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The Imprisonment of Mentally Disordered Offenders*

By J. H. ORR

Introduction

I am glad to have this opportunity to talk about an unfortunate consequence of developments in the Health Service over recent years. My theme will be what is now happening to mentally disordered people who have committed criminal offences. At present, many of them are going to prison. The prison system—already severely overcrowded—contains some hundreds of mentally disordered offenders who in the opinion of prison medical officers need and are capable of gaining benefit from care, management and treatment in psychiatric hospitals. When using the term 'mental disorder' I shall, of course, be referring to those states of mind which have been classified and defined in Section 4 of the Mental Health Act 1959: members of the College who work in the National Health Service will be relieved to know that I do not share the view of the citizens of Samuel Butler's *Erewhon* that crime itself is an illness, whose sufferers should *all* be placed in the hands of the omniscient psychopathologists. Indeed, when one has the practical responsibility for the provision of health care for prisoners, it is quite irrelevant whether or not they committed their offences as a result of a mental disorder or whether their mental disorder developed before or after the offence or trial. The only thing that matters is their present condition. If a prisoner is suffering from mental disorder of a nature or degree that warrants his detention in hospital for treatment, then the prison medical officer will want to bring about his admission to hospital under the appropriate section of the 1959 Act. This is wholly in accordance with the philosophy of the Act, which does not limit hospital admission to cases in which the criminal offence was causally related to a mental disorder. In this talk I shall want to consider why in so many cases hospital places cannot be found.

How many?

First a brief mention of the numbers involved. At the middle of last year we instituted a survey in which all prison medical officers were asked to record, at six-monthly intervals, the numbers of prisoners in their care who satisfied the 1959 Act's requirements for admission to hospital and would benefit from admission. As I have mentioned, the first returns show that there are some hundreds of prisoners concerned, distributed among all four categories of mental disorder identified in the Act. We are not yet ready to give a more precise estimate of the numbers, as all statistical exercises of this kind need careful assessment. The figures should be set against, on the one hand, a daily average prison population of over 42,000, and, on the other hand, the total number of hospital orders made last year, which was 924. We in the Home Office are most concerned about prisoners suffering from mental illness. As far as mental subnormality is concerned, you will know that the official guidance to doctors making reports to courts is that some offenders can properly be accommodated within the prison system; and as to personality disorders there is, of course, scope for considerable argument about the extent to which these are amenable to present forms of treatment. However, I should stress that prison medical officers have been asked in the survey to record only those subnormal offenders who are *unable* to cope with the prison regime, and those psychopathic offenders who it is thought *would* respond to hospital conditions. Various estimates have been made from time to time of the proportion of prisoners who are mentally abnormal or peculiar in one way or another: they range from 10 per cent to over

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half. The survey is not designed to count them, and I make no Erewhonian plea on their behalf.

What is happening?

This is not only a very worrying situation; it is also something which would have deeply surprised our predecessors. I should like to quote from the book *The Modern English Prison* by Sir Lionel Fox. Such a title smacks of the 1930s and indeed the book was published in 1934, when Fox was an Assistant Commissioner of Prisons; he later became Chairman of the Prison Commission. 'Considerable advances have been made since the war (that is, the 1914–1918 war) in the treatment of problems connected with mental disease among prisoners; indeed, it would seem that today the investigation and recognition of mental states, with the accompanying administrative and forensic work in preparing certificates and reports and giving evidence in courts, have come to form the most important part of the Medical Officers' duties. Prior to the war all that was, broadly speaking, expected of the prison authorities was the recognition of cases certificable under the Lunacy Acts. The Mental Deficiency Acts 1913–1927 (which only began to operate effectively after the war), together with the increasing recognition of the importance of the psychological factors associated with crime, have completely altered this position. It is of course self-evident that prison is not the place for an offender who is either insane or mentally defective, and both the Lunacy Acts and the Mental Deficiency Acts provide machinery enabling the courts to deal with such persons without sending them to prison. Nevertheless, a considerable number of convicted prisoners are found after reception to be insane or mentally defective, and it is important that these should at once be recognized, certified and removed to Mental Hospitals or Institutions for Mental Defectives: in 1931 in local prisons 98 convicted prisoners were certified as insane, and 45 as mentally defective; in convict prisons seven men were certified as insane and two as mentally defective'. Disregarding the pre-1959 Act terminology, the message is clear. Some mentally disordered offenders will slip through the forensic net into prison, but they can be quickly removed. The situation now is quite different: mentally disordered offenders are entering prisons not because the net is insufficiently wide or discriminating but because hospital places are not forthcoming. It is an irony that under the Mental Health Act 1959, which gives us a net of unparalleled width, we imprison more mentally disordered offenders than under the old Lunacy and Mental Deficiency Acts. In 1931 (when the average prison population was about 12,000) 105 sentenced prisoners were recognized as suffering from mental *illness* and transferred to hospital. In 1976 the number of sentenced prisoners recognized as suffering from mental illness was more than double this figure, but the number transferred under section 72 of the 1959 Act less than half.

