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Elective Blog 2015

Midwestern adventures into the mind

1. Arriving in St Joseph

An hour into the first day of my medical elective in Northwest Missouri Psychiatric Rehabilitation Centre (NMPRC), I was ushered out with speed from one of the 'cottages' which house some of the more independent patients, into the very British, grey, drizzly weather outside. A loud ominous siren bellowed out over the county of Buchannan, Missouri (USA). This, I was told, is a sound I should never forget during my time here in Missouri; this is the warning siren of an oncoming Tornado. I froze. I was then informed it was just a drill. The lead nurse of the cottage and my clinical supervisor Dr Jim Reynolds smiled at my obvious fear as colour finally returned to my face…

This time almost a year ago I first got in touch with Dr Peter Hughes, a UK based Psychiatrist, having discovered the Volunteering and International Psychiatry Special Interest Group. I asked Dr Hughes if he had any contacts abroad of any people I could spend my elective placement with. One of the many returns I got was from Dr Jim Reynolds, a Forensic Psychiatrist and medical director of NMPRC. Jim's enthusiasm and my curiosity with visiting the Midwest of America sealed the deal. Dr Reynolds kindly organised accommodation for me with a retired attorney and a plastic surgeon in their welcoming home just 10 mins away from the hospital. They have previously put up British medical students, so are familiar with our particularities.

My first day included a tour of the grounds (including my first siren experience) and the usual administrative jobs such as ID cards, computer log in's, confidentiality training etc. This process was not quite as drawn out as it can be in the UK, where getting IDs and logins is usually the sole task of the first day of placement. Throughout the day I was introduced to every staff member and patient on route, a somewhat confusing introduction at

times, as both myself and Dr Reynolds often stumbled on my title as I exist in the land between post finals and pre graduation. I have been medical student, student doctor, new doctor, resident, intern and trainee. Unfortunately I did not succeed in remembering anyone's name (a skill I am aware I need to work on) but I was struck by the friendly atmosphere and the smile on everyone's faces including all the patients.

NMPRC is a 108 bed adult minimum secure government forensic inpatient facility. It was opened in July 1997 replacing the old St Joseph state hospital just across the road. The facility is primarily inpatient psychiatric care for long-term patients who are "Not Guilty by Reason of Mental Disease or Defect," and intermediate length care for Incompetent to Stand Trial patients. Outpatient forensic evaluations are also carried out here and monitoring of forensic release patients in the community. The majority of the patients have a diagnoses of Schizophrenia, Bipolar Disorder, Personality Disorder and Psychopathy. NMPRC has a coloured level system for the patients. All new patients are admitted with a blue ID pass. Patients can work their way up through 5 colours to green ID, which grants patients the most freedoms including the ability to move into the cottages just off the main hospital building and also to participate in work therapy and earn some money. The colour system also acts as a visual aid for staff members to know what freedoms and access rights different patients have.

This week I was lucky enough to attend court on two occasions with Dr Reynolds. One case involved Dr Reynolds informing the court that he believed the defendant was responsible for the crime that he was accused of committing. The second case was a conditional release case, whereby Dr Reynolds made a case to the court that he believed one of the inpatients was suitably rehabilitated to return to the community. Two things struck me. One, was how influential and important Dr Reynolds testimony appeared to be for the decision making of the court. Each time Dr Reynolds spoke I felt the judge and Jury really took note and felt this was key to their understanding of the case. Secondly, I was struck by how much I felt like I was on a film set. One of the courts we attended was in a small town 20 miles or so out of Kansas City. This town had seen little change over the

decades (I believe). It maintained its traditional layout of a square shaped town with a court house in the centre. The architecture of the town reminded me of the old Wild West films. It was a curious place indeed.

In the time spent on the ward this week, I acquainted myself with some of the patients. Taking histories was entertaining at times as most of the patients seemed more interested in taking my history then allowing me to take theirs. My English accent is creating quite a stir. For many of these patients they have not left the local towns nearby and so for some, I am the first British person they have spoken with. And so my first week draws to an end. I intend to busy myself with exploring the local town over the weekend, and taking a trip to Kansas City, why not, it is tornado season after all…

2. Not guilty by reason of insanity

The law requires specific answers.

The law has rigid consequences based on the specific answers that a defendant gives.

Patients with mental illness may not be able to work within these rigid frameworks.

Forensic psychiatrists attempt to bridge this gap by understanding their patients clinically and then converting this into a language that the court can understand. However, this does not prevent the court from trying to categorise these patients using the categories they know, e.g. murderer, burglar, stalker etc. and then sentencing these patients accordingly.

