REPORTS AND PAMPHLETS

Report on the Work of the Prison Department. Home Office. HMSO, Cmd 6877. 1976.

•

Report on the Work of the Prison Department. Statistical Tables. Home Office. HMSO, Cmd 6884. 1976.

It is a century since the Prison Act placed a statutory obligation on the Prison Commissioners to present an annual report to the Secretary of State and Parliament; in recent years numerical facts relating to the prison population have been published in a separate volume of Statistical Tables. Together these volumes provide an account of the administration of the penal system during the previous year. To those who are familiar with bureaucratic reticence in these matters the reports provide welcome information: for others who work in the prison service, normally constrained by the Offical Secrets Acts (1911 and 1920), the reports act as a valuable mouthpiece.

The care of many individuals which was previously the responsibility of the medical profession is increasingly being delegated to 'subordinate' groups, thereby adding an intolerable burden to the work of the Prison Department; Ivan Illich termed this process 'planned patient dumping'. Thus the report acknowledges that prison has always served as a temporary refuge for the schizoid tramp, the mentally deteriorated alcoholic, and the person of low intelligence and defective personality, but it emphasizes that 'mentally ill people are entering prisons and borstals in increasing numbers, and people of previous good personality, whose offences frequently stem solely from their illness are now being refused admission to psychiatric hospitals and are instead being received and detained in establishments'. And later: 'the prison system was then (late 1976) holding some hundreds of offenders who are in need of, and capable of gaining benefit from, psychiatric hospital care, management and treatment in psychiatric hospital.' The report provides a timely rejoinder to those who refuse to provide facilities themselves and yet criticize the standard of health care in prisons: 'apart from the inhumane aspects of committing mentally disordered offenders to prisons and borstals, it is not possible to provide many of these unfortunates with the medical and nursing care their condition requires whilst they are in custody.'

Medical services to prisoners should be considered in relation to more general information on penal establishments. Overcrowding was greatest at local prisons, and the prison population reached a new peak of 42,419 in October 1976; the greatest rise was amongst sentenced young prisoners who increased by 22 per cent in one year. This growth in population was related to two processes: more were received into prison under sentence, and there was an increase in the average effective sentence length following the introduction of suspended sentences in the Criminal Justice Act of 1967 (the average length of sentence in adult males was 40 per cent longer in the years immediately following 1968 than in the preceding years). The processes which increased the prison population were mitigated by a reduction in the average proportion of sentences which were served in prison. However, the overall effect of these changes was that nearly 40 per cent of inmates were sleeping two or three in a cell, and by the end of 1976 there were 1,220 male prisoners serving life sentences. Although there was a minimum improvement in staffing the officer-inmate ratio (1:2·89) was still lower than it had been in 1975, and the prison service was also required to reduce overtime costs as well as expenditure on prison building. (Some would argue that since prisons do not protect society but merely damage those who are incarcerated they should not be rebuilt or expanded but emptied.)

Twelve per cent of the prison population are awaiting trial or sentence, and of these about a quarter are remanded solely for medical reports. The number remanded into custody for court reports (which are almost exclusively psychiatric) reached a peak in 1970 and has fallen since. For the years 1955–59 an annual mean of 8·7 per cent of those remanded were recommended for psychiatric treatment by the courts, and the proportion increased to 13·7 per cent for the years 1961–64 following the implementation of the Mental Health Act (1959); however, in the last decade there has been a trend for a diminishing proportion of those remanded to receive a treatment recommendation, so that in 1976 it was 10·5 per cent. The greatest reduction has been in Part V MHA orders made in the categories 'subnormality' and 'severe subnormality', which are numerically only a third of what they were in the early 1960s; similarly orders made in the category 'psychopathic disorder' have been reduced by more than 50 per cent in the last ten years (in 1976, 871 orders were made under section 60, MHA: subnormality, 90; severe subnormality, 19; psychopathic disorder, 43). The numbers found 'unfit to plead' and 'acquitted on the grounds of insanity' remain stable at about 30 and 5 per annum respectively.