How has this come about?

It would be tedious and unproductive to go over the ground which has already been so ably covered by Dr Robert Bluglass in his recent article in the *British Medical Journal* (25 February 1978), and I would urge anyone who has not yet read it to do so. However, I think it would be useful to remind ourselves of some of the historical trends.

(i) *Open-door policy*. As Dr Bluglass said, the introduction of the open-door policy in many NHS hospitals by definition produced a shortage of places for people (whether offenders or not) who needed to be kept in conditions of at least, some security some of the time. This in turn obviously meant that the Special Hospitals became and stayed grossly overcrowded, and that offenders needing security not available in the health service will end up in prison. Dr Bluglass also noted that the open-door policy meant that hospital staff, primarily nursing staff, have come to lose the skills needed to care for difficult and disturbed patients. It is not for me to accept his suggestion that local NHS hospitals should again provide secure accommodation and re-acquire those skills; but perhaps I could note that the whole rationale of the open-door policy was therapeutic. However, those patients who benefited from it must not be considered in isolation from those who could not be treated in open wards and so received no hospital treatment at all. Those

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people—and the prison staff who have to look after them as best they can—are paying the price of the open-door policy.

(ii) *Asylum*. Hospitals have also clearly sought to divest themselves of their traditional role of providing asylum for people unable to cope elsewhere, even if there is no specific treatment for their condition such as to ameliorate it or prevent it from getting worse. The Mental Health Act 1959 defines 'treatment' as including nursing care under medical supervision; but there has clearly grown up a tendency within the NHS for hospital doctors to decline to admit a mentally disordered person on the ground that his disorder would not be amenable to treatment. Despite the definition in the Act, treatment seems often to be regarded as simply the application of specific clinical measures, surgery being the paradigm. This development has come about in no orderly or systematic way, and it too has a price. If no asylum is offered, then it will often happen that the person concerned falls into a vicious circle of crime followed by imprisonment. The circle is vicious because the longer the criminal background the more definitely the offender is typecast as the irredeemable client of the penal system. Whether or not a particular person can or should be treated is, of course, a matter of clinical judgement, but obviously that judgement will depend on the meaning given to 'treatment'. This is in a sense the most worrying development: after all, open doors can be locked again, but, if hospitals are to admit only those they can make better, this effectively excludes the possibility of a hospital disposal for quite a large number of 'inadequate' offenders who require long-term care within a sheltered environment.

An exchange of letters

To illustrate the philosophical gulf that now divides the profession, I should like to read you an exchange of letters that recently took place between a prison medical officer and the specialist in Community Medicine of a Regional Health Authority. At issue was a 27-year-old man, suffering from schizophrenia, for whom the medical officer was trying to find a hospital place. The Specialist's letter ran:

'It is a cardinal principle of the health service that the decision about the admission and discharge of patients to and from hospital is the responsibility of the consultant who will be in charge of the patient's treatment and rehabilitation. This is a fundamental principle, and clearly any other system would not be in the best interests of the patient and would certainly be abhorrent to the profession. In reaching his decision a consultant must exercise his judgement, having, where necessary, discussed aspects of the case with his own colleagues, nursing staff, family practitioner, social worker and, in the case of those in prison, with medical officers such as yourself and your colleagues.

