Section of Psychiatry

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Management of the Mentally Abnormal Offender

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Management of the Mentally Abnormal Offender: Integrated or Parallel

In 1961 the Working Party on Special Hospitals (Ministry of Health 1961) recommended that regional hospital boards should arrange their psychiatric services to ensure the provision of a variety of types of hospital unit, including some secure units, with transfers being made between them as necessary. They also strongly advocated diagnostic and treatment centres for patients who present special difficulty because of their aggressive, antisocial or criminal tendencies, and who also present special problems of diagnosis, treatment and management. These recommendations were never implemented, and now we are faced with a crisis because special hospitals, which provided maximum security, are full, many very mentally ill patients are sent to prison because of a shortage of NHS facilities, and some mentally ill patients are not able to get accommodation or treatment at all (Gunn 1974*a*,*b*). In response to the crisis we have had not one but several further reports. The Interim Butler Report (Home Office & DHSS 1974), and the Glancy Report (DHSS 1973) both recommend the building of a security unit in each NHS Region of England and also in Wales. The final Butler Report (Home Office & DHSS 1975) reaffirms the original proposal and chides the Government for delay. The DHSS Guidelines (DHSS 1975) set out what they believe is required. We have had statements in the House of Commons from the Secretary of State for Health and Social Services, first saying that special monies would be allocated for the capital development involved, and then later confirming that the revenue required to run the new units would also be specially allocated. However, no unit has yet been built and the Department of Health is now setting up yet another working party to examine the reasons for the slow progress!

It was with some trepidation, therefore, that I agreed to contribute further to this plethora of discussion, debate and paper-work. It could well be argued that my time would be better spent elsewhere. However, I was persuaded that if any programme is so frequently discussed to so little effect then perhaps there are delaying aspects to which we should pay particular attention. I used to argue that the 1961 recommendations were never implemented because there was no funding to support them; I still think that was an important omission, but I no longer believe it was the only factor.

Staff Opinions

The history of events in my own region, South East Thames, has suggested other more important issues. In response to the Interim Butler Report and the Glancy Report, the Bethlem Maudsley Joint Hospital set up a working party which recommended that the Joint Hospital should develop a regional medium secure unit. Quite quickly, however, it became apparent that this was unacceptable to the hospital staff and so a second working party was established which spent most of its time on a detailed consultation exercise with all grades of staff. The conclusions of this second group then needed discussion throughout the region. This was done by a series of seminars at all the large mental illness and mental handicap hospitals. The working party recommendations received considerable support and as a result a series of project teams is now hard at work. The greatest anxiety at present is that in spite of everything that has been said and done, adequate finance will not be forthcoming at this difficult period of British history.

It quickly became apparent that the concept of security is an emotive one. Many are agreed that

something has to be done, but preferably somewhere else. The battle of the early 1950s to get doors open, to get staff to understand the idea of community care rather than institutional care, to respect patients as having individual rights, to put the emphasis on informal treatment, has been well and truly won. Staff are therefore no longer willing to see themselves as custodians for the benefit of the public and are only interested in therapeutic programmes which are related to the new concepts they have now fully accepted. If it is suggested to them that a particular patient needs to remain in hospital for a period of time simply because he might be a nuisance to other people, or even a danger to other people, they will rapidly retort that it is not part of their job to provide such a service.

In the face of this powerful viewpoint some of us found ourselves in a small minority when advocating that it is the job of a caring health service sometimes to protect the mentally disturbed from the consequences of their own actions, always provided of course that such a paternalistic arrangement is properly monitored and open to independent discussion. Asylum has become a devalued term and is frequently equated with harsh institutionalization.

Scepticism may lead to the view that ethical debates such as these are less significant than economic ones. The 'if we are going to run a secure unit then we must be paid extra' brigades certainly are in evidence, and just to rub in governmental misunderstanding of this problem they won an early but irrelevant victory about the pay lead for nurses. What impressed me, however, was how much less important this economic argument was than the much more fundamental one, 'Here we are understaffed and undertrained, working in deplorable physical circumstances, not a consultant in sight most of the time, uncertain of our rights and responsibilities, subject to increasing public criticism and you want us to take on an extra custodial role'. The truth is that most mental hospitals are demoralized. Ever since Mr Enoch Powell read out their death sentence in 1961 (*see* Jones 1972) they have had an air of doom and decline. To suggest – as many staff feel is being suggested – that they should go back to a custodial role, is too much for them to bear.