The Law wants to know three things;

1. Is the defendant (patient) responsible for his crime?
2. Is the defendant competent to stand trial?
3. Are there any psychiatric factors for mitigation of the penalty?

If the answer to number 1 is ‘No’ then the patient is ‘Not guilty by reason of insanity’ (NGRI).

Having observed several pre trial court evaluations (a detailed assessment of the defendant/patient carried out by a doctor or psychologist to specifically answer these two questions asked by the court), I now understand how complicated answering these questions are.

An example is a defendant/patient I saw today. He is accused of arson, after firing a Molotov cocktail into an occupied building. He is at risk of facing a maximum sentence of 30yrs in prison, as the incident is considered as attempted murder. No one was killed. This patient has a 12 year history of Schizoaffective disorder and has spent most of his adolescence and adult years in and out of psychiatric hospitals. However, just because the defendant has a mental illness does not automatically mean he cannot be held responsible for his crime. Of course people with a mental illness are often able to determine right from wrong, and often experience periods of improvement in their condition.

This particular patient described in great detail the intricacies of his psychoses on the day of the alleged crime. He describes how he had only just been discharged from a psychiatric hospital and decided not to take his discharge medications. He also describes feeling manic, and having visual, tactile and auditory hallucinations on the day of the alleged crime which he believes ultimately guided him towards committing the crime. The patient then ran away from the scene of the crime and hid out in his house until he was found. Today he was stable, on medication and able to reflect with insight into the events of that day.

So was he irresponsible for the crime? Does his escape from the scene of the crime suggest that he was aware of the wrongdoing of his crime, therefore making him responsible? Or was his running away from the scene of the crime part of the paranoid delusions he had regarding the people inside the building? In this case the patient was deemed irresponsible for his crime. However, it is not always that clear cut.

Deciding if a patient is NGRI is even more complicated when they have an extensive history of mental illness but are held to be responsible for their crime. As far as the law is concerned here, the defendant is guilty and they will be sentenced accordingly. However for the forensic psychiatrist, they will consider the whole history and ask themselves, despite the patient being responsible for the crime, would this patient have committed this crime if they did not have this mental illness, considering the impact their mental illness may have had on them throughout their life? Therefore, is it not more beneficial for this patient to be treated as NGRI and then held and treated within mental health services, rather than spend their sentence in a prison?

Forensic psychiatrists really do have a hard job of trying to look out for the best interests of their patients whilst also trying to work within the structures of the law.

3. Coffee and the death penalty

During the day there is always a window of opportunity to pass by Dr Reynolds office and catch up on how the day is going. I really enjoy these chats, as more often than not, the 'catch up' turns into an hour long (plus!) discussion about interesting cases, ethical dilemmas etc. So I usually top up my coffee on route to his office. Here I must add that there is a constant supply of free, fresh coffee for all the staff in the hospital in every department. Britain, please take note.

One of my first 'catch ups' with Dr Reynolds involved a lengthy discussion on the Death Penalty, a relevant topic to being a forensic psychiatrist in the state of Missouri. He must have sensed my curiosity in the matter before I even voiced it. Missouri is one of 5 states that make up 65% of the executions that take place in the US. There have been 82 executions in the state of Missouri since 1976, all by lethal injection. I, as I suspect many Brits would, struggle with the whole idea of the death penalty. Are we really still doing this in 2015?

The opinions that still drive the existence of the death penalty include views such as ‘it is the ultimate punishment’, ‘proportionality for the crime committed’ and that this form of ‘justice’ would act as a ‘deterrent’. Some also believe that an execution would save the state money on appeals and imprisonment. However, those states that have outlawed executions have based this on their views that executions are a violation of the 8th amendment of the US constitution (‘Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted’), that execution is irreversible and does not allow for rehabilitation, the paucity in evidence that execution acts as an effective deterrence, the fact that other countries without the death penalty often have lower crime rates and finally the risk of executing an innocent person.

I wanted to know what role a forensic psychiatrist had in all of this. Is it like abortions in the UK, where if you are morally opposed you do not have to take part? Thankfully this is the case. When a forensic psychiatrist is asked to be involved in the assessment of a defendant who is at risk of facing the death penalty the psychiatrist can refuse to take on the case. The only forensic psychiatric issue exclusive to death penalty cases, concerns the competency to be executed. If found incompetent, an execution cannot be carried out, due to: ‘prohibition of execution of an insane prisoner’.