'As far as admission to ordinary mental illness hospitals is concerned, if an individual is not going to respond to treatment in the broadest sense and if for his proper care he does not require skilled nursing or other specialist facilities provided in a hospital, then admission is contra-indicated.

'The days have gone when the mental illness hospital was a repository for those who were socially unacceptable. The policy at that time did indeed, as you say in your letter, keep these people out of the way of the public and the Courts, but the hospitals were dreadfully overcrowded with people who should never have been there. You will know the history subsequent to the late sixties following various hospital inquiries. The admission policy now adopted is one which has been demanded by the public and is supported by the medical and nursing professions.

'Unhappily, at the same time as the health service was implementing national policy, there was not always the increase in sheltered accommodation which it is now the responsibility of the Local Authority to provide. It is this lack of custodial provision for those who should not be in prison and for whom hospital treatment would be valueless which ensures that our institutions still have to care for inappropriately placed individuals.

'We in the health service also have further developments which we must pursue, particularly in the provisions of regional secure units, and it seems to me inevitable that until proper sheltered accommodation is provided by the Local Authority and regional secure units are provided by the health service some individuals will always be misplaced. All we can do is to mitigate the effects of these misplacements as best we can within the resources available to us'.

The Medical Officer's reply ran, after the usual preliminaries:

'Whilst I of course agree in principle to para. 2 of your letter, the fact remains that in these cases other responsible medical officers of equivalent quali-

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fications—or more—to the admitting RMO have signed Hospital Orders indicating the need for a patient to have treatment. They have almost invariably had mental hospital experience themselves and are fully aware that mental cases *can* be contained in a mental hospital safely and more humanely than in a Prison: whatever the Porters and/or unqualified Nursing Staff may have the effrontery to suggest. Whether that treatment is long term, or even for life, is immaterial. To make it contingent upon a patient's likelihood of response to treatment is a cynical and recent innovation—it certainly was not a criterion in the early 60s—seemingly elaborated by either idle doctors or incompetent staff to save them some trouble. Because there is still no—repeat, NO—certain cure for schizophrenia, chronic schizophrenics are or can be a demanding nuisance; but that, one was led to believe, is what mental hospitals are for: to look after mentally ill or disturbed patients.

'Shortly before I went to the mental hospital where I trained, the enlightened Medical Superintendent, in the guise of Pinel reborn, endeavoured to clear the wards of such alleged deadwood, the merely "socially unacceptable" patients. The Chief Male Nurse kept a record of the three hundred men cast out upon the world, and in three years all had either returned to the hospital, gone to another mental hospital, were in Prison, or had died. None at that time were viable in the community. Some bright psychiatric—or psychological—spark then produced the concept and explanation of "institutionalization", as if this explained everything. In fact it could equally be said that all this meant was that chronic patients tended to treat the institution like home, and were lost outside it. That would *not* therefore necessarily mean that they could *ever* have existed outside, whether before or after institutionalization. I deny categorically that in my time there were ever people in my wards who "should never have been there". What I do admit is that there was a need for more long-stay chronic beds with minimum nursing but adequate security; which local hospitals all demanded every year but which none of them offered to provide, and which neither the Regions nor the Elephant & Castle were ever competent to organize. Now we have a shining local mental hospital in this region with 70 empty beds and a *waiting-list* of 30. This paradox is not a mile from the hospital which has just accepted X (the prisoner in question) as an *out-patient*. Are mental hospitals run for the patients or for pressure-groups?'

