MEDICAL PRACTICE

Contemporary Themes

Mentally abnormal prisoners on remand: I—Rejected or accepted by the NHS?

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Abstract

Increasing numbers of mentally abnormal offenders are sentenced to prison. The decision to treat or imprison them is influenced by the attitudes of consultant psychiatrists and their staff. The process whereby those decisions were made and the willingness of consultants to offer treatment were investigated. A retrospective survey of all (362) mentally abnormal men remanded to Winchester prison for psychiatric reports over the five years 1979-83 showed that one in five were rejected for treatment by the NHS consultant psychiatrist responsible for their care. Those with mental handicaps, organic brain damage, or a chronic psychotic illness rendering them unable to cope independently in the community were the most likely to be rejected. They posed the least threat to the community in terms of their criminal behaviour yet were more likely to be sentenced to imprisonment. Such subjects were commonly described by consultants as too disturbed or potentially dangerous to be admitted to hospital or as criminals and unsuitable for treatment. Consultants in mental hospitals were most likely and those in district general hospitals and academic units least likely to accept prisoners.

The fact that many mentally ill and mentally handicapped patients can receive adequate care and treatment only on reception into prison raises serious questions about the adequacy of current management policies and the range of facilities provided by regional health authorities.

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Introduction

It has been said that there are three types of consultant psychiatrist responsible for mentally abnormal offenders in a catchment area: those who never go to assess the offenders in prison, those who go and take their fee but never take a patient, and those who go and take patients. Perhaps this anecdote reflects the increasing frustrations of prison staff, who perceive a growing burden of mentally abnormal prisoners,[1] which is probably in direct proportion to the rising population in prisons.[2] Concern has inevitably been expressed over the willingness of NHS psychiatric hospitals to admit mentally abnormal offenders,[3,4] especially on hospital orders from the courts.[5] Offers of treatment made to the court when it passes sentence are influenced by the diagnosis and course of the prisoner's illness and the attitude of the consultant psychiatrists and their ward staff towards mentally abnormal offenders.[6-8]

I examined the process whereby the decision to offer treatment was made and the extent to which NHS psychiatrists were prepared to recommend to the court that men on remand should be admitted to hospital for treatment. I aimed the study at eliciting the proportion of mentally ill or mentally subnormal prisoners on remand accepted for treatment or rejected by their consultant, how they were rejected, and the reasons given for rejection.

Subjects and methods

I carried out a retrospective survey of mentally abnormal men remanded to Winchester prison over the five years 1979-83. This local prison had a population of about 400 sentenced prisoners but also received about 2000 unsentenced men a year who had been remanded into custody from magistrates' and crown courts over a wide area of southern, central, and western England. The prison hospital received men transferred from Reading, Oxford, and Dorchester prisons, which did not have facilities to treat seriously disturbed men for long periods or to prepare psychiatric reports for the court. Thus Winchester prison acted as a regional resource centre and was staffed by three full time medical officers, two half time NHS consultant psychiatrists, and two visiting senior registrars in forensic psychiatry.

The sample included all unsentenced men remanded during the five years for reports on their state of mind and health or their fitness to plead. Men involved in civil cases (contempt of court) and those given voluntary reports (not requested by the courts but offered by the prison doctors) were excluded. Only men with primary diagnoses of mental illness or subnormality according to the criteria of the Mental Health Act 1959 were included; these criteria were also applied in the last year of the survey, which was partly covered by the new Act of 1983. Men with psychopathic disorders, alcoholism, drug dependence, personality disorders, epilepsy, or sexual perversion were included only if mental illness or subnormality was diagnosed in addition.

I diagnosed the men's conditions according to the International Classification of Diseases' by reviewing hospital case notes and reports to the court. I based the final diagnosis on the prison doctor's report rather than that of the psychiatrists for the catchment area. Three cases in which I and the prison doctor disagreed on the diagnosis were excluded.

I completed a check list developed specifically for the survey for each man every time he was remanded to the prison over the five years. It recorded demographic and diagnostic data, the most serious charge, the conviction and sentence, and data on the man's social circumstances at the time of reception into prison. In addition, data on the response of the consultant psychiatrist for the catchment area, and the final recommendations to the court by him and the prison doctor were included. The final outcome at court was verified from the prison's "nominal" card to check for any last minute offers of treatment that might not have been recorded. Rejection of a remanded prisoner by his consultant was conservatively defined as having occurred when written records of the prison doctor showed that the consultant had refused or failed to offer any form of treatment after the man had appeared in court and that, in the doctor's opinion, treatment was the most suitable recommendation. The catchment area was determined by the man's place of residence, his last admission to hospital, or the location of his offence.

