out about oneself in personal management is always fascinating (well to one person anyway), and some useful teaching skills were explained. Operations management led to some interesting computer games at which the public sector showed its inexperience at getting material profitably across a factory floor. Marketing is where we are told the NHS is going and the French mistress who taught us ensured undivided attention. Unfortunately I was occasionally reinforced in what I know, that you cannot lecture for up to two hours and maintain an individual's interest, no matter how dedicated they are and no matter how well plied with coffee and orange juice they are in the breaks. I would have liked more time learning in groups with a few other course members.

After two weeks good behaviour, we were allowed home to our families, who seemed to have forgotten who we were. Relaxation was short-lived for Finance V beckoned at 9.00 a.m. on Bank Holiday Monday morning, and we were all there! We then set about putting our newly acquired skills into practice to the encouragement and groans of our teachers. Looking at other people's businesses, especially over the weekend, while the sun shines outside is a sore test of dedication, but it meant time with other course members whose skills in areas such as accountancy and computer manipulations were quite humbling, as was their willingness to work late into the evening, weekdays and weekends.

There was a little word called Project that kept echoing round the panelled walls of Ashridge and I certainly thought about, but did not act upon, what the word meant before I went. As a consultant on a management team I felt it was my responsibility to help consultants and managers work more constructively together for the benefits of our patients. Unfortunately, Ashridge did not give me any meat for this project. However, it did keep seducing me with how to market my own service in the brave new world of 'internal markets'. However, all the time I spent on analysing my industry and developing my marketing strategy, I had this guilty feeling it was not what I was really there for, and if my colleagues thought I had taken a month off to get ahead in the marketing race, I did not think they would be best pleased. Our problems are restricting usage in an all carers' market and working to a fixed budget which we have now power to expand. Businesses have not had to address these issues and hence they were not covered at Ashridge.

I emerged from Ashridge a fitter if fatter individual who had learnt about such ephemera as Total Quality Management, Shamrock organisations, Bullet points, the opportunity of redundancy and flexible manufacturing systems. More importantly I had the privilege of working with a skilled and knowledgeable group at a college of excellence. I may now be able to market my own service better in a competitive world, but I am uncertain I know any more about working as a consultant in the management of the Health Service, but thanks Ken, can I book again for next year?

This article will also appear in *Yorkshire Medicine*.

Psychiatric Bulletin (1990), **14**, 722–724

Trainees' forum

Forensic psychiatry – a tale of two systems

NEIL BOAST, Senior Registrar locum, St Luke's Hospital, Woodside Avenue, London N10

During registrar training I had the privilege of working in the interim secure unit at Friern Hospital in London. To gain further experience in the field of forensic psychiatry, I secured (if that is an appropriate term), a post as trainee psychiatrist at James Nash House, centre for forensic psychiatry, Adelaide,

South Australia. This article compares the legal and health care frameworks in England and South Australia relevant to mentally abnormal offenders. The two units are described and differences in facilities, patient populations and working practices are discussed.

Legal provision for mentally abnormal offenders

The states of Australia have separate mental health acts and judicial systems. Some have a criminal law code, but South Australia still refers to English law for the basis of its legal system. For instance, legislation and legal practice associated with unfitness to plead and not guilty by reason of insanity are similar. In South Australia, after such verdicts, individuals are detained at the 'Governor's Pleasure'. With the exception of those individuals who become fit to plead, the government decides after medical consultation, when to release patients from detention.

The South Australia Mental Health Act (SAMHA), 1976–79, and the Mental Health Act, England and Wales (MHA) 1983, have origin in the 1959 Mental Health Act, England and Wales. Both acts make provision for the detention in hospital of a person suffering from mental illness, mental health review tribunals, and guardianship. The acts differ greatly, however, in terms of legislation specific to mentally abnormal offenders. The SAMHA has no equivalent of the MHA 1983 section 37 hospital order, the section 41 restriction order, or powers to transfer accused persons and sentenced prisoners to hospital. In South Australia the power to transfer prisoners for voluntary psychiatric treatment in hospital derives from the criminal law acts. In addition, the SAMHA may be used to 'detain prisoners' to James Nash House. All such individuals transferred to hospital remain prisoners within the wider correctional system.

Health care

The Australian health care system, which includes Medicare, like the National Health Service, is funded from taxation. Within the National Health Service, general practice and out-patient treatment are provided free at source. Medicare, however, funds 85% of the government approved medical consultation fee. This system of subsidised private practice is utilised by psychiatric patients, as doctors are available who waive patient charges in cases of financial hardship. State hospital treatment is free for residents of both countries.

Secure provision

Friern interim secure unit, which opened in August 1986 with no direct predecessor, owes its origin to the Report of the Committee on Mentally Abnormal Offenders (1975). It recommended the provision of treatment facilities for both offenders and non-offenders in conditions of security between that of a special hospital and a locked psychiatric ward. Prison facilities such as Grendon Underwood and open wards are also part of the range of secure provision for mentally abnormal offenders. In contrast the only secure hospital for the in-patient treatment of offenders in South Australia is James Nash House. The unit was purpose built at a cost of $Aus 6.5 million (£3 million sterling) and is based in the grounds of Hillcrest Hospital, one of the two state psychiatric hospitals. It is managed and revenue funded as part of the health service.