I quote this exchange of letters simply to illustrate the deep division of opinion about the proper role of hospitals. I do not necessarily endorse all the Medical Officer's polemical points, and it is not for me as Director of Prison Medical Services to speak *ex cathedra*, but my own view is that the treatment of a patient is, after all, no more than the means to an end, namely the overall benefit to the patient, and not an end in itself. With this in mind I often find it difficult to see how it can be to a mentally ill offender's benefit to have to remain in prison even if hospital is not the ideal location for him. The principle cited by the consultant sounds unexceptionable: if an individual is not going to respond to treatment in the broadest sense—that is, in the sense of the 1959 Act—and if he does not require skilled nursing or other specialist facilities provided in a hospital then admission is indeed contra-indicated. But what does 'respond' mean? It ought not to entail an actual change in a person's condition, since otherwise hospital treatment would never be justified to halt its deterioration. There is no doubt that an offender's mental condition can deteriorate in prison and as a result of imprisonment. Another question: what is the time scale within which the response has to occur? The 1959 Act made no distinction between acute and chronic conditions.

'No facilities'

At the same time as withdrawing asylum, however, the hospital system as a whole also seems to be unable to cope with all the offenders who need not a minimum but a lot of nursing attention and supervision. In many cases there is no dispute about the clinical features of the case and the need for treatment, and admission is refused not on the ground that devoting nursing and other facilities to an unresponsive offender would be wasteful, like using the best claret for cooking, but rather that these facilities are not available in the first place, and that offenders do need intensive nursing which the hospital cannot provide.

Who should be in prison?

I ought again to make it clear that prison medical officers are not seeking simply to shift the burden of looking after offenders on to other

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shoulders. The passage that I quoted from Sir Lionel Fox's book went on: 'But even when the clearly insane and defective have been eliminated, there remains a considerable number of "mental" or "psychopathic" cases, not certifiable under any existing legislation, who are nevertheless unsuitable for prison discipline and environment'. Unsuitable they may be, but medical officers and other prison staff accept that prisons will, unfortunately probably always, have the responsibility for containing men such as Tony Parker's 'Charlie Smith': persistent offenders who have never been absolved from legal responsibility for their crimes and yet who obviously have certain persistent psychological incapacities. And prison staff recognize, too, that many mentally handicapped offenders are best placed in prison, as in hospital they would dominate the more docile patients for whom the facilities and staffing levels are designed and would be very difficult to contain. The particular and new worry is rather the entry into prisons of people suffering from mental illness, who in the past would have been admitted to hospital without question. After all, even with serious offences it is to some extent a matter of chance whether a mentally disordered person falls into the criminal justice machinery. Suppose a woman suffering from schizophrenia is commanded by voices to poison her husband. If she tells her doctor, she may well receive rapid hospital treatment under Part IV of the Act; if she does not, she may well receive ten years for manslaughter. Yet her mental condition and psychiatric needs would not be different.

What prisons can and what they cannot do

A penal system—any penal system—is an official mechanism designed to inflict deprivation on those who break the law. Just as important as the unpleasantness of prisons is the fact that they are and have to be highly ordered and organized institutions. They contain a lot of people in a small space against their will. There has therefore to be a rigid daily timetable of movements: unlocking, collecting food, exercise and so on. The mentally disordered cannot cope with this routine and with prison discipline. It might be objected that some dangerous offenders will be in custody in prisons such as Parkhurst, whose staff have a tradition of containing difficult and highly disturbed men and which has a good range of facilities and a fairly relaxed regime, and that medication can be administered as well there as in Broadmoor. In some cases this may well be so, but Parkhurst is by no means typical. Consider the busy local prison: in many cases the offender will not need its secure conditions, but open prisons have only basic medical cover, and in any event there are undertakings to the local communities about the kind of prisoners that will be sent there. Local prisons are tremendously busy places, whose population is constantly changing; and staff simply do not have very much time to get to know individual prisoners, let alone their anxieties and beliefs. Gross symptoms can be contained or masked by medication, but little more can be done. The Regional Health Authority Specialist whose letter I quoted made it clear that hospitals cannot have a purely custodial function, and this is readily accepted. But prisons can often offer little more than custody to the mentally disordered. Of course, all institutions have their own rules and involve restrictions on individual liberty; but anyone who has worked, as I have, in both prisons and hospitals will appreciate the qualitative distinction between them. And one should remember that a significant number of offenders become mentally disturbed in some way *as a result* of their containment in prison. The phenomenon used to be known as 'prison psychosis'. The prison environment is therefore hardly a therapeutic one.