It is notable that following the implementation of the Mental Health Act a majority of individuals who were made subject to sections 60/65 were admitted to regional hospitals, whereas in recent years more have been admitted directly to Special Hospitals (see Criminal Statistics. Home Office. HMSO). There has also been a reduction in the total number of restriction orders made, which has accompanied the decrease in the proportion of restricted patients who have been accepted by regional hospitals. This diversion of the more seriously disturbed patients from regional hospitals to Special Hospitals is reflected in the trend for proportionately more restricted patients to be admitted to Special Hospitals directly from courts and fewer to be admitted from regional hospitals.

The last twenty years have witnessed a dramatic increase in the number of remanded prisoners recommended for psychiatric treatment as a condition of a probation order from an annual mean of 62 for the period 1955–59 to a mean of 532 for 1965–69. However, throughout the 1970s the numbers have fallen, and in 1976 there were only 290 such recommendations. This reduction is particularly unfortunate since voluntary treatment as a probationer would appear to provide an important alternative disposal for courts who have tended to view psychiatric treatment as only possible for in-patients under Part V MHA. It is possible that these 'good-risk' cases are being bailed and thereby diverted to NHS psychiatric clinics. However, the bail facilities in the prisons (Brixton, Durham, Holloway and Risley) are under-used: they have a capacity to prepare more than 1,400 annual reports, but in 1976 they did only 268. Deficiencies in the use of Section 3, Powers of Criminal Courts Act (1973), whereby an offender can receive treatment as a condition of a probation order, appear to be due to a number of reasons: firstly, a recommendation can be made to a court for such an order to be made, but the patient may later decline to receive treatment voluntarily, or the necessary consent may not have been received from probation officer or psychiatrist; secondly, even after the court has imposed such an order many offenders never present for treatment; thirdly, the drop-out rate of those who are seen in out-patients is particularly high. These difficulties could be overcome if there were a regular review jointly between the psychiatrist and the probation officer involved with each case.

Psychiatrists are reluctant to accept mentally disordered offenders as in-patients, and the number of patients from 'forensic' sources who are treated in English NHS facilities is therefore small: 2·7 per cent of admissions are referred by the courts or the police; 0·65 per cent are admitted from prison, borstal or approved school, etc.; 0·5 per cent of admissions are subject to Part V MHA (see Psychiatric Hospitals and Units in England and Wales. DHSS. HMSO.). Why then are those whose offences stem solely from their illness being denied treatment? Psychiatric units linked to District General Hospitals tend to select the 'nicer' band of voluntary patients with neuroses and acute psychoses; they largely reject patients with chronic psychoses and superadded problems such as addiction. The larger understaffed mental hospitals also tend to reject patients whose care will be labour-intensive, such as the violent and those on restriction orders which demand close supervision. Attitudes to patient management are such that any form of involuntary treatment—the discussion of professional responsibility to society, or the acceptance of an 'asylum' role—is seen as anathema to modern concepts of liberal treatment and rehabilitation. To those who are unnecessarily incarcerated in the prisons or Special Hospitals these arguments must seem to be merely callous rationalizations.

A paradigm of this process is seen in the 'open-door movement' which the Council of the College has belatedly suggested should be an approach to treatment rather than a factual description of physical arrangements (*News and Notes*, April 1977). Most mentally abnormal offenders are not treated in conditions of security, but consultants who work in hospitals which retain a locked ward as part of their treatment paraphernalia tend also to have attitudes which favour the acceptance of mentally disordered offenders; in comparison with consultants who work in completely open hospitals they refer fewer patients to Special Hospitals and they take more patients from the courts and the Special Hospitals; they also assess fewer of their patients as needing to be treated in conditions of security.

The development of regional forensic services has been hindered by the apathy and sometimes hostility of the profession itself and by the fact that developments have proved to be a convenient excuse for unions vying with each other in giving an appearance of greater militancy to potential recruits. In addition the press and community organizations have had a field-day in scaremongering. It is also evident that even when a financial allocation is made to provide a service for a particularly underprivileged group it is not protected from the grasping hands of the 'haves'. This tragic paradox was revealed in a Parliamentary written answer on 23 June 1977. In 1976/7 regional health authorities were allocated a special revenue of £5·2 million in connection with the provision of

secure psychiatric facilities; of this amount only £351,263 was spent on such developments and the remainder was used to promote other services, or to pay the debts accrued by them.

