Interim report of the Committee on Mentally Abnormal Offenders.

HOME OFFICE

DEPARTMENT OF HEALTH
AND SOCIAL SECURITY

Interim Report of the Committee on Mentally Abnormal Offenders

Presented to Parliament by the Secretary of State for the Home Department
and the Secretary of State for Social Services
by Command of Her Majesty
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Committee on Mentally Abnormal Offenders

INTERIM REPORT

To the Secretary of State for the Home Department and the Secretary of State for Social Services.

1. We have the honour to submit an Interim Report.

2. The Committee was set up on 21 September 1972 with the following terms of reference:—

(a) To consider to what extent and on what criteria the law should recognise mental disorder or abnormality in a person accused of a criminal offence as a factor affecting his liability to be tried or convicted, and his disposal;

(b) To consider what, if any, changes are necessary in the powers, procedure and facilities relating to the provision of appropriate treatment, in prison, hospital or the community, for offenders suffering from mental disorder or abnormality, and to their discharge and aftercare; and to make recommendations.

We have held 18 meetings and have received written and oral evidence from a large number of witnesses. We have also visited numerous institutions, including Parkhurst and Grendon prisons, Broadmoor, Rampton and Moss Side special hospitals, and a number of National Health Service psychiatric hospitals. Other visits are in prospect. We should like to say how much we have appreciated the evidence we have been given and the willingness of those in the institutions we have visited to show us round and talk to us about the problems.

3. We are now formulating the recommendations we shall put forward in our Report. In the meantime, there is one matter on which we think it desirable to present our views without delay: the need for regional secure hospital units in the National Health Service. We are aware that the Department of Health and Social Security is considering this question at the present time and that an internal Departmental Working Party, which has given evidence to us, has recently prepared a consultative document which, indeed, we have had the advantage of seeing. We consider it important that while this subject is under consideration the Secretaries of State should be aware of the Committee's views on this subject and of the importance we attach to the provision of these units.

4. At present, psychiatric patients—non-offenders and offenders alike—may be accommodated either in a National Health Service hospital for the mentally ill or mentally handicapped or in one of the three hospitals for persons who, in the opinion of the Secretary of State, require treatment under conditions of special security on account of their dangerous, violent or criminal propensities*. These three "special hospitals", which are provided and managed directly by the Department of Health and Social Security, serve the whole of England and Wales, and accommodate some 2,350 patients. At the outset of our inquiry we were made aware of the

* These criteria are laid down in section 40 of the National Health Service Reorganisation Act, 1973.

extreme pressure on this secure accommodation, and the need to provide relief in one way or another. On our visits to the special hospitals it is not too much to say that we have been astonished and shocked at the overcrowding, particularly in Broadmoor, where in some wards the beds, in rows right across the room, are no more than eighteen inches apart. In these dormitories, the patients, who are by definition likely to be detained for long periods (although not throughout in these same wards) and are all suffering from mental disorder, can obviously have no privacy, and as there is no cupboard room they are living out of suitcases. We note that the Parliamentary Estimates Committee reported that their Sub-Committee had been "appalled" at the conditions when they visited Broadmoor in 1967–68.* They paid a tribute to the work of the staff in these adverse conditions, which we whole-heartedly endorse. The conditions are in no way the fault of the staff, but arise directly from the overcrowding. Obviously the position is no better than when the Parliamentary Committee reported. A fourth special hospital is being planned and work on an advance unit of 70 beds should be completed later this year. However, even when the new hospital is ready there will be less than 100 extra places for male patients because Broadmoor is to be re-built and reduced in size.

5. Between the overcrowded but secure special hospitals and the National Health Service hospitals providing no security there is, to borrow a phrase from a memorandum of evidence of the British Society for the Study of Mental Subnormality, a "yawning gap". The many other witnesses who have drawn attention to this lack of intermediate provision and the resultant problems include:—

The Justices' Clerks' Society
The Confederation of Health Service Employees
The Chief and Principal Nursing Officers (Special Hospitals)
The National Association for Mental Health
The Oxford Regional Hospital Board
The Royal College of Psychiatrists
The Consultant Forensic Psychiatrists
Individual consultant psychiatrists
The Institute of Professional Civil Servants
Representatives of the Prison Medical Service
Representatives of the Probation and After-Care Service
The Royal College of Nursing
The Parole Board
HM Judges
The TUC
The Howard League
The National Council for Civil Liberties
The Magistrates' Association
Cambridge City Magistrates
The Board of Visitors, Ashford Remand Centre
The Broadmoor Medical Advisory Committee
The British Association of Social Workers.

