extended part time course over two years for general practitioners working within the prison setting. Again psychiatry will make up a significant proportion of the syllabus. The third course will be an extended course, of similar length to the generalist course, for psychiatrists working in prison. The proposed syllabus has been modeled on the suggested outline given above (see Specialist Training) but with an obvious emphasis on the perspective of working within a penal institution. An area that demands especial attention is ethics and the law; the detention of persons involves an inevitable loss of certain civil liberties over and above the actual loss of freedom. In these circumstances respect for human rights and the protection of civil liberties becomes even more important. When the detention is for a criminal offence and treatment of a psychiatric disorder is also required the distinction between custody and care needs to be carefully identified and maintained.

OTHER DISCIPLINES

The contributions to be made to, and by, other disciplines in terms of training is beyond the scope of this article. Centres for training other professional groups, be they clinical (for example, nursing staff, psychologists, social workers, occupational and creative therapists) or non clinical (for example, the police, lawyers, the Probation Service) are likely to develop in tandem with those for psychiatrists and so could be receptive to a cross fertilisation of ideas and projects.

INTERNATIONAL ISSUES

The opportunities for developing training programmes are, to an extent, limited by the existing national or local infrastructures. However, training and infrastructure are in a dynamic relationship and will evolve together. For example, in England and Wales twenty years ago there were no medium secure units; now there are many. Indeed,

recently in the UK, there was a major review of services for mentally disordered offenders (Department of Health & Home Office, 1992) which made numerous strategic recommendations relevant to forensic psychiatry including training, academic and staffing issues. With the ongoing development and expansion of forensic psychiatry and particularly of medium secure hospital services the way continues to open up for new venues for training and experience and also new styles of working, especially within the community. Developing forensic psychiatric training within a nation where it is as yet absent will always be a challenge and will often need a champion (perhaps someone with international experience) for the cause. Such training in forensic psychiatry must also satisfactorily coexist within the broader context of national psychiatric training (e.g. Chen, 1994). It is always important to create an academic base at an early stage of training development, even if it is modest. The training programme developed should use local facilities to their fullest potential and attempt to offer clinical, theoretical and research experience with relevant peripheral support as outlined above. It should be able to offer training to future forensic psychiatric specialists and encourage generalists with an interest in forensic psychiatry. Multidisciplinary aspects must not be forgotten.

Such local training in forensic psychiatry should include, and be facilitated by, international opportunities; after all learning is a two way process and the sharing of information and the establishing of important professional links is assisted by attending international conferences, courses or visiting centres in other countries. Funding such ventures can be problematic and sponsorship, be it from professional organisations, employing authorities, Government sponsors or private sources, is often a way to overcome the financial difficulties. Most health regions in England can offer forensic psychiatry training to psychiatrists who hold the MRCPsych qualification or equivalent. In addition, with appropriate negotiation shorter individual periods of training or experience, which can be certified and may lead to a higher qualification, can often be arranged, such as at the Institute of Psychiatry.

POSTGRADUATE QUALIFICATION

The Department of Forensic Psychiatry at the Institute of Psychiatry, University of London, has lengthy experience in arranging individually tailored training attachments for psychiatrists from abroad who desire experience in forensic psychiatry, even if only a short attachment is required and the doctor has had little previous exposure to forensic psychiatry. Other centres may sometimes also be able to organise placements.

The same Department now also offers a Diploma in Forensic Psychiatry to foreign psychiatrists, as well as those in the United Kingdom. This University of London course is full time and runs for nine months, including clinical and academic experience. The course also offers the opportunity of working within hospitals with inter-national reputations such as the Bethlem Royal and Maudsley Hospitals and Broadmoor Hospital. The course also incorporates the features of training that we have referred to above. (Those requiring further information are invited to contact the authors.)

CONCLUSION

Working with mentally disturbed offenders and other dangerous patients can be difficult and demanding. Providing effective care, balancing security considerations with the civil rights of the patient and without compromising public safety requires a high degree of specialist training. Forensic psychiatry is a young specialty that is evolving and knowledge of the subject is being constantly updated. A thorough training provides the foundations on which professional practice and the ability to care effectively for patients is built. It also instills the discipline of self education.

REFERENCES

- Blom-Cooper, L., Hally, H. & Murphy, E. (1995) **The Falling Shadow: One patient's mental health care, 1978-1993**. Duckworth. London
- Bluglass, R. & Bowden, P (eds.) (1990) **Principles and Practice of Forensic Psychiatry**. Churchill Livingstone. Edinburgh.
- Chen, C.N. (1994) Psychiatric Training (Editorial). **Journal of the Hong Kong College of Psychiatrists**, 4: 3-4.
- Chiswick, D. & Cope, R. (eds.) (1995) **Seminars in Practical Forensic Psychiatry**. Gaskell (Royal College of Psychiatrists). Trowbridge.
- Cordess, C., Riley, W. & Welldon, E. (1994) Psychodynamic forensic psychotherapy, an account of a day release course. **Psychiatric Bulletin**, 18: 88-90.
- Department of Health & Home Office (1992) **Review of health and social services for mentally disordered offenders and others requiring similar services. Final Summary Report**. Cm 2088. (Reed Report). HMSO. London.
- Department of Health and Welsh Office (1993) **Code of Practice: Mental Health Act, 1983**. HMSO. London.
- Exworthy, T. & Parrott, J. (1993) Evaluation of a diversion from custody scheme at magistrates courts. **Journal of Forensic Psychiatry**, 4: 497-505.
- Faulk, M. (1994) **Basic Forensic Psychiatry**. Second Edition. Blackwell Scientific Publications. Oxford.
- Gunn, J., Robertson, G., Dell, S. & Way, C. (1978) **Psychiatric Aspects of Imprisonment**. Academic Press. London.
- Gunn, J. & Taylor, P. (eds.) (1993) **Forensic Psychiatry: Clinical, Legal and Ethical Issues**. Butterworth-Heinemann. Oxford.
- Knesper, D. (1978) Psychiatric manpower for state mental hospitals, a continuing dilemma. **Archives of General Psychiatry**, 35: 19-24.
- Oxford English Dictionary (1989) **The Oxford English Dictionary**. 2nd Edition. Clarendon Press. Oxford.
- Ritchie, J.H., Dick, D. & Lingham, R. (1994) **Report of the Inquiry into the care and treatment of Christopher Clunis** (Chairman J.H. Ritchie).HMSO. London.
- Royal College of Physicians, Royal College of General Practitioners, Royal College of Psychiatrists (1992) **Report of the Working Party of Three Medical Royal Colleges on the Education and Training of Doctors in the Health Care Service for Prisoners**. H.M. Prison Service. London.
- Royal College of Psychiatrists (1994) **Regulations for the MRCPsych Examination**.Royal College of Psychiatrists. London.
- Royal College of Psychiatrists (1995) **Joint Committee on Higher Psychiatric Training: Handbook**. 7th edition. Occasional Paper OP27. Royal College of Psychiatrists. London.
- Tait, D. (1994) Special Committee on Continuing Medical Education. **Psychiatric Bulletin**, 18: 285.

*Clive Meux MBBS, MRCPsych, *Senior Clinical Lecturer in Forensic Psychiatry, Institute of Psychiatry*
Tim Exworthy MBBS, MRCPsych, *Clinical Lecturer in Forensic Psychiatry, Institute of Psychiatry*

* Correspondence: Department of Forensic Psychiatry, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London, SE5 8AF, U.K.