The Third Service

As our regional discussions progressed it became clear that there was another underlying issue which we were not debating. Should a security programme be integrated with NHS psychiatric facilities or should it run in parallel to them? There are overlapping aspects to these two approaches but there are also some basic differences which may influence the other debates. Fig 1 shows the integrated approach. It is assumed that there are

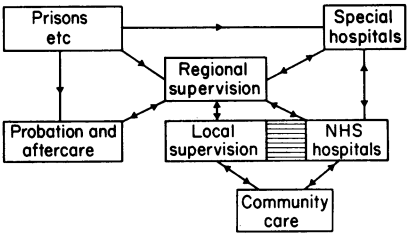

Fig 1 *An integrated system of psychiatric services*

basically two forms of health care which can be applied to mentally abnormal offenders: the care of the penal system including prisons and probation, and the care of the National Health Service including special hospitals, regional security units and general psychiatric facilities. The arrows indicate the possible movements for patients. Such a system is never openly challenged; after all, we only have two departments concerned, the Department of Health and the Home Department. Yet sometimes there seems to be a hidden desire to have what only a few people are honest enough to call a third service. For while it is true that there are only two government departments concerned, it is also true that the elements of a third service already exist. Most of our psychiatric services are run by the regional, area and district structure we all know so well. Special hospitals, however, are not within this system and in England are managed directly from the Department of Health in London by a special section of the mental health division. No doubt regions could mirror this and develop their own security sections with direct responsibility for a regional unit. Ultimately it would therefore be quite possible for us to establish in this country three systems of health care all running alongside one another, in parallel. The first would be the penal system, then there would be this new system of special hospitals, regional security units and whatever community facilities develop from them, and thirdly the general psychiatric system. Fig 2 shows this possibility.

Department of Health and Social Security (DHSS) documents do not advocate a parallel

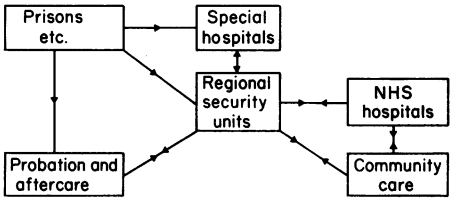

Fig 2 *A parallel system of psychiatric services*

system; indeed the civil servants concerned are adamant that they want an integrated system. Yet in many ways a parallel system is a natural development. The special hospitals began at the turn of the eighteenth century, with the first Criminal Lunatics Act in England being passed in 1800. This had been prompted by the attempted assassination of George III by the insane James Hadfield. The Act provided that persons endangering the sovereign's person could be kept in safe custody. Hadfield was at first kept in prison but later transferred to Bethlem. In 1807 a select committee recommended that there should be a special place for insane offenders. Bethlem was just about to be rebuilt at St George's Fields in London and in 1814 it opened with a separate wing for criminal lunatics. This wing rapidly became overcrowded and Broadmoor Hospital began its life in 1863 by taking all the criminal lunatics from Bethlem. Before long Broadmoor found itself taking all the criminal lunatics in the land including the non-dangerous ones. At the turn of the nineteenth century it was decided to build a 'Broadmoor' for the north and a hospital for dangerous defectives. Rampton Hospital was completed in 1912 and Moss Side in 1914. Neither operated as intended during World War I and at the end of that war there seemed to be a sudden decrease in demand for all types of asylum beds. Consequently Rampton became the state hospital for dangerous defectives and Moss Side was handed over to the Ministry of Pensions as an epileptic colony. However, by 1933 Rampton was overflowing and Moss Side was reclaimed for its original purpose. Currently Broadmoor is so overcrowded that a fourth special hospital, Park Lane, is being built next door to Rampton. Eventually it should take 400 male patients, but it currently houses an advance unit of 70 patients. Much of the impetus for the new security programme comes from the fact that the maximum security hospitals are being asked to take more and more patients who have been extruded from other parts of the system and who very often do not present maximum security problems at all. It could be argued that we are now about to embark on the building of little special hospitals all over the country, one per region. (Mowat 1966, Walker & McCabe 1973, Home Office & DHSS 1975).