I wondered that if the forensic psychiatrist’s evaluation ultimately results in the defendant being executed, does this indirectly conflict with the doctor’s oath of ‘thou shalt do no harm?’ ….. Dr Reynolds was able to assist me with this ethical dilemma as he previously worked on a death penalty case and spent a considerable amount of time in the lead up to the trial researching the ethics of his involvement. He informed me that many people agree that whilst it is ethical for a forensic psychiatrist to comment on a defendant’s competency, it is not ethical to assist in the execution itself, with regards to administering drugs and confirming death.

Dr Reynolds also shared with me other considerations he had had to make; What if a defendant was facing the death penalty and you not getting involved in the case may mean that another, perhaps less

qualified/experienced doctor got involved instead and miss perceived a defendant as competent and then they incorrectly get executed? With this in mind, is it not more ethical to involve yourself in a case if you feel confident about your clinical skills, and know that you will act honestly?

What would I do if I was working in Missouri and was asked to assist in a Death Penalty case? I am going to be honest. I am most definitely against the Death Penalty, and prior to my chat with Dr Reynolds I would have said with confidence that I would refuse to take on a Death Penalty case. However, if I had the opportunity to look over the case first, I may take it on if I felt confident that the patient was in fact incompetent and that my involvement would prevent the defendant facing the Death Penalty. However, if the trial did not go my way could I live with the consequences? The thought that perhaps I under performed in my ability to convince the court of my clinical findings, or perhaps in my own discovery that on closer assessment the patient was in fact competent and I must therefore act with honesty and inform the court.

Honestly, I am just glad that this is one less ethical mind field that we do not have to deal with back home in the UK…

4. US Vs them

Having studied medicine in the UK, we often referred to the US healthcare system as an example of how one should not structure a healthcare system. Although convincing and an opinion I have whole heartedly adopted, I thought it more sensible to try and understand and learn about the system whilst here, in order to judge for myself.

This has been a harder task then I anticipated. I started by asking my colleagues if they could explain how it all worked to me. This was very helpful, but there would always be lots of questions that still could not be answered, why?… “well, it’s a complex system”. Even people that live here admit it is not very straight forward. So I took to looking online too, trying

to find an equivalent of 'an idiot's guide' to the US healthcare system. Most of the things I found confused me even more, but there were some helpful resources.

Just in case you do not have a grasp of the US healthcare system I am going to attempt to give the most concise summary I can on it. So, here it is in a nutshell….

In general, Americans need to be insured in order to receive medical care. The medical insurance can come from the following:

- Your employer
- The government (the largest being Medicare and Medicaid – providing for the elderly, poor, disabled, and those with end stage renal failure and ALS)
- Private/personal insurance if your employer does not provide insurance, you're unemployed and can afford it or are self employed
- Children's health insurance programme (provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid)

When you have insurance this means the insurance company will make a contribution towards the cost of your healthcare. So, for example, you may only need to fork out 20% of the total cost, and the insurance company will cover the rest. However, something I learnt was that the insurance companies will only pay the 80% contribution of what they think is fair, i.e. If your doctor is charging more then what the insurance company will pay, they will only pay a percentage of what they think is a fair rate, so you may end up forking out for the rest.

So, what about the patients here at NMPRC?

Well, the majority do not have savings, and often have no medical insurance. However, they MUST be treated as they are here at the hospital on court orders. Therefore, the state covers the cost of their treatment. I was also encouraged to hear that these patients are also eligible for a

stipend whilst they are here so that they have some spending money, for the tuck shop, treats, toiletries etc. Some of the patients here have insurance with Medicare or Medicaid. These insurance companies will be billed for the treatment of these patients. If a patient does not have health care insurance but declares their savings/wealth, then they will be directly billed for their treatment. I say 'declare', as usually there is no way of proving that these patients have assets or savings in bank accounts unless the patient states it.

Ok, it seems a bit complicated, but everyone appears to be covered right? So, where are the problems? Well, outside of forensic medicine, where treatment is not ordered by the courts things are different. There are people that fall through the cracks, that are not covered for health care. These can include patients that are eligible for medicare/medicaid, but may be suffering from mental health problems or learning difficulties and are are unable to navigate the system in order to set themselves up with insurance. There are the patients with no fixed abode, or are homeless, these patients do not qualify for insurance. How about the lower middle income people that are not eligible for medicare/medicaid, but have a low enough income which means that they often struggle to afford health care insurance and sometimes their employer may not provide it. College students and young people without savings are also often not able to afford, or may not choose to prioritise spending their money or student loan on health care insurance.