* Second Report from the Estimates Committee, Session 1967–68, paragraphs 12–13.

There are various reasons why these problems have developed in recent years and are becoming more acute, particularly in relation to offenders. The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954–1957* said in paragraph 519 of their Report that dangerous patients should be specially accommodated in a few hospitals having suitable facilities for their treatment and custody, leaving other hospitals free to dispense with restrictive measures to the greatest possible extent; but such special accommodation has not been provided. Meanwhile, the development of treatment in "open" conditions has made National Health Service hospitals increasingly reluctant to accept offenders: the number of hospital orders made by the courts has fallen year by year from a peak of 1,259 in 1966 to 924 in 1972. Custodial requirements cannot be reconciled with an "open door" therapeutic policy†, and when offender patients abscond much time and trouble are involved in effecting their return. The nursing staff dislike the custodial role, and their numbers are insufficient to deal with dangerous patients. They see it as the proper function of the prisons and special hospitals to cope with these people. There is also concern that offenders may harm or pilfer from non-offender patients. In the result, many psychiatric hospitals are unwilling to accept offender patients and do not make arrangements to provide for them. Even when offender patients have been accepted in National Health Service hospitals it may be found that they cannot be contained satisfactorily and have to be transferred to the already crowded special hospitals. The special hospitals can do very little to help themselves. They are bound to accept dangerous psychiatric cases from the open hospitals but have found it increasingly difficult to transfer patients to the psychiatric hospitals when they are no longer dangerous. Two consequences follow from this: one is that many patients in the special hospitals need not be there for reasons of security; and the special hospitals have to refuse admission to cases they could appropriately accept if they had room.

6. These problems rebound on the courts and the prisons and they are likely to increase as treatment of psychiatric cases is developed in district general hospitals. The courts are experiencing more and more difficulty in dealing with mentally abnormal offenders who need psychiatric treatment but who must be kept in secure conditions. Even where a hospital may be willing to accept such patients, judges are often reluctant to send offenders to "open door" hospitals because of the ease with which they can abscond and also because of the possibility that if they are found to be uncooperative and therefore untreatable they may soon be discharged into the community. On the other hand these offenders may fail to satisfy the fairly stringent criteria for admission to a special hospital.‡ The result is that the courts may be obliged to impose a prison sentence as the only way out of the dilemma—an unsatisfactory outcome from almost every point of view.

7. Evidence received from the Home Office and from members of the Prison Medical Service has indicated growing concern among those respon-

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* Cmnd. 169.

† The contradiction in aims has recently been the subject of a leading article in the British Medical Journal (23 March 1974).

‡ It is noteworthy that of 12,000 offenders remanded for medical reports in 1971 only 173 were admitted to special hospitals from the courts.

sible for the administration of the prisons about the increasing numbers of mentally abnormal offenders in the prison population. Despite overcrowding, the prisons have no choice but to accept the offenders sent by the courts, including the mentally abnormal people who are sentenced to imprisonment, for want of acceptance by a hospital. To these are added numbers of prisoners who develop psychiatric disturbance in the course of their sentence and should be transferred to a hospital if any hospital would admit them. Prisoners who have been accepted as requiring treatment in a special hospital often have to wait many months for a vacancy. Prisons in general are not equipped or staffed to treat serious mental disorder; furthermore, the presence in overcrowded prisons of seriously disordered persons gives rise to grave difficulties of control.

8. Without prejudice to other measures which may be taken, such as the provision of more special hospital places, which are likely to be required in any event, we advocate the provision, as a matter of urgency, of secure hospital units in each regional health authority area.

9. We see these units as centres for the development of forensic psychiatric services. They will fulfil a need for non-offender patients, while advancing the general cause of the "open door" policy in psychiatric hospitals by enabling the most difficult cases to be treated in more appropriate conditions; but, by reason of our terms of reference, our main concern is that the units are crucial to the greater flexibility in placement which is needed for mentally abnormal offenders, and to the early relief of the prisons and the special hospitals. We think it right that offenders and non-offenders should be treated together; they should share all the facilities of the units, without any distinction being made between them. At present the services dealing with the mentally abnormal offender are fragmented, and we have received a great volume of evidence urging closer co-operation among them and the more effective use of the scarce professional resources. By focussing the activities and expertise of the various professions in these centres much can be achieved towards these ends. The offender in need of treatment will be better served, not least because of improved assessment, which will also be of immense value to the court in deciding what to do with him; and, besides providing reference points to which the probation and after-care service will be able to turn for the advice which they have told us they often need, the centres will have an essential role in training and research, for which reason they should be closely associated with the universities.