There is also the consideration that a prisoner has to be released at the end of his sentence. Mentally disordered offenders rarely qualify for or are suitable for parole, and there is no provision in law for any compulsory supervision or after-care after their release. Again, prison staff and the probation officers attached to the prison will do their best, but as the person's underlying mental disorder will remain so will the probability of his committing a further offence of one kind or another. And a further irony: the more offences that he commits, the less attractive as a potential patient he will become to hospital staff.

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Whose fault?

It is, of course, nobody's fault. Taken in isolation it is perfectly reasonable for staff at hospital X to decline to admit patient Y on the grounds that they do not have the facilities to look after him properly, even accepting that it was as a result of their own decisions that these facilities are lacking. The trouble is that you cannot take hospital X in isolation: the country is full of such hospitals. It is almost as if half the hospitals in the country decided that they would specialize in heart disease and admit only cardiac patients. What is a prison medical officer to do when faced with a situation in which everyone is agreed that an offender is mentally ill and in need of hospital treatment, but in which local hospitals insist that he should be in a Special Hospital and *vice versa?*

The Secure Units

This brings me on to regional secure units. Obviously I welcome them, and sincerely hope that their eventual introduction will help to resolve all too common situations such as the one I have just mentioned. But I am also rather worried about the possible effect these units might have on the difficulties I have been discussing today. Dr Bluglass, in the paper I have already mentioned, noted that there was currently a belief by some that all difficult patients will be accommodated in the units and that the NHS psychiatric hospitals would have no further concern with their problems. Such a belief, would, however, be clearly quite mistaken. The initial aim of the Department of Health and Social Security is to provide only 1,000 places in secure units, and this aim is unlikely to be realized for a number of years yet. Even when the units are established and opened, there will remain a large number of 'difficult' patients, offenders and non-offenders, who if they are to receive the treatment they need will have to be accommodated in and cared for by NHS hospitals, as they are supposed to be at the present time. Unless NHS psychiatric hospitals are prepared to take this responsibility on, and to return to something more approaching their traditional role, the problem of mentally disordered offenders in the prisons will continue unabated or may even get worse.

Conclusion

I have no wish to understate the difficulty of looking after the mentally disordered. Many are what the late Dr Peter Scott called 'unrewarding' patients. But I do not think it any less self-evident now than it was to Sir Lionel Fox in 1934 that the insane and mentally defective should not be in prison. There is a simple answer to the proposition that is sometimes canvassed that mentally disordered offenders should be treated in the prisons (which would of course require a considerable injection of therapeutic resources) and that the time has to come to recognize that for better or worse the hospital system is not prepared to accept all the 'unrewarding' patients that it once did. The answer is this: as the prisons are at the moment a therapeutic environment can be provided for only a tiny minority of inmates. 'Treatment' may be defined broadly in the 1959 Act, but that is not to say that medication plus secure custody constitute adequate treatment. No, in order to do the job properly it would be necessary to recreate something like the old Lunatic Asylums and Institutions for Mental Defectives and call them prisons. This would, of course, be administratively and financially bizarre—for example, how would these institutions be staffed, and what would happen if they could not be staffed? Indeed, there is a paradox here: developments such as the open-door policy which are seen as progressive are cancelled out by their retrogressive consequences. If I may be permitted to conclude with a moral: unless and until psychiatry achieves the therapeutic efficacy of orthodox medicine, is it right that hospitals providing psychiatric care should seek to model themselves in every way on hospitals providing orthodox medical care? Medical progress alone will truly open the locked ward.

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