However, in the US, if a patient turns up in the emergency department they will be seen and treated regardless. Obviously if they have insurance this will cover the costs, but if they do not, they will still be treated, this is in fact a legal obligation. This has resulted in emergency departments being over saturated with patients with chronic problems that cannot afford to see a doctor, but know they will be seen here.

In terms of mental health specifically, treatment of major thought disorders, such as Bipolar Disorder and Schizophrenia are usually covered by medical insurance companies. However, this is unlikely to be unlimited, i.e. an insurance company may cover you for 5 admissions to a psych

hospital and 5 yrs treatment for example. Chronic conditions like Depression, personality disorders and anxiety are not usually covered in medical health insurance. Patients would be expected to pay for this themselves.

So, in essence, insurance is out there if you know how to access it and if you have a fixed address. If you are in need of emergency treatment you will be seen and if you have a chronic problem, you need insurance or else you will be expected to pay the bill yourself. If you have neither insurance nor personal savings, well, I'm afraid you will not receive treatment. Healthcare is still not universal. This is a problem.

Obama Care aims to address some of these issues, and fill in the gaps. It also attempts to regulate the cost of healthcare insurance and forces employers to offer it. This is still in the early stages and is not yet fully off the ground.

I asked a few of my colleagues here, if you were given the choice would you opt for a healthcare system like ours? 60% of them said 'yes', 40% said 'no'. I asked why some had said 'no' and some of the responses included, 'I wouldn't trust the government to look after the healthcare system and spend our money fairly', 'I do not want to have to pay higher taxes', 'I prefer to have a choice as to when and how much insurance I am willing to pay'. Personally I think I would be more likely to trust the government with my money (well…) rather than an insurance company who are solely driven by profit!

I suppose we just get used to a system and often people fear change more than the current state of affairs. Having spent some time working here, talking to residents, patients and healthcare professionals, I think the opinion I had already formed still stands. I believe our system takes better care of vulnerable people and those with lower incomes, and this is an essential.

As a final thought, Dr Reynolds suggested that perhaps the fierce capitalist model of healthcare here in the US acted as a driving force for innovation

and research. He suggested that there is a greater incentive here to produce new drugs and technologies as there is lots of money to be made by the healthcare professionals involved. This is an interesting point and perhaps a fair argument for the current system they have here. But I do believe we still have that drive here in the UK, and I believe one of our incentives is to make research an increasing pre-requisite to further your career prospects. We are all expected to have done some research, or perhaps even complete PhD's during our careers, so although not exactly a financial incentive, it is still one none the less.....

5. "It don't have you, you have it"

Since arriving in NMPRC, I have spoken to many patients at different stages of their treatment and recovery. Some of the patients are still acutely unwell, and some have been here for decades, and are seemingly static in regards to their mental health. We are always encouraged as medical students to try and follow the whole journey of a patient from admission to recovery/stability, to understand the entire approach to managing the patient, to gain an appreciation of the trajectory of the mental illness, how it presents over time and how it responds to treatment.

I have had the pleasure of following the journey of a 27 year old male patient, Mr L.A, who was admitted to NMPRC in my first week here. He was admitted from a jail where he was being held for an alleged assault and crossing a state border when he was not legally allowed to, due to previous convictions. It was in the jail that his illness really took hold of him. Mr L.A spent several days in jail awaiting a bed here at NMPRC, floridly psychotic and not receiving any treatment. His mental state deteriorated. Staff here at NMPRC described their concern when this young man was finally admitted, how sick, incoherent, unkempt and confused he appeared to be and entirely unable to communicate.

I eagerly skipped down the hall with my medical student enthusiasm to meet and greet the new admission. I knocked on Mr L.A's door, and peered

around to see him lying very still in bed. I went a bit closer to make sure he was breathing (a habit I can't seem to kick with every sleeping person….probably not a bad thing really with regards to my job), which he was. I will come back later I thought. He remained like this for the rest of the day.

It was not really possible to engage with Mr L.A in the first few days, he just lay in bed with a distressed look on his face. Staff continued to check in on him, offer him food, company and importantly started his treatment. He was started on a mood stabiliser (Lithium), an antipsychotic (Risperidone), an alpha blocker (Prazosin) for night terrors, a benzodiazepam for his anxiety (Lorazepam) and an anti-histamine for insomnia (Benadryl).