10. Our final Report is likely to have more to say about the need for forensic psychiatric services and the scope of their functions, of which the provision of assessments for the courts will undoubtedly be one of the most important. These assessments will be carried out both on an outpatient basis and during remand in custody in the secure unit. Witnesses closely connected with the courts—magistrates, barristers and the probation and after-care service—have stressed that the courts should always be made aware of mental abnormality in the offenders appearing before them, and that, to this end, they should have ready access to adequate assessments, including, where appropriate, psychiatric, psychological and social reports. In general, the present arrangements for obtaining psychiatric reports are unsatisfactory for a variety of reasons, except in certain favoured

places, such as, for example, where appointments of joint forensic consultants have been made between the prison system and the health service. We are strongly in favour of increasing the number of these appointments, as we are of the development of forensic psychiatry generally.

11. It would obviously be in the interests of the most effective use of scarce resources that these assessment services which, like the secure units we are proposing, should be located accessibly in towns, should be integrated wherever possible with the secure units, although assessment centres may also be required in some places where there are no such units.

12. It is our intention that the secure units should be therapeutically orientated, and have the use of workshops and adequate recreational areas. Various kinds of work should be available: all should be as interesting and as relevant to normal industrial employment as possible, and, so far as can be contrived, the conditions under which the work is done should be those of the outside industrial world. For some longer stay patients a planned programme should contain measures for training in various fields up to a level which industry would accept upon the patient's discharge. Educational facilities should also be available, especially for the not insignificant number of illiterates or near-illiterates. Besides relieving the general psychiatric hospitals and special hospitals, they would receive patients on transfer from prison and admit offenders directly committed by the courts. It should be their purpose to satisfy the needs of the regional areas in which they are placed, with the advantage of being reasonably near to the patient's home and family; but they should not be precluded from accepting cases from other regional areas if this would be helpful in particular circumstances. Units of this kind have sometimes been described as "medium security units", but we think this title misleading; it would be difficult to define what "medium security" means, and ambiguity of intention would create uncertainties and difficulties for the staff. The units need not be as secure as the special hospitals, but they must be adequately secure for the safe containment of the people they would be intended to accommodate. These should not, in our view, include aggressive psychopaths or any patients who would be an immediate danger to the public if at large. The necessary degree of security should be achieved partly by a high ratio of staff to patients (see paragraph 18 below), partly by the regime and partly by the design and physical characteristics of the buildings.

13. It is not easy to estimate the total number of secure places required, but after careful consideration we would put the figure at around 2,000 beds. The DHSS Working Party, referred to in paragraph 3 above, has estimated that about 1,000 places are required for the accommodation of patients currently in NHS hospitals who need more secure provision than the hospitals can now provide. To these must be added the people at present in the prisons and special hospitals who could more appropriately be placed in the secure units and those remanded to the units for assessment before trial. We were informed in evidence that a survey among prison medical officers produced an estimate that some 500 patients in prison would be better placed in hospitals outside the penal system, including 127 who, in the opinion of the prison medical officers, should be in the special hospitals. We have also had evidence, including evidence from the special

hospitals, that some 450 to 500 patients in the special hospitals could with safety be transferred into regional secure units, the precise number depending on the degree of security to be provided in the units. The hidden demand from the prisons and the special hospitals evidently presents a need for some 900 places, apart from the need to provide for in-patient assessments for the courts. Given that the Prison Medical Service at present provides 12,000 reports a year for the courts, there is likely to be an additional requirement for several hundreds of beds for in-patient assessments, even though many assessments for the courts will continue to be made during remands to prison or on bail. Bearing in mind that the demand altogether is increasing, it is clear that, even if one discounts these estimates to some extent, an initial target of 2,000 secure places is by no means generous to provide for the needs of the National Health Service, the special hospitals and the prisons, and for in-patient assessments for the courts.