Results

Altogether 362 men who met the criteria for admission to the study were remanded over the five years. Hospital files were available for 334. Of the 28 missing files eight had been sent to prisons elsewhere (where the men were currently serving a sentence) and the rest could not be traced. Copies of the reports to the court (all of which were available) did not suggest that these 28 men differed appreciably from the rest of the sample in terms of diagnosis or recommended treatment or that the absence of their files biased my findings.

DIAGNOSES

Two hundred and twenty nine of the 334 men were in the age range 20-39. Table I shows that most of them had schizophrenia. Many had a chronic illness and were well known to hospitals in their catchment area. But some had not been admitted to hospital or were in an acute stage of a relapsing illness. Thirty four were of subnormal intelligence. In 17, for whom data were available, the mean full scale intelligence quotient was 67 (range 53-75). The other 17 had at some time been under the care of a consultant in mental handicap and most were in the mild or borderline range of subnormality. All subjects with depressive illness had psychotic symptoms, several with paranoid features. Two subjects had received emergency electroconvulsive treatment during their remand. Two subjects had presenile dementia; one had multi-infarct dementia; one had Alzheimer's disease, and one had Huntington's chorea. Ten subjects had post-traumatic brain damage, six after motorcycle accidents, three after postviral meningitis, and one after a subarachnoid haemorrhage. One man had deteriorating normal pressure hydrocephalus and epilepsy that was poorly controlled.

PRISONERS ON REMAND

Of the 334 men, 291 were remanded once, 35 twice, six three times, one four times, and one five times, totalling 388 separate remands over the five years. Of the final reports, 222 were prepared by consultant psychiatrists, 154 by prison medical officers, and 12 by senior registrars. Two hundred and two men had been remanded direct to Winchester prison, and 97 had been transferred from Oxford prison, 45 from Dorchester, and 44 from Reading.

As expected, most charges (122) were burglaries and theft (table II). Many of these, however, were minor incidents involving hungry and destitute men, such as shoplifting food and stealing pies and bottles of milk from private houses. Twenty eight men were charged with fraud and deception: virtually all of these had eaten meals in restaurants without the money to pay or had been caught after bilking taxi fares. The second most common charge was damage to property (84 cases). Although there were a few bizarre attacks on public property or that of their neighbour by men with acute psychosis, most of those charged had broken windows. Of 73 offences of other violence, most constituted minor assaults, often on the police who had attempted to move the man on when he had been found asleep or acting bizarrely in a public place. Only 32 men had committed offences primarily for gain or in a professional context. Thirty were described as having been drunk at the time of the offence and nine as intoxicated with drugs, but this was probably an underestimate. One hundred and six offences seemed from the case notes to have been committed primarily to obtain food or shelter. In 197 cases the men were of no fixed abode on arrival in prison, and in 136 cases the prison doctors considered the men to be incapable of caring for themselves independently in the community at the time of their arrest.

After exclusion of subjects with organic brain damage, dementia, and subnormality 258 of the 334 men showed florid acute or acute on chronic symptoms of mental illness during admission to the prison hospital. Whether these symptoms had been present at the time of the offence or had developed while the man was on remand could not always be established. Histories obtained from the consultant for the catchment area showed that many of the men had been difficult to manage. Eighty two of the men had a history of absconding from hospital or of persistently failing to attend all outpatient appointments, or both, and a further 41 could not be relied on to comply with their treatment. In addition, 57 had a history of violence or seriously disruptive behaviour while in a NHS psychiatric hospital.

TABLE I—*Conditions diagnosed by prison doctor in 334 prisoners, 1979-83*

Primary diagnosis	No	Additional diagnosis	No
Schizophrenia	242	Alcohol dependence	32
Schizoaffective disorder	8	Personality disorder	22
Paranoid psychosis	3	Drug abuse or dependence	20
Mania	23	Epilepsy	5
Depression	8	Other	21
Organic brain damage	11	None	234
Dementia	5		
Mental handicap	34		

TABLE II—*Most serious charge in 388 cases of remand, 1979-83*

Charge	No of cases	Charge	No of cases
Manslaughter	15	Related to drugs	1
Other violence	73	Drunkenness	2
Rape	8	Vagrancy and public order offences	20
Other sex offence	7	Fraud and deception	28
Arson	18	Theft and burglary	122
Damage to property	84	Other	10

ASSESSMENT AND RECOMMENDATIONS

In 348 cases the prison doctor initially considered treatment in hospital to be the most suitable recommendation to make to the court, but the consultant for the catchment area was contacted to discuss this in all but 33 cases. In the 45 cases in which treatment was not finally recommended the prison doctor believed either that the defendant had not shown symptoms of a previously diagnosed mental illness at the time of the offence or while on remand, or that despite a low intelligence quotient admission to hospital was unsuitable, or, more commonly, he had failed to obtain a bed for the defendant before.

