- Scan your hard disk, including all logical and network drives, with an anti-virus programme. Infected files should, ideally, be deleted and reinstalled from clean backups. If deletion is not practical, an appropriate anti-virus package can be used to repair contaminated files. After a successful repair or deletion, re-scan the hard disk to confirm it is clean.
- Scan all floppy disks and backup files to locate the source of the infection. throw the infected disk away.
- Notify your colleagues – so they can check their computers and floppy disks.
- Report the incident to the Computer Crime Unit.
- If the virus cannot be removed by these simple measures, or you are a complete novice at computing or in any doubt about the best thing to do, do not dabble. Get expert help. Try your local University's computer advisory service. If this service is not available to you, advice can be obtained from Virus News International (S & S International, Berkley Court, Herts HP4 2HB, Telephone 0422 877877).
- If all attempts to remove the virus fail the hard disk will have to be re-formatted. The software will have to be re-installed and your data recreated from backup disks. Avoid disaster: take regular backups!

In summary, prevention is better than cure. Infection by computer viruses can be avoided by ownership of information and good computing techniques. While anti-virus software can assist with recovery from a viral infection, it is critical to perform regular backups.

Further reading

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Innovations

An integrated service for mentally disordered offenders

SUBE BANERJEE, Research Fellow, UMDS (Guy's Campus) & The Health Care Centre, HMP Belmarsh, Western Way, Thamesmead, London SE28 0EB; TIM EXWORTHY, Research Fellow, UMDS (Guy's Campus) & South East London Court Liaison Scheme; KIKI O'NEILL-BYRNE, Research Fellow, UMDS (Guy's Campus) & HMP Belmarsh; and JANET PARROTT, Consultant Forensic Psychiatrist, Bracton Clinic, Bexley Hospital & HMP Belmarsh

In recent years there has been increasing concern about the plight of the mentally ill in prisons, particularly those on remand. The 1976 Bail Act gives everyone the right to unconditional bail but mentally disordered offenders find themselves disadvantaged in that their right to bail can be set aside not only because of the gravity of the alleged offence but also for reasons consequent to their mental illness. These include lack of community ties, their own protection or most commonly for the preparation of psychiatric reports. The mentally disordered may thus be remanded in custody even if the charge against them is minor or not punishable by imprisonment.

Coid (1988) and Bowden (1978) have drawn attention to the fact that at the end of a period of remand

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for medical reports a psychiatric disposal may not be offered. This is one of the reasons why the venue for selecting those appropriate for psychiatric treatment has begun to shift from the remand prison to the magistrates' courts. Court liaison schemes have been set up in some courts to assess defendants and to "divert from custody" whenever appropriate. This is often not possible, however, since catchment area beds may not be available for immediate transfer; moreover, most magistrates' sessions do not have a psychiatrist in attendance. For these reasons people with mental disorder continue to be remanded in custody.

The mentally ill pose difficulties in prison. Psychiatric care in prisons is not equivalent to that provided in psychiatric units, since it is usually provided by prison medical officers, many of whom have not had post-graduate training in psychiatry, with consultant psychiatrists visiting on a sessional basis. Between them they are responsible for the preparation of reports, arranging referrals and transfers under the Mental Health Act as well as the day-to-day management of inmates with mental disorder. There is a particular problem regarding compulsory treatment. Prison hospitals are not recognised as "hospitals" within the 1983 Mental Health Act and compulsory treatment is therefore not possible, except under Common Law, even if inmates have been remanded for reports or have been placed on sections of the Mental Health Act and are in custody awaiting a hospital bed. An early transfer to hospital is therefore frequently desirable.

The piecemeal nature of provision of psychiatric care to the mentally ill in the criminal justice system has resulted in a fragmented service. This emphasises the need for an integrated scheme incorporating prisons, courts and hospitals to achieve rapid access to appropriate psychiatric care. This paper describes a model for the provision of an integrated psychiatric service for mentally disordered offenders which has been set up in the south east of London.

Description

The service described is based around the Bracton Clinic, Belmarsh Prison and the South East London Court Liaison Scheme (SELCLS). The Bracton Clinic is a 15-bedded regional secure unit (RSU) providing forensic psychiatric services to Lewisham and North Southwark, Greenwich and Bexley health districts. Belmarsh Prison is a newly opened mixed remand and sentenced prison serving seven magistrates' courts and the Inner London Crown Court in south east London. SELCLS provides a psychiatric assessment service to four magistrates' courts in the catchment area of the Bracton Clinic (Tower Bridge, Greenwich, Bexley and Woolwich).

Court liaison

A research psychiatrist with a community psychiatric nurse (CPN) visits the four magistrates' courts weekly to assess defendants referred by the court for a psychiatric opinion. Interviews take place in court on the day of appearance and an oral report is given following discussion with solicitors, catchment area psychiatrists and hospitals. When possible the mentally disordered are diverted directly from custody either to out-patient treatment and reports or to hospital or the court is informed that no other psychiatric report is necessary.