14. As to the location of the units, in our view it is absolutely essential that they should be situated in *centres of population*, and closely accessible to other medical, especially diagnostic facilities, the courts and Departments of Psychiatry (and eventually Departments of Forensic Psychiatry) of universities. They must also be accessible to the community they serve, not only for ease of contact between the patients and their families, which is of great importance, but also because we envisage, as we have already mentioned, that out-patient facilities should be associated with these units, both for purposes of post-discharge supervision and treatment (and ready re-admission if necessary) and to provide assessments for the courts.

15. We recognise that there may be practical difficulties in placing secure units on district general hospital sites, and no doubt the practicability of doing so will depend on many factors, especially the characteristics of the particular sites. However, where it may be possible to provide a secure unit without prejudice to the general hospital, the advantages of ready recourse to the hospital facilities are so obvious that we think this solution should be considered.

16. We have received conflicting evidence on the question of the ideal size for the units, ranging from units of 30–50 beds up to units of "at least 250 beds". Where the situation of the units enables them to share common services and other facilities with an existing hospital, we think that a range of 50–100 in-patient places would be about right; but where the sharing of facilities is not possible the units would need to be considerably larger, probably about 200 beds, to justify the expense of equipping them with self-contained resources, including, particularly, workshops and recreational facilities, to which we have alluded in paragraph 12 above.

17. There is a risk that when this accommodation has been provided it may gradually be diverted from its intended purposes by the accumulation of more or less permanent residents who are not acceptable elsewhere or fit for discharge. Every effort should be made to prevent the use of the units as permanent accommodation for difficult long-stay patients. The duration of stay should in every case be minimised, and there should be regular reviews of cases needing to stay for a considerable time.

18. In the interests of assessment and treatment, as well as security to which we referred in paragraph 12, a high ratio of staff to patients is required. We recognise that there is a shortage of all kinds of professional staff, and that it will not be easy to find sufficient suitable people, but this is absolutely necessary and special measures may have to be taken. A ratio of one nurse to one patient must be regarded as a very minimum. In some comparable units on the Continent the ratio is substantially higher. The nursing complement must be of high quality, with a high proportion of specially trained staff. For the purpose of spreading expertise it should be possible for staff of the special hospitals and the regional units to be interchanged, at least on a temporary basis. A period of work in a secure unit should be regarded as part of the career pattern of all junior psychiatrists. We consider it desirable that a permanent social work staff be developed in each unit to liaise with social workers outside. The social work staff should be numerically sufficient to allow for the supervision of trainees who would have much to gain from the experience of working in a secure unit.

19. Subject to considerations of safety, it will no doubt be possible to discharge some patients from secure units direct to local authority care or into the community. However, although the scale of provision of community social services varies from place to place, in general the services that exist are as yet insufficient for the tasks they have to do and it would be unwise to expect too much of them for some time to come. If secure units are provided as quickly as the need requires, there will be many patients fit to be discharged from them, whom the community services will be unable to supervise but who could appropriately be cared for, and their treatment continued, in other psychiatric hospitals. It is hoped that the Department of Health and Social Security will emphasise to psychiatric hospitals and psychiatric units within general hospitals the important part that they will be expected to play in the continued treatment and rehabilitation of offender patients who do not require secure conditions.

20. In conclusion, we emphasise the urgency of the provision of secure units, which is indeed the reason for presenting this Interim Report, as we have explained. The provision of such units is by no means a new idea. The effect on the special hospitals of developments in the National Health Service was recognised in the Report of a Working Party on the Special Hospitals set up by the then Ministry of Health, which recommended as long ago as February 1961 that "regional hospital boards should arrange their psychiatric services so as to ensure that there is a variety of types of hospital unit, including some secure units . . .". The Ministry issued a memorandum to Regional Hospital Boards in July 1961 giving advice on the implementation of that recommendation and others in the Report, but not a single secure unit materialised.

21. One reason may have been the lack of any special financial provision. We recognise the difficulties for the health authorities in the regions in giving priority, within limited budgets, to expenditure on secure units for the treatment of psychiatric patients, and especially for patients who have committeed offences, when there are so many other pressing needs to be satisfied. We therefore propose, and we regard this as of the greatest

importance, that the provision of the regional secure units should be financed by a direct allocation of central Government funds to the regional health authorities for this specific purpose. In addition to this special financial arrangement, we urge that in all other respects the greatest possible encouragement and help should be given by the central Government to the responsible regional health authorities, to ensure that the units will become available in the shortest possible time.

The Right Honourable the LORD BUTLER OF SAFFRON WALDEN, KG, CH (Chairman)

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