Consultants assessed the subjects themselves in 231 cases and in 18 cases sent junior doctors. They discussed the case over the telephone in 88 cases and by correspondence alone in 15 cases. In only three cases were all overtures from the prison doctor ignored. A slow response from the consultant in 85 cases meant that the prison doctor had to request an extension of the period of remand to complete the assessment.

Table III shows the final recommendations; two thirds of all prisoners on remand received some offer of treatment from their psychiatrist, 149 on a hospital order. Offering an outpatient appointment or informal admission to hospital (42 cases) was at best unrealistic as few of those on remand were likely to go independently to the hospital from the court.

REJECTION BY THE NHS

Seventy seven men on remand on 83 occasions were rejected for any sort of treatment by NHS psychiatrists; table IV shows the reasons given for

refusal. In several cases the consultant gave more than one reason, and I then chose the official or administrative reason disclosed. In most cases the consultants did not consider admission to hospital for treatment to be suitable, sometimes stating that in their opinion the subject was a criminal and should be punished accordingly. Secure beds were not available for the mentally handicapped in any region during the study period. Several men who were mentally ill could not be placed in one region because it did not have any secure beds despite the official claim that it could cope without a secure unit and cater for all patients except those needing special hospital security. In 10 cases in which the diagnosis was disputed the prison doctor elicited symptoms of psychotic illness whereas the consultant for the catchment area diagnosed a personality disorder or insisted that the subject was feigning illness. In three other such cases the consultant insisted that the man was a psychopath and that his subnormal intelligence was irrelevant. In the final case the prison doctor, using one test, regarded the man's intelligence quotient as being in the range of mild mental handicap whereas the consultant, using another test, regarded it as being at the bottom of the normal range. In most cases in which admission was refused by the staff correspondence or a note by the prison doctor after a telephone conversation recorded that nurses were unwilling to accept the prisoner. I could not always ascertain, however, whether the nurses had actually been consulted.

TABLE III—*Final recommendation for 388 men on remand, 1979-83*

Recommendation	No
Hospital order (section 60, Criminal Procedures (Insanity) Act)	135
Hospital order, special hospital (section 60, Criminal Procedures (Insanity) Act)	19
Unfit to plead (section 5, Criminal Procedures (Insanity) Act)	9
Unfit to plead, special hospital (section 5, Criminal Procedures (Insanity) Act)	4
Transfer for treatment (section 73)	5
Probation order, inpatient (section 3, Powers of Criminal Courts Act)	30
Probation order, outpatient (section 3, Powers of Criminal Courts Act)	12
Informal admission to hospital	12
Outpatient attendance	30
Civil admission for observation (section 25)	1
Deportation	3
No recommendation	45
Rejection of treatment	83

TABLE IV—*Reasons for rejecting treatment in 83 cases, 1979-83*

Reason	No of cases	Reason	No of cases
Treatment not appropriate	23	Beds full	2
No secure beds	16	Hospital strike	2
Diagnosis disputed	14	Insufficient nurses	1
Admission refused by staff	12	Industrial dispute	1
Failure or refusal of consultant to visit	8	Patient blacklisted	1
Blocked by committee	3		

TABLE V—*Comparison of characteristics of men not recommended for treatment by prison doctors, 1979-83*

	No (%) of men		Significance	
	Not recommended (n=45)	Recommended (n=343)	χ^2	p Value
Symptom free	38 (84)	92 (27)	56·7	≤0·001
Absconder or refused treatment	17 (38)	64 (19)	8·8	0·003
With previous remand	25 (56)	100 (29)	12·69	≤0·001
Subnormal	8 (18)	31 (9)	3·36	0·06
Committed crime for gain	13 (29)	19 (5)	28·6	≤0·001
Sentenced to prison	22 (49)	61 (18)	22·8	≤0·001

A multidisciplinary committee on admissions kept three men on remand out of one hospital, and six other subjects were excluded from receiving necessary treatment as a result of shortages of beds and staff, strikes, and a union dispute. One patient had been blacklisted by his hospital for bad behaviour and would not be accepted by any other in the region.