A few days later I went again to visit Mr L.A. I knocked on his door and opened it when I heard a grunt which I interpreted as ‘please come in’. He agreed to come out to the patients lounge to speak with me. This was the first time we had really spoken. He was tense, nervous and reserved. He did not say a lot, but was very polite. I attempted to take a history from him, he answered questions with only 'yes' and 'no'. Mr L.A kept looking over his shoulder, glancing to the left and to the right throughout the whole conversation, obviously distracted by something I was not aware of. I could sense his discomfort at being in this communal space, so I suggested we catch up another day.

I came to see Mr L.A again a few days later. This time he was sitting at a table in the corner of the communal area, alone. I asked if he would be happy to speak with me today, he smiled and said ‘yes ma’am’. We spoke a lot. I managed to get quite a thorough history from him. I could not believe how far he had come since I last saw him. He still seemed on edge but was much more able to verbalise how he was feeling. Mr L.A informed me that he was battling with auditory and visual hallucinations, even as we were sat there at the table. This, he told me, was what was making conversation so challenging, but he wanted to continue anyway. His glances to the side, eyes shooting to and fro, a change in facial expression, a sudden hand gesture

were all suggestive of the battle he was having with focusing on me whilst experiencing his hallucinations.

Mr L.A was very willing to describe to me the things that he was seeing and hearing, that I could not. He described seeing a man, who was stood in the corner of every room that Mr L.A was in. He was not sure that he recognised this man, and he explained that this he was silent and did not move. However, this man often troubled Mr L.A, as he appeared to be judging him, or was seemingly disappointed in things Mr L.A had done, 'Sometimes, he just stares at me and makes me feel uncomfortable'. Mr L.A struggled to describe this mans appearance, that even determining his skin colour was challenging. This demonstrated to me, how hallucinations, although seemingly realistic at times, do not always appear in forms that can be described in the same way that we describe things and people in reality.

Mr L.A then went on to tell me about the voices. This had been the first symptom Mr L.A had ever experienced of his illness when he was 18 years old. At first he could not decipher them from a just a thought he was having and does not remember being particularly concerned about them. But as the years passed by the voices became louder and more intrusive in regards to his thoughts and actions. At its worst Mr L.A described that there were several voices, both male and female. Sometimes they spoke to him, and sometimes they spoke about him. Sometimes they were so loud he could not hear anyone or anything else and would just crawl under the duvet in the hope they would quieten down. Other times he would try and distract himself from the voices, by playing video games, or preparing some food in the hope that it would block out the voices. It did not always help. Mr L.A was mainly distressed by the voices; he did not want them around. He found it hard to articulate, but felt that ultimately they were not on his side, but instead were against him and holding him back from getting better. Sometimes they directly insulted him, and put him down. On a good day, he thought the voices might not be against him after all, and found them less obstructive. His inability to place the voices as friend or foe appeared to be most distressing for Mr L.A as he was not sure what they wanted, if he

should or should not trust them and therefore how he should respond. I found this concerning too, as I could not decipher whether these voices were going to work with us or against us in terms of helping Mr L.A comply with his treatments and engage with the staff.

I saw Mr L.A today. He is now 2 weeks into his treatment. He was standing at the T.V set when I walked onto the ward. I approached him and had to tap him on the shoulder to get his attention. His frozen appearance concerned me, but I quickly realised he was just completely gripped by the soap opera on T.V. “Oh, hi! It’s the English girl! Was'sup? Let’s go chat”. He led me over to a table in the lounge. He was talkative, smiling and even cracked a joke (an inappropriate but admittedly humorous joke) about one of the patients and was generally alert and engaged. He was still hearing voices, but had not seen the man in the corner of the room for a few days. He described that the voices were not so loud now, and were no longer able to make him do anything he did not want to, and that now the voices did not seem to mind too much when he ignored them. He felt he had gained back some control. Mr L.A appeared to have good insight, he knows what is happening to him and is aware that he still has a long way to go, but he was excited as he felt he was getting better. It was nice to feel I was finally meeting Mr L.A, getting to know his personality, his cheeky sense of humor and strong religious faith. I enjoyed learning about his childhood, his friends and family and what it was like to grow up in Kansas City in the 90's.