Both integrated and parallel approaches have advantages and disadvantages. Obvious attractions of the parallel system are that it corresponds with the view of many NHS staff that there is a group of patients who, whilst not fully responsible and therefore not suitable for punishment, are too difficult or perhaps too nasty to be dealt with as 'ordinary' patients. Secondly, it is relatively easy to build one separate unit, once the site has been agreed, select staff on a special recruitment basis and give a set of specialized skills. The number of negotiations and the capital costs are both kept to a minimum. What are the disadvantages, however? Initially a separate site must be obtained which will put all the feared patients in one place. Then there is the pressure to increase the number of patients who belong to this rejected group; I will call this pressure 'banishment pressure'. History demonstrates that a building programme does not stem banishment pressure, it increases it, so that more patients will be moved over from so called 'ordinary' psychiatric care into this rather specialized care for less desirable patients. Special hospitals are at the wrong end of the one way system caused by banishment pressure and their patients are returned to their local mental hospitals only with great difficulty. Banishment pressure is, perhaps, the product of two forces: first stigma, but just as important, fear in the face of inadequate skills and resources. The parallel system will not improve the skills and facilities currently available in the general psychiatric services. The current crisis can be alleviated only if the new developments concentrate very determinedly on rehabilitation and resettlement, so that as soon as patients are ready they can be moved from the special hospital level to the regional level. The Eastdale Unit at Balderton Hospital which takes patients from Rampton and Moss Side with the explicit aim of discharging them in eight or nine months, is a very good example of this essential component in any parallel system. A likely side effect of the parallel system is that banishment pressure would expand the third service as fast as resources would allow. If money were more freely available than at present, this third service expansion would result in numerous secure mental hospitals spread throughout the kingdom, just like the old county asylums were. History would have come full circle.

What about the integrated service? This may be heresy, but I submit that it is no longer possible – even if it ever was – for every hospital and every district to offer a full range of facilities and skills, so that every patient, no matter what his problem, can be treated by the general psychiatric consultant in charge of the area in which he lives. However, each large psychiatric hospital surely can expect to have a wide range of services. An alcoholism service would seem to be vital, an acute ward for the severely psychotic is another essential, an adolescent unit is highly desirable, and in that array of shared facilities some kind of special supervision arrangement for patients who are otherwise rejected may fit in quite naturally. Certainly local specialized facilities, even if shared by several districts, will keep stigmatization to a minimum, and should enable specialized skills to be developed locally and disseminated widely quite

easily. Rehabilitation and resettlement should be easier to organize than it would be from a distance.

The big problem of the integrated system is that, however good, however well staffed, it may not be able to cope with all the banishment pressure a society can generate. The man who kills his family in a depressive illness may sometimes be unacceptable in the early stages of his treatment. If he does not need maximum security, sending him to a special hospital would be economically wasteful and indeed possibly antitherapeutic. Another difficulty for an integrated supervision service is linkage with the special hospitals; each and every hospital with supervision arrangements will have to establish its own rapport with each special hospital. This no doubt can be done, but it will be less satisfactory from the special hospitals' point of view because different parts of any one region will have different policies.

There are probably economic differences between the two systems. If facilities are built or adapted in several places, capital expenditure may be more than for one large unit. However it is difficult to calculate which service will be the more economic to run. I suspect that the integrated service is cheaper to run because it will make fewer demands for new and autonomous service arrangements, but a considered evaluation by an economist is required.

South East Thames Region

Staff rejected our earlier parallel ideas and demanded a community care service; our philosophy was pushed a long way towards a fully integrated system. However, in an attempt to have the advantages of both systems, some elements of the parallel arrangements have been kept. Each area has a responsibility to develop some kind of integrated local service including both inpatient and outpatient facilities. There will also be a small regional unit between the special hospitals and these local facilities. The policy aims to keep the regional unit fully integrated with the local facilities and in this way keep to the integrated model as far as possible. The regional unit will have the special responsibilities of staff training, management of problems considered too difficult for the local services, development of liaison with the special hospitals and provision of regional advisory and back-up services. In effect the plan is for a four-tiered service (South East Thames RHA 1976). Tier 1 comprises the special hospitals and they will continue to provide maximum security; tier 2 is the regional unit; tier 3 is a variety of inpatient arrangements in the large mental hospitals; and tier 4 is community care, which may occasionally need to be carried out by the special supervision service itself for a longer or shorter period and which will involve both psychiatrists and community nurses.

Conclusion

The pressure to reorganize the secure psychiatric facilities of this country is growing. Profound and neglected recommendations were made by the Emery Committee (Ministry of Health 1961). Although the Butler Committee, the Glancy Committee, and the Secretary of State for Health have urged regions to build regional security units, and in spite of protected funding, no substantial developments have taken place yet. Perhaps this is related to a misunderstanding of staff attitudes on the one hand, and a lack of debate about the possible development of a third service on the other. Security reorganization can use an integrated model, a parallel model, or a mixture of both. In the absence of experience it is difficult to be certain which is correct. Surely it would be a mistake to apply one blueprint to the whole country? Given the shortage of funds and the reluctance of some regions to develop security policies, perhaps the best tactic is to fall back on administrative empiricism, encourage developments by adequate funds but allow different schemes to develop in different regions so that disparate knowledge can be accumulated gradually.

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