In not recommending admission for treatment the prison doctors distinguished a group of subjects who were unlikely to comply and whose antecedents suggested that admission was probably unwarranted (table V). In contrast, table VI shows that the rejected men comprised a chronically handicapped group, as was reflected in their criminal behaviour and social

TABLE VI—*Comparison of psychiatric and social characteristics of men rejected for treatment by psychiatrist and remaining men, 1979-83*

	No (%) of men		Significance*	
	Rejected (n=83)	Not rejected (n=305)	χ^2	p Value
Schizophrenia	52 (63)	245 (80)	11·35	0·001
Subnormal	16 (19)	23 (7)	9·93	0·001
With organic brain damage	6 (7)	7 (2)	4·90	0·06
With psychotic symptoms	43 (52)	215 (70)	10·22	0·001
Psychopathy diagnosed by consultant	42 (51)	52 (17)	40·01	≤0·001
Of no fixed abode	52 (63)	145 (48)	5·95	0·01
Unable to support self	42 (51)	94 (31)	11·21	0·001
With previous remand	35 (42)	90 (30)	4·78	0·03
Violent and disruptive	26 (31)	31 (10)	23·31	≤0·001
Vagrant	8 (10)	12 (4)	4·34	0·04
Committed burglary or theft	36 (43)	86 (28)	6·97	0·01
Committed crime for food or shelter	33 (40)	73 (24)	8·22	0·004
Sentenced to prison	44 (53)	39 (13)	62·7	≤0·001
Served sentence on remand	11 (13)	11 (4)	11·35	0·001

inadequacy. Yet their consultant was more likely to diagnose psychopathic behaviour or personality disorders and describe them as previously disruptive and potentially violent.

Not recommending or rejecting prisoners for treatment significantly increased their chances of being sentenced to prison. A quarter of these rejected prisoners were released straight back into the community, having served their sentence while on remand.

Discussion

At a conservative estimate one in five prisoners on remand were rejected for treatment. These generally were the men most in need of care and exhibiting the severest degree of social impairment, which is a cause for great concern. Furthermore, the findings support those of another study suggesting that these men are a subgroup of mentally handicapped subjects no longer admitted to NHS hospitals when they exhibit deviant behaviour.[5] Probation orders were no more likely for this group (who were the most likely to be rejected for treatment), indicating that responsibility for care and supervision of some subjects with chronic psychosis has now been shifted from the mental health and social services to the probation service on the grounds of criminal behaviour.

I found that the rejected men posed the least threat to the community in terms of their criminal behaviour. Many lived essentially as tramps for periods of their lives and their crimes allowed them to survive in the community or forced others to impose a much needed period of care and asylum. High mobility and chaos in their lives reduced their chances of acceptance in aftercare hostels and their regular receipt of benefit from the Department of Health and Social Security—a common factor in their recidivism. Only a small proportion warranted an opinion from a special hospital or a consultant in a secure unit, yet consultants for the catchment area often described them as too disturbed or potentially dangerous for their units. Had a proportion been labelled as psychopaths or as having personality disorders as a convenient excuse to exclude them? The tolerance threshold of some psychiatric units for any disturbed behaviour must now be questioned.

On the other hand, the worst states of psychotic disturbance could be observed in a few subjects, particularly when the local psychiatric hospital had failed to act to prevent their deterioration in the community and the police had been forced to intervene. Yet prison doctors were occasionally faced with absurd dilemmas over treatment: if the men were left untreated the consultant or nurses would say that they were too disturbed for admission, and if treated successfully that they no longer needed to be admitted or, alternatively, that no evidence of mental illness could be found.

Perhaps it was their need for long term care rather than short term treatment that rendered these men so unattractive. Consultants from older mental hospitals were more likley to accept prisoners, particularly on hospital orders, than were those from district general

hospitals and prestigious academic units, especially those espousing a community based rather than a hospital based approach. Perhaps this was reflected in the rejection of one man by a consultant on the grounds that his unit offered only sociocultural therapy.