Today in the hospital there was an annual event called 'Respect' taking place. The Respect organisation is made up of health care professionals, patients and their families. It is offers support and information for people affected by mental health and they have annual events in hospitals where patients have an opportunity to stand on stage and tell us their journey, sing, read poems etc. It is very heart warming and patients seem to really look forward to it. One patients account of his journey really stayed with me. He recalled his battle with manic depression. It took him years, he said, to realise that “It don’t have you, you have it”, and only then, he said, did he

feel he could overcome this. I thought of Mr L.A and hoped that he may be entering this phase of his recovery too.

6. Ghosts and stuff

I have identified a theme for this trip of mine to St Joseph. It is not one that I would have chosen; in fact it is one I most definitely would have avoided. That theme is the 'supernatural and murder'. Yep, that's right.

It all began when I first arrived and a colleague of mine spotted me on my way home from work taking a picture of the house I was staying in to show to my family back home. The next day at work she approached me cautiously, "I saw you taking a picture of that house yesterday evening", "you did?" I replied. "Yes, I did, I am pretty sure that that house is haunted" she said….Ok, this is another city, this is another country, in fact this is another continent, so let me take these claims more seriously. "what's that sorry?" I reluctantly enquired, she replied "I just think that that house is haunted, is that where you are staying?", "yes….it was, I mean yes it is" I answered, "Well if I was you I would buy some sage and burn it if you feel any presence in the house" she advised, "Right….ok, well thank you for that, I'll erm…bare it in mind". Unfortunately my hosts were away on my second night, so I was home alone, quite soon after the news my colleague had given me. I hovered outside the grocery store on the way home perusing the herbs and then decided it was ridiculous and continued on my way. I am not going to lie, I slept badly that night. It is an old house, there were many sounds, which logically were pipes clanking, wooden boards creaking with age etc. but that night, those sounds were very well the rising dead.

I came to learn that lots of people here are into the idea of ghosts. Several of my colleagues have mentioned them over the weeks, and in fact have been known to go on ghost hunting holidays. I did not realise that these stories were having an effect on me, but it did, and I found myself leaving lights on all over the house and peering round doors before walking into rooms. I

have always been this way inclined but something about this town definitely accentuated it.

So, I took to spending more time outside, where I felt more sure about the sounds I was hearing. There has been some good weather recently. My host told me about this pathway near where I was staying that was good for running and walking, so I began running there after work. I found a lovely lake on route and spent some time enjoying it in the sun. The next day I told my colleagues about my evening by the lake….. "You mean THAT lake!" one shouted, "yes….it was very nice" I said, realising I was about to rapidly change my opinion on that beautiful spot. "well" she said " a few months ago someone supposedly committed suicide there, although it was odd because he was found with a traumatic head injury to the back of his head", "right, so sounds like a murder?" "yes, it does doesn't it". Well, that put a downer on my new running path. I was adamant to continue running there; however the next time I ran I nearly fell over as I spent half the time looking back over my shoulder.

A few weeks later a similar episode happened whereby I went on a sunny afternoon bike ride with a new friend I had made from St Joseph. He took me along the Missouri river, which divides this state and that of Kansas. It was very pleasant, lots of dog walkers, people enjoying the sun etc. (you get the picture, it was a positive scene). The next day, I picked up the local paper; the headlines read "BODY FOUND IN MISSOURI RIVER, ST JOSEPH". You are kidding me.

I feel I am presenting St Joseph unfairly here. These are very rare occurrences, and people here generally describe the town as very safe and friendly, although perhaps haunted. It is much safer than any part of London, that's for sure. I think I was probably just more receptive to all these events and stories as this is a new town and I did not know anyone when I first arrived. I also spend my day in a forensic psychiatric hospital, where I would often hear harrowing tales, get emails about how to 'survive a shooter on site', being taken to shoot in an indoor firing range (all a bit of

a culture shock really for a Brit) and what with the wailing winds and storms we have seen, well it just set the scene really.

In addition, just so I do not put people off coming here, as that is far from my intention, in fact quite the opposite, let me tell you about the other things that I have done and seen that are of the non supernatural/murder variety. There is a beautiful theatre in town, where I saw “A streetcar named Desire” and I also saw a symphony orchestra. There is also the university which has hosted some good plays too that I have been able to go and see. Kansas City is a short drive away, so I have gone there on day trips too. Since making friends with some of the locals, I have also been able to tap into the local music scene and experience some of the local bars, which are pretty friendly, as lots of people seem to know each other as it is such a small town.