The DHSS and several Government committees (e.g. HSC(1S)61; Special Hospitals Working Party, 1961; Glancy Committee, 1974; Butler Committee, 1975) have repeatedly emphasized that psychiatric hospitals should continue to manage difficult patients, the violent and the majority of mentally abnormal offenders who are subject to Part V MHA, and where necessary hospitals should provide for treatment in conditions of security. If this situation is achieved the proposed forensic developments will provide additional facilities for mentally abnormal offenders. Future Prison Department reports might then be concerned more with the resolution of penal problems than with the difficulties of managing those thrust into it by other defaulting services. If forensic developments result in a further discussion of difficult patients and offenders from the mainstream of psychiatry it will be counterproductive: a few Regional secure units will not possibly be able to manage, the Special Hospitals will rightly resist excessive demands as they do at present, and the prisons will continue to bear the brunt. These problems arise because repeated recommendations, assertions and policy documents do not represent the views of the profession as a whole. The forensic developments envisaged by both Glancy and Butler, and their implications for general psychiatry that services to difficult patients, whether offenders or not, are maintained and improved, are obviously unacceptable to the majority of psychiatrists. That official policy runs counter to the will of the profession must be faced. Penal reform begins at home.

PAUL BOWDEN

CORRESPONDENCE

HEREDITARY HYSTERIA

DEAR SIR,

A family group is being studied which has a unique symptomatology. In their early twenties affected members develop whispering dysphonia, invariably diagnosed as hysterical, then they go on to develop spasmodic torticollis and in some cases generalized choreiform movements indistinguishable from Huntington's disease. What makes this family so interesting is that two members in the fifth Australian generation have Wilson's disease.

Two sisters who migrated to North Queensland in 1886 and who brought this condition to Australia came from Heacham in Norfolk, and it is inherited as an autosomal dominant with complete penetrance. I am going to England for six weeks from mid-December 1977 to study relatives in the United Kingdom and am keen to investigate any families who may possibly have this complaint. It would be greatly appreciated if any of your readers who know of patients with hysterical whispering dysphonia and with a relative diagnosed as having Huntington's disease, would contact me, care of Dr Edward Bird, Department of Neurological Surgery and Neurology, Addenbrooke's Hospital, Hills Road, Cambridge CB2 2QQ.

NEVILLE PARKER

112 Park Street,
South Melbourne 3205,
Victoria,
Australia

REVIEW OF THE MENTAL HEALTH ACT

DEAR SIR,

In *News and Notes* of April 1977, Dr A. C. P. Sims, writing in relation to the Review of the Mental Health Act refers to the use of police stations as 'places of safety' under section 136. There is one important aspect of the matter which appears to me to be implied in his letter and to be overlooked by many when they advocate that psychiatric hospitals should be used. This is that the person taken to the psychiatric hospital is automatically admitted. Section 136 of the Act says that the person may be 'taken to' a place of safety and there detained, etc. Nowhere does it say 'admitted'.

BJPsych Bulletin

Report on the Work of the Prison Department
Paul Bowden
Psychiatric Bulletin 1977, 1:13-15.
Access the most recent version at DOI: 10.1192/pb.1.5.13

References This article cites 0 articles, 0 of which you can access for free at:
http://pb.rcpsych.org/content/1/5/13.1.citation#BIBL

Reprints/ permissions To obtain reprints or permission to reproduce material from this paper, please write to **permissions@rcpsych.ac.uk**

You can respond to this article at **/letters/submit/pbrcpsych;1/5/13**

Downloaded from http://pb.rcpsych.org/ on December 18, 2017
Published by The Royal College of Psychiatrists

To subscribe to *BJPsych Bulletin* go to:
http://pb.rcpsych.org/site/subscriptions/