The development of community based programmes has been followed by a realisation that there are limitations on the type of patients who can be cared for. An inevitable bias exists towards white, middle class, middle aged patients and women who have conditions that respond to treatment and are easy to manage, such as neurotic, affective, and eating disorders. In the United States it is precisely people at the opposite end of the demographic spectrum and those showing criminal and aggressive behaviour who are admitted to the state mental hospitals.[10]

The position is unlikely to alter without large changes in the attitudes of staff, management policies, and provision of adequate resources. Whether management in the style advocated by Griffiths will offer better funding to those units prepared to provide a comprehensive service for their catchment area remains to be seen. Consensus management by multidisciplinary teams has done little to benefit mentally abnormal offenders and merely increased the chances that admission will be vetoed by at least one member of the staff team. Hospital staff clearly do not consider the management of difficult patients to be a part of their responsibility. In addition, the shortage of nurses with the necessary skills to cope with such patients and escalating legalistic interference in their treatment and management[11] have further combined to discourage admission and reduce morale. Nurses accompanied consultants increasingly during the years studied, but their influence on decisions could not be determined and needs further study. Junior trainees visiting instead of their consultant, however, not only showed little understanding of the needs or workings of the court but did not accept patients.

Under section 39 of the Mental Health Act 1983 courts are empowered to obtain information personally from the employers of consultants in the catchment area when a bed is not forthcoming. Yet without comprehensive facilities coercion to admit mentally abnormal offenders is not enough. Many rejected men fell through the yawning gap between open wards and community programmes on the one hand and the regional secure units and special hospitals on the other. Some regions have deliberately run down their locked wards, and although conditions of security are not suitable for most subjects, it is somewhat unrealistic to try to manage all acutely disturbed patients in an open unit. Similarly, management policies for providing services are often inadequate and unsuitable for chronically handicapped, rootless subjects who are unwilling or unable to accept what is offered. After their release into the community many prisoners are prone to behave in exactly the same deviant manner as before, and few are able to break out of this vicious cycle.

If patients continue to be too mad to be admitted to mental hospitals yet not sufficiently bad for long term imprisonment where are they to go? Rejecting them will not make them disappear; it merely displaces them temporarily into another institution that does not have the luxury of being able to refuse them. During this study I was distressed to see how psychotic and helpless men were ignored by the hospital responsible for their care. Men with chronic schizophrenia who hurl bricks through plate glass windows and wait for the police to arrive are trying to tell us something. An enterprising man with schizophrenia, recently discharged against his will, actually sought out the offices of the regional health authority in a city and threw a brick through a window to complain about his treatment. Another, hearing that he had received a conditional discharge back into the community, showed his sheer desperation by setting fire to his clothing in the court in a pathetic attempt to force someone to send him back to an institution.

If such patients are rejected by hospitals it is unrealistic to expect them to survive in the community and inevitable that without treatment, supervision, and accommodation they will come to the attention of the police. By finding their way into prison many are obtaining the only care and treatment that anyone is prepared to offer them.

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What efforts should be made to control or channel the sexual drive of patients in psychiatric hospitals?

In men the sexual drive can be dampened with benperidol or cyproterone acetate. I have used these drugs only with sexual offenders and only with the patient's informed consent. Such treatment has usually been combined with psychological treatment by a clinical psychologist, the broad aim being to help the patient to recognise when he is in danger of reoffending and to be on guard. Some psychiatrists have used implants of oestrogen in men to give a prolonged antiandrogen effect. I have no personal experience of this. Under the 1983 Mental Health Act such implants are legal only with the patient's consent *and* a second opinion.

I do not know of any medication used to reduce sexual drive in women. Such treatment might well raise ethical problems because female sexuality seldom causes a patient to be in trouble with the law. Is it right to try to abolish a natural urge merely to make patients more "manageable"? Nursing management is important in treating female hypersexuality in psychiatric hospitals as it does cause problems in the artificial environment of single sex wards. Lesbian relationships between patients do occur and, to a large extent, the staff turn a blind eye unless they cause jealousy and quarrels, when counselling will have to take place. Similarly, women patients can develop an attraction towards members of staff. This may cause management difficulties if the staff are unaware of the fact. Such patients will often attack or try to provoke that member of staff in order to procure the physical contact needed to restrain them.

Sexual frustration is inevitable in single sex wards. Although the sexes mix socially, there is no opportunity for sexual intercourse to take place because of supervision by staff. Masturbation is then the only outlet. Some psychiatrists have tried the use of vibrators to help lessen the sexual frustration of female psychiatric patients. Of course the use of such appliances and the practise of masturbation must be carried out in private. This is even more difficult where patients sleep in dormitories. Some patients deliberately do something that results in their being placed in seclusion in order to have the opportunity to masturbate uninterrupted.

All psychiatrists should be aware of the problems that normal sexuality and hypersexuality of psychiatric patients cause. On humanitarian grounds patients should be afforded privacy to practise masturbation when they need to do so.

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