2 days later…

I have hesitated in posting this blog entry, as I thought I was being unfair to St Joseph and perhaps misrepresenting it. However, yesterday I went on another bike ride with my friend, and as we passed through a cemetery (of course) I ran my ideas past him. I asked him if the whole interest in ghosts was really a thing here in St Joseph or whether I had just happened to encounter a few people that were into it and made massive generalisations. He laughed, and said “yes , that’s interesting you picked up on that, it is a thing people seem to be interested in here”. So when I heard that I felt kind of proud of my perceptiveness in catching onto that, and thought, right, I’ll publish this post.

7. The road to recovery

When patients are sent here from the court, they are expected to engage with a treatment programme with the aim of becoming competent to stand trial, or becoming well enough to gain a conditional release back into the community.

The actual pharmacological treatment of most of the mental illnesses here are very similar to that in the UK. The only major challenge for me has been trying to get my head around all the trade names of drugs, as we only use the generic names!

I have been impressed with how busy the patients often seem here. There have been numerous occasions when I have come onto the wards looking for a patient to speak to and they are at a therapy group or participating in a recreational activity. Here at NMPRC there are activities scheduled for patients both on and off the wards. The range of interventions and groups reflects the vast needs of the patient population. Here at NMPRC the majority of patients have an AXIS I (all psychological diagnostic categories except mental retardation and personality disorder – as categorized by the 'Diagnostic & statistical manual of mental disorders IV') diagnoses of Schizophrenia. Second to this is mental illness due to alcohol abuse. Other common diagnoses include cannabis related psychosis, anxiety disorders, Bipolar, depression, dementia, polysubstance dependence, paedophilia, schizoaffective disorder and non specified psychotic disorder.

I thought it might be interesting to share with you a potential day in the life of one of the patients here, they will be called Ms B. So, Ms B would likely wake up at 7:30am in time for breakfast. She then has the opportunity to go to the gym if she wishes until 09:15am. After this Ms B may choose to sit in the communal areas of the lounge and participate in a nurse led discussion on the ward, which may be about health issues, current affairs, or sometimes on discussions around spirituality. Ms B would have her lunch around midday. After this there are options to go to the library for a while, to sit and read and also take out some books to read once back on the wards. After this there is another nurse led group session on the ward to keep her busy. There is a slot in the day before supper where patients can choose different activities they may like to do, Ms B may choose for example to play chess with one of the other patients, or attend an art class. After supper there is a nurse led relaxation group, some patients may retire to their room after this or watch TV, but as Ms B has higher privileges so may instead choose to return to the gym or spend some time in the gardens

if the weather his nice. Ms B may have other activities to slot into her busy timetable, scheduled by the therapists and psychologists. Unfortunately for Ms B she has been struggling with alcohol and substance abuse problems, so may benefit greatly by attending Narcotics and Alcoholics Anonymous groups. She is also a spiritual woman so enjoys bible study group. As Ms B is looking forward to a conditional release in the near future, she may also engage in a programme called 'strategies for success', to help prepare her for a bright future. Ms B eventually retires to bed in preparation for another full day.

The list is endless; there are numerous groups patients may be involved in. Two of the off ward groups I have sat in on were Dialectical behavioural therapy (DBT) and Safe offender strategies (SOS). DBT is a type of cognitive behavioural therapy which is used here to help better treat borderline personality disorder. These particular patients are more prone to react in a more intense manner towards certain emotional situations. DBT tries to offers skills to help manage this reaction. The DBT session I sat in on tried to tackle the issues of 'prejudice' and 'jumping to conclusions'. We were given a four sentence story about a man whom went into a shop and took some money. The language was purposefully vague. We were only allowed to read the story once and then turn it over and answer questions about it, for e.g. "did the asian shop owner hand over the money?", we do not know he is Asian. "Did the man who was robbing the shop keeper successfully take the money?" we do not know that the gender of the robber was male. The exercise was trying to highlight the parts of the story we automatically filled in with our stereotypes, and assumptions. I too had made many assumptions which concerned me.

I was particularly interested in the second group I attended, Safe Offender Strategies, a group for patients admitted with sex offences. This was a new programme (in fact it was only the second session that had run) that used an innovative group treatment approach that targets deficits in self-regulation—a central problem for sex offenders. It is essentially about managing emotions and impulses and learning how to have healthy relationships. In some ways it was a shame it was such a new programme

here as I was really interested to know how effective it was. In the session the psychologist was going over what constituted a ‘sex offense’ and trying to establish if the group were both aware and in agreement with these.