Description of the units

The Friern interim secure unit occupies a spacious first floor ward situated within Friern hospital, which was built as a Victorian asylum. Security is improved by shatterproof windows and the addition of a second entrance door to create an 'airlock', but staff need to carry and constantly use keys. It has ten beds for patients from the North East Thames Regional Health Authority catchment area, with the majority of patients coming from inner city districts. James Nash House provides beds for 30 patients in three separate wards, the roles of which can be described as assessment, treatment and pre-discharge rehabilitation. The building design cleverly incorporates a number of features to improve security. The external walls of the assessment and treatment wards, their courtyards, and the gymnasium, have no doors or windows. This removes the need for perimeter fencing, except around the tennis court area. Security staff based at the reception monitor the surroundings of the building and control all movements into, out of and within the unit, by way of electronically operated doors, and unobtrusive video cameras.

In terms of facilities, both units offer a pleasant living environment for patients, with Friern having the advantage of subjective spaciousness. There are sufficient ward based rooms for occupational therapy, meetings and interviews, but James Nash House has better provision of offices and conference space. Additionally it has a gymnasium, tennis courts, a recreation area with restricted access and courtyards for continual daytime use. In both units doctors, nurses, occupational therapists, psychologists and visiting teachers are employed in similar staff/patient ratios.

Patient population

Friern caters primarily for patients on hospital orders, with or without restriction orders. Non-offenders, accused persons and sentenced prisoners are in a

https://doi.org/10.1192/pb.14.12.722 Published online by Cambridge University Press

minority at any given time. In contrast the majority of patients at James Nash House are admitted from prison on a voluntary basis. Prisoners detained under the SAMHA form a minority of patients, and there can be up to three 'Governor's Pleasure' in-patients at one time. The overwhelming majority of the patients at Friern have a diagnosis of psychosis, predominately schizophrenia, while at James Nash House the range of cases includes abnormal personalities, sexual deviancy and adjustment disorders.

Working practices

The South Australian system permits a more rapid admission and discharge of patients, with acutely mentally disordered prisoners admitted in a few hours. Prison Medical Officers may detain involuntary patients to James Nash House under the assessment powers of the SAMHA. The majority of patients, however, are arranged admissions selected from clinics at the metropolitan gaols. The remand centre clinic is the registrar's responsibility and involves the assessment of between five and eight patients per week. On release from custody in-patients must be discharged from James Nash House. Those in need of further in-patient psychiatric treatment, whether voluntary or detained, are admitted to the state psychiatric hospitals. Friern interim secure unit, as part of a wide range of secure hospitals, must negotiate admissions on an individual basis, in advance, often at distant prisons and psychiatric hospitals. Discharge plans may have to be agreed with the local hospitals, which are often reluctant to accept 'forensic patients'.

Although the clinical practice of psychiatry within the units is similar, there are differences in the powers and responsibilities of the consultants. At Friern, the consultant has the power to discharge, transfer or permit absence from the ward of patients on hospital orders. With the permission of the Home Secretary, the same powers apply to patients on restriction orders. In James Nash House as all patients remain prisoners, the medical staff do not have this discretion and patients are always escorted by correctional staff on leaving the building. The unit, however, has only one prison officer in a liaison administrative role and internal security as at Friern is a nursing and medical responsibility.

The out-patient work of both units consists of liaison with the parole and probation service and the provision of court reports. South Australia has a well developed system of guardianship, with a statutory guardianship board. This regularly reviews those patients who, after the application of strict medico-legal criteria, are found to be in need of supervision and treatment in the community. As there is no equivalent of a restriction order, compulsory aftercare is provided by the use of guardianship and parole conditions, the latter expiring at the end of the sentence.

Comment

Each unit is a reflection of the medico-legal system within which it operates. Both units have points of recommendation and weakness. Neither system resolves the psychiatric and ethical issues raised by the inter-relationship between mental disorder and criminal behaviour. Legislation in England and Wales is more paternalistic with the diversion of some but not all mentally abnormal offenders away from the penal system. South Australia is more legalistic in its approach with the omission of hospital order type legislation. This avoids dispute between hospitals regarding the placement of mentally abnormal offenders and permits rapid treatment. Patients, however, always remain prisoners and consultant management discretion is limited. In summary James Nash House represents a unique facility for the integrated provision of psychiatric services to prisoners and those on parole and probation orders, whilst Friern interim secure unit provides compulsory treatment for a more highly selected group of patients.

Acknowledgements

I appreciate the thoughtful comments of Drs d'Orban, Hill, O'Brien and Taylor.

References

HOME OFFICE/DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1975) Report of the Committee on Mentally Abnormal Offenders (Cmnd. 6244). London: HMSO.