FIRST PERSON

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'Forensic' derives from the Latin forensis, 'relating to the business of the Roman Forum esp. legal'. Telling people at a party that you prepare dozens of court reports every year does not sound very exciting. But the traditional unease between doctors and lawyers and the difficulties of the expert witness in the adversarial system can be balanced by basking in the glory of having interviewed one of the country's most notorious serial killers.

But someone inevitably asks why the jury totally ignored all the psychiatrists' evidence and the judge sent him to prison anyway. Running a Regional Secure Unit was once summarised back to me as locking up criminal lunatics let off under the Mental Health Act ('yes, but can you actually do anything for them?' or even worse, 'I think that people like that ought to be hanged!').

Most people have heard of a forensic pathologist and so talking loosely about 'dissecting' the criminal/mentally ill mind seems to make some sense even if sounding a little vague. Describe the intense satisfaction to be gained from eliciting the sadistic fantasy that precisely related to a particularly unpleasant murder, followed up by the delusional ideas and auditory hallucinations that resulted in an attempted rape, and suddenly you notice that everyone is beginning to eye you suspiciously. This is another salutory warning that a substantial proportion of the lay public regard psychiatrists as at least as strange as their patients.

Having one of the most complex and varied roles in medicine does not make it easy to explain forensic psychiatry. Part III of the Mental Health Act gives considerable powers to psychiatrists and the management of deeply damaged, frequently disturbed, and sometimes dangerous patients poses ethical as well as practical challenges and responsibilities. On the one hand you are expected to treat and rehabilitate in the traditional role of curer and carer, on the other you are required to control and detain your patients for the protection of others. Few colleagues entirely understand forensic psychiatrists' fascination for the type of patient they strive to avoid in their own out patient clinics and to exclude from their wards. We also come in for a degree of criticism from our colleagues in general psychiatry, being seen as more extroverted, having a black sense of humour, and even, heaven help us, as being macho. ('I don't treat depressed housewives anymore unless they have murdered their husbands') We also appear to be younger. This partly reflects a rapid expansion of the subspeciality and the optimism that comes from building a new service whilst the rest of psychiatry undergoes cuts and stagnation along with other health care services in this country. Most consultants are full time practitioners and their working life is taken up with patient care, court work, and the inevitable managerial duties.

There is still only one fully funded university chair of forensic psychiatry but the academic base is slowly developing; some consultants like myself have additional academic contracts, and the recent publication of a major text book has been a watershed in our development. Most of the purpose-built Regional Secure Units have finally opened and there are still not sufficient trained consultants to staff them all. But it is not just the better resources that our colleagues envy. Forensic psychiatry still retains much of the original 'medical model' that has disappeared from certain branches of psychiatry and we are safely down the other end of the spectrum from the demoralising mess of 'Care in the Community'.

'I don't treat depressed housewives anymore unless they have murdered their husbands'

Most of this work is in the Regional Secure Units or in maximum security ('special') hospitals. Clinical practice involves preparing reports or giving evidence in court as an expert witness, giving specialist advice to other colleagues or agencies such as the probation service, and the management and treatment of mentally disordered offenders in conditions of security. A small number of consultants have beds on open wards and treat voluntary patients or are attached to other specialist services such as assessment centres for adolescents; those with more time available give voluntary sessions to the Prison Medical Service.

I would like to be able to describe a regular daily routine, but in fact I have to remain flexible. Two ward rounds and an out-patient clinic are the only regular weekly fixtures. One week I can be visiting a man remanded to Brixton Prison for armed robbery to prepare a report for his solicitor, the next I might travel to Broadmoor to assess a chronic schizophrenic who killed his mother 10 years ago. The following week I make a trip to Parkhurst Prison where a drug dealer is serving a 7-year sentence and has now developed a psychotic illness, is refusing food, and needs transfer for psychiatric treatment. In between, the letters and phone calls come in for advice and a large patient is smashing up the ward in the local mental hospital and would I take him away please? Being called to the Old Bailey at short notice to give evidence in a contested case of diminished responsibility will disrupt any vestige of routine.

Despite being a 'forensic' psychiatrist, going to court is by no means the highlight of my working week. It is the patients themselves who are the most engrossing part of the job. The majority are suffering from schizophrenia or psychopathy (or both) and a small number present with sexual deviations. Few are over 40 and half are afro-caribbean. Over 80% have been referred following violent crime or violence in another NHS hospital. I am told that my patient profile is unusual and reflects the East End of London which is the area covered by my service. I am always struck by the patients I do not see anymore. Shoplifters are never referred to me, I have only prescribed one anti-depressant since I took up my post, and I see very few women. Many of the patients are part of a criminal subculture as well as having psychiatric problems and I could not get by without advice from a multi-racial team of nurses in the secure unit. But I still have no intention whatsoever of returning to general psychiatry and treating depressed housewives - unless they kill their husbands!

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