Likely satisfactions and frustrations

Although some may find certain aspects of the work upsetting, the RSU consultant has a busy and varied job. There is satisfaction in managing and advising on complex cases. While appearing in court may be anxiety-provoking for the uninitiated, such work can be stimulating and challenging for the experienced.

A major stress can be the responsibility involved in supervising the treatment of many dangerous individuals, particularly the continuous care of discharged patients on Home Office Restriction orders (Section 41 of the Mental Health Act) who are subject to recall by the Home Office.

Most RSU consultants will, because of their regional status, have considerable input into undergraduate and postgraduate psychiatric training which can be especially rewarding.

A final point to note is that there are financial advantages in working for the courts and solicitors.

Prospects for research

Research opportunities are available for enthusiastic forensic psychiatrists. Most RSUs and special hospitals have ongoing research projects and trainees are encouraged to spend two sessions on research. The research field is wide open but because the recent development of forensic psychiatry was service-led, the academic base has not yet caught up, and only the Institute of Psychiatry has a proper academic department of forensic psychiatry with a professor, senior lecturers and lecturers. The other academic centre in Edinburgh has vacant posts. Regional secure units are beginning to develop formal academic links. An indication that the subject has reached academic respectability in this country is the recent publication of the new *Journal of Forensic Psychiatry* and two recent textbooks.

Conclusion

Forensic psychiatry is an absorbing subject, and the work of forensic psychiatry is quite different to that of general psychiatry. It is perhaps more suitable for psychiatrists who enjoy and are undaunted by the adversarial nature of medico-legal work, and the volume of administration and report writing necessary (for the courts, Mental Health Review Tribunals and the Home Office) and those who are prepared to work under the time constraints imposed by the courts. A number of consultant posts should become available in both regional forensic psychiatric services and the special hospitals over the next few years for those entering the subspeciality.

Further reading

BLUGRASS, R. & BOWDEN, P. (1990) *Principles and Practices of Forensic Psychiatry*. London: Churchill Livingstone.

FAULK, M. (1988) *Basic Forensic Psychiatry*. Oxford: Blackwell Scientific.

GRIFFIN, N. V. (1989) Multiprofessional care in forensic psychiatry: realities and constraints. *Psychiatric Bulletin*, **13**, 613–615.

ROYAL COLLEGE OF PSYCHIATRISTS (1988) The role, responsibilities and work of the consultant forensic psychiatrist. A discussion document. *Bulletin of the Royal College of Psychiatrists*, **12**, 246–249.

Psychiatric Bulletin (1991), **15**, 152–153

Trainees' forum

Training on the Regional Brain Injury Rehabilitation Unit: six months registrar experience

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There is an increasingly large population of those who are chronically disabled as the result of brain injury (Jennett & Macmillan, 1981). These injuries can be the result of trauma, infections, tumours, hypoglycemia, anoxia or other damaging conditions. The large majority of rehabilitation units cater for physical problems only. However, it has been recognised that patients with brain injury often develop

behavioural disorders during the early recovery phase and in a few cases these persist (Eames & Wood, 1989).

This disordered behaviour such as aggression, sexual disinhibition, or even apathy, often precludes the patient from taking part in a conventional rehabilitation programme. The North West Thames Regional Brain Injury Unit (BIRU) was established to cater for those suffering acquired neurological lesions resulting in behavioural disorders.

BIRU aims to modify this behaviour, to maximise the individual's potential and eventually to improve the quality of the individual's life.

I am writing about my experience as a registrar on this unit which was a six month placement within the Northern Sector of the Charing Cross training scheme in general psychiatry.

The unit

The BIRU – is the first of its kind within the NHS – was formally opened in 1989. It is placed within Napsbury Hospital which is a Victorian mental hospital with pleasant grounds. At present the unit is staffed with 25 nurses and care assistants. The medical staff consists of a consultant psychiatrist, lecturer and a psychiatric registrar. The unit is further staffed with a physiotherapist, occupational therapist, social worker, psychologist and speech therapist.

The patients

At the time of writing this article there are six male and three female in-patients on the unit; one patient returns regularly for respite care. Over the recent months the weekly out-patient department has become busier, and there are about four to five patients seen each week.

I will describe two in-patient cases to give a better understanding of the work done in the unit.

Mr A

Mr A was admitted to this unit a few weeks ago. He is 21-years-old and four years ago he was knocked off his moped by a car. He sustained a severe head injury which left him with spasticity, dysarthria and marked personality changes with sexual disinhibition. Due to this behaviour Mr A has been excluded from several rehabilitation programmes.

In order to modify this, a behavioural programme was designed and after five weeks we are now seeing minor improvements and hope that after six months he will be able to attend a day centre.

Mr B

Mr B is a 58-year-old man who has severe memory problems following herpes encephalitis five years ago. Before his admission to BIRU he was placed on a long-term psychiatric ward. Due to his severe memory problems, Mr B found himself constantly in a new and puzzling environment because he could not form the memories which would orientate him. This in turn led to frustration and subsequent aggressive outbursts.

The treatment of Mr B consisted of behavioural programmes and training in the use of external compensatory mechanisms for his deficient memory. Through the use of a diary, Mr B developed a pattern in his daily life and subsequently his behaviour and life quality improved. This will enable him to be resettled into the community.

Comments

The very complex needs of brain injury patients require assessment and treatment by different disciplines. During my time at BIRU I have learnt that only the co-ordinated approach of a multidisciplinary team can bring the necessary results.

Following a successful treatment period at BIRU patients are resettled into a community setting which offers them the highest quality of life possible. This implies that patients are carefully assessed for their potential.

In the out-patient department I learnt to monitor brain-injured patients in the community and gained an understanding of the difficulties patients with brain injury and their families experience.

I have found the clinical experience of working with patients with brain injuries extremely beneficial. I have gained experience in distinguishing organic and functional psychiatric symptoms and learnt about psychological difficulties caused by organic brain lesions. I feel that this is a particularly important experience for a psychiatrist in training.

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References

EAMES, P. & WOOD, R. LL. (1989) The structure and content of a head injury rehabilitation service. In *Models of Brain Injury Rehabilitation* (eds R. Ll. Wood and P. Eames), pp. 31–47. London: Chapman & Hall.

JENNETT, B. & MACMILLAN, R. (1981) Epidemiology of head injury. *British Medical Journal*, **282**, 101–104.