Reed report on mentally disordered offenders

They need health and social services, not prison

How serious are the government’s intentions to improve services for mentally ill offenders? In The Health of the Nation health authorities are required to include mentally disordered offenders in their strategic and purchasing plans.1 The government has now published the final report of a joint review by the Home Office and Department of Health of services for mentally disordered offenders and others requiring similar services.1 The committee, chaired by Dr John Reed, senior principal medical officer at the Department of Health, began its work in January 1991. Consultation papers on community, hospital, and prison services were issued in November 1991,4 and papers on finance, staffing, research, and academic developments followed in June. The final report draws together the conclusions of the consultation papers and makes 276 recommendations. It applies to services in England. The Welsh Office is currently considering responses to its report on forensic psychiatry services produced earlier this year.5 In Scotland there has been a comparable review.

Underlying Reed’s report are clinical scenarios for which medical responses are rarely adequate. When the police apprehend a disturbed young man suffering from schizophrenia what action might they reasonably expect from medical agencies? How should a psychotic offender remanded in prison for a psychiatric report, wait until a psychiatrist for the catchment area comes to see him? Where a patient detained in a special hospital is considered ready for transfer to another hospital how long should he have to wait before it takes place?

Reed rightly proposes that these and other needs can be met
only by a broad and integrated range of health and social services. The principles espoused by Reed are that high quality care should be provided by health and social services (not in the criminal justice system) according to individual need, near to the patient’s home or family, as far as possible in the community but otherwise in conditions of no greater security than is justified; the ultimate aim should be to maximise rehabilitation or opportunities for independent living.

A multiagency approach and local ownership of services are seen as crucial. Most mentally disordered offenders should be cared for by general psychiatry and learning disability services, with access to more specialised resources when necessary. There should be an expansion, and wider range, of community based facilities. A stronger academic and research base should be established to underpin developments and play a key part in training.

The Reed report has profound implications for the government, patients, doctors, and managers. The government must decide what it will accept and fund. The report is impressive because it is comprehensive. It cannot be implemented in whole overnight. (Where, for example, are 175 new psychiatrists and 80 forensic psychiatrists to be found?) But its recommendations are interdependent, and large chunks cannot simply be jettisoned. For example, what use are the 900 extra places in regional secure units proposed by Reed if there are no appropriate facilities for aftercare? What value is a nationwide system of court diversion schemes if there are no beds to which patients can be diverted?

The chief implication for patients is that they should not be disadvantaged by their status as offenders. General practitioners and psychiatrists will need to accept that at times some mentally disordered patients may be violent, for that is the nature of serious mental disorder whether in patients suffering their first episode of schizophrenia, long stay patients newly settled in the community, or mentally ill residents in hostel accommodation. These patients do not forfeit their entitlement to care by manifesting features of their illness.

The Reed report will tax the ingenuity of managers in the NHS and in local authorities. It has not priced its recommendations, but emphasises the need to consider the costs to all agencies of “misplaced” patients and the costs incurred by denying early intervention. It emphasises the pernicious financial disincentives that influence agencies to deflect responsibility for mentally disordered offenders. Such a patient in prison or special hospital costs a district health authority nothing. It therefore proposes that each district

A national standard for entry into general practice

Practical and symbolic benefits

A national standard of entry into general practice—under consideration by the Joint Committee on Postgraduate Training for General Practice—has important implications for all of general practice but particularly for vocational training. It puts general practice on the same footing as other specialties. If the recommendations of the working party set up to advise the joint committee are accepted, then knowledge, performance during consultations, practical and management skills, and ability to audit will be taken into account together with trainers’ overall assessments. No final summative assessment (end point assessment with set standards) has yet been agreed, but, if a standard for entry is to be set and a certificate which determines competence awarded, it is hard to avoid the need for one.

Knowledge is best assessed by multiple choice or modified essay questions; why the working party thought that this should be set and applied locally is hard to fathom. The multiple choice questionnaire and written component of the examination for the MRCPG are already accepted by most trainees, academic departments of general practice, and general practice partnerships as a national standard of written knowledge. The examination’s timing and purpose as an end