Another group that runs that is more specific to a forensic hospital setting is the Competency Education group. This is essentially a group that aims to teach and inform patients about the legal process, including the layout of the courts, the roles of the different members of the court room, how the patient should behave in the courtroom, and whom is acting in their defense and whom is prosecuting. This is an opportunity for patients to ask questions in preparation for standing trial, and also an opportunity for staff to see if the patient is competent to stand trial, i.e. do they understand what lies before them.

Engagement in the groups is a way for patients to progress through the level system I described earlier, so that they can have increased privileges. This also puts the patients in good standing when they are in court defending their case. Regardless of the incentive it is always reassuring to see patients in psychiatric hospitals being busy, too often I have been in hospitals where I recall patients spending hours on end staring at the wall at the end of their bed, or just watching TV. So it has been a really positive experience working somewhere where the staff are really engaged with the patients and have a lot of opportunities for them.

8. Leaving St Joseph

It is hard to believe that my medical elective has come to an end. The medical elective is often seen as the highlight of medical school, the final task/holiday that the school sets before you are sent out into the big wide world. I always looked at it as so far away in the distance that its arrival was inconceivable. However, in keeping with the chronology of life it did unsurprisingly arrive, and not only that, it also ended.

My final week at NMPRC consisted of lunchtime outings with my colleagues to 'Garage Sales' (a more organised version of a car boot sale, where cars are not actually involved), eating out at some of the infamous take outs including the renowned 'Taco Bell', and most importantly a pot luck dedicated to me! I had chosen the theme of Mexican food, a cuisine I had grown to love on this trip. Everyone brought in a different Mexican dish for all to share and eat, there were desserts a plenty, all with the essential ingredient (for anyone that knows me) of peanut butter. I was overwhelmed and touched both emotionally and gastrointestinally by the whole affair. I was also kindly presented with a sac of mementos of my time in St Jo, including mugs, Reeces Pieces and even some highly comedy art work made by non other then NMPRC security! It was quite a send off.

I spent my final afternoon going round the wards saying goodbye to all the patients I was privileged to meet. It was sad. They had let a complete stranger into their worlds, and been so honest and open with me, and I was grateful for that. From these patients I had learnt about life growing up in St Joseph and Kansas City mainly. The schooling, family life, mentalities, politics and religions of these communities. I also gained an appreciation of the types of stressors, pressures and drugs people were exposed to, and what measures were in place to help them throughout. I also learnt from them and their stories how their experiences and their mental health problems began and how these influenced their run ins with the criminal justice system. This I was particularly interested in, as prior to this elective I had had only a minimal exposure to forensic psychiatry. Commonly, patients experiences with the criminal justice system involved substance abuse. Often patients recalled starting to abuse drugs during times of mental ill health and being vulnerable to the environment around them. Others recalled later developing mental health problems as a result of substance abuse and may then turn to criminality in order to fund the drug habit. Other situations involved patients with paranoid delusions, who committed crimes when in a state of florid psychoses, seemingly to them, acting in self defence. But all here at NMPRC were not guilty of their crimes, as the law recognised the role of their mental ill health on the alleged crime committed.

I remember being hesitant before choosing this placement for my medical elective, as I would be alone, and in a location where there would be no other medical students. I also considered the fact that I was going to the Midwest of America, not a common holiday spot, few beaches etc..would I have fun? However, I am so glad I made this choice, as being alone often opens so many more doors, people are more receptive to you, opportunities are easier to come by, and the whole experience is generally more immersive, thus allowing you to really integrate and get the most from an experience. It was a massive culture shock for me coming to St Joseph. It was a completely different way of life to what I am used to in London. It is a much more rural existence, generally more conservative, and much less multicultural. Despite these differences and challenges I learnt so much, made friends I intend to keep, found commonalities, and importantly, we all relished in the comedy value of our differences.

All the staff and in particular Dr Reynolds really went above and beyond to make this an unforgettable experience. In addition to ward opportunities, drives across the state to talks, conferences, court hearings and trials, Dr Reynolds also took me shooting. Yes, shooting. Of paper targets of course. He was also kind enough to lend me his bicycle for the duration of the trip, of what benefit cannot be understated. Having a bicycle in St Joseph made a world of difference to my ability to get around, and was also integral to me meeting other cyclists and making friends. People who cycle are generally a safe bet. Importantly, Dr Reynolds also organised my accommodation with my wonderful hosts, who became both good friends and like parents to me whilst I was here.

So, farewell St Joseph, thank you for having me. I have every intention of coming back next year for the Forensic Conference, and catching up with all you wonderful people.