Belmarsh Prison

Two post-membership psychiatrists are seconded to Belmarsh Prison from the United Medical and Dental Schools (UMDS), each of whom works four days a week in the prison. Their work includes: preparing psychiatric reports, providing psychiatric care for the in-patients in the prison hospital, assessing referrals from prison medical officers, arranging assessments by catchment area services and expediting transfers to hospital under the Mental Health Act. They are also involved in staff education, suicide prevention, screening new receptions to the prison, a number of clinical research projects and in audit of the service. They are supervised by the prison's Senior Medical Officer and the consultant forensic psychiatrist from the Bracton Clinic.

Forensic psychiatry

The consultant forensic psychiatrist co-ordinates the service described here. The consultant and her senior registrar prepare murder reports and provide specialist forensic advice to the resident psychiatrists. Forensic psychology services are purchased from the Bracton Clinic. The consultant in psychiatric intensive care from Bexley Hospital also visits weekly to assess patients from Bexley and Lewisham and North Southwark for their need for intensive care and also to advise the resident psychiatrists.

Comments

The Bracton Clinic opened in 1985, but it was the opening of Belmarsh Prison shortly after the start of SELCLS in spring 1991 which provided the opportunity to attempt to set up a comprehensive service for mentally disordered offenders in this area. The aims of the service are to provide the best possible psychiatric care for this group and to arrive at appropriate disposal whether to hospital, the community or to the penal system as quickly as possible.

The novel aspects of the service described here are the presence of post-membership psychiatrists full-time in prison and the level of integration of its

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constituent parts. This integration is achieved by a weekly meeting of all participants, exchange of information between the prison-based and the liaison psychiatrists before and after each session in the magistrates' courts and by the overall co-ordination of the consultant forensic psychiatrist.

SELCLS, by providing reports in court, reduces the number of remands in custody for psychiatric reports. The prison-based psychiatrists aim to reduce the amount of time spent on remand for reports by completing them within the first week of remand. This contrasts with the process in other prisons where reports may take several weeks as prison medical officers and visiting consultant psychiatrists collaborate. For those who require in-patient treatment, referral to the general psychiatric service, intensive care unit, RSU or Special Hospital as appropriate is also made in the first week of remand.

While court liaison schemes do divert mentally disordered offenders to appropriate psychiatric care, many people with mental disorder continue to be remanded in custody. The care of these people in prison hospitals may not be of the same standard as in psychiatric units because of the training of prison medical officers and nursing staff and also because of difficulties in treatment detailed above. The presence of psychiatrists working full time in the prison means that there is continuity of skilled care and constant availability to assess referrals from any of the prison staff. There is also the opportunity for education in psychiatry for members of staff.

Certain problems and difficulties have been identified with the system. These include increased pressure on psychiatric resources which are already in short supply in London and the difference in ease of transfer between hospitals with whom the psychiatrists have developed strong informal links and those with no such links. Further development of the service will include attempts to create formal links with the psychiatric services inside and outside the catchment area of the Bracton Clinic and the CPN working in SELCLS and developing links with district teams to facilitate community follow-up.

This paper is not an analysis of the service described. Detailed evaluation of the constituent parts of the system as a whole are in preparation. This paper attempts to describe one model of integrated service provision for mentally disordered offenders in an area where psychiatric and prison services are to a large extent conterminus. It is not suggested that this is the only way for services to be effectively provided to this group. However, placement of psychiatrists in court and full-time in prison with a high degree of integration seems to have many advantages.

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"It is well-known that societies are extremely anxious to obtain this privilege, although I am not aware of any very definite advantage that accrues from it; still it is well known that this title is supposed to confer very considerable general advantage". (Dr D. Hack Tuke on the value of a Royal Charter, 1891. The Association was eventually granted a charter in 1926.)

"I am no prophet, and I know it is a dangerous thing to prophesy, but as your county asylums in England come to be officered by the men who are at present assistants, and they find that the lunacy laws allow them to make provision for a certain number of private patients, I shall be very much surprised indeed if you do not find in every asylum in England the mixing up of classes. I believe that this tends to raise the status of asylums in many respects; it is good for the patients and it tends to elevate the staff". (Dr T. Clouston of Edinburgh Royal Asylum on private patients, 1891).

"Dr Clouston has spoken on the question of education, and I heartily sympathise with him in regard to the advance that has been made in the education of medical students in psychology, but as one of the Commissioners said to me the other day, "You must take care in attempting to do what you are now doing in regard to examinations that you do not also increase the number of lunatics". (Laughter.) One is a little afraid that by over-study we may increase the number of patients, as well as the knowledge acquired by medical students". (Dr D. Hack Tuke on examinations, 1891).

"Members knew that Sir John was a man of abysmal knowledge, also that he was an orator, therefore those who had heard this lecture were not disappointed. It had been a most charming lecture, and delivered with the greatest eloquence". (Dr W. F. Menzies commenting on Sir John Macpherson's Maudsley lecture, 1928).

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