Mentally abnormal prisoners on remand: II—Comparison of services provided by Oxford and Wessex regions

JEREMY W COID

Abstract

Most regional health authorities have or plan to have secure units for treating mentally abnormal offenders. A retrospective study was carried out to compare the effectiveness of the health care services for men remanded to Winchester prison from Oxford and Wessex regions over the five years 1979-83. Thirty seven (30%) of 124 prisoners from Oxford region were rejected for treatment compared with 36 (16%) of the 220 men from Wessex region. Men from Oxford region were significantly more likely to be recommended for admission to a special hospital than those from Wessex (13/124 (10%) *v* 9/220 (4%), respectively) and significantly less likely to be recommended for admission to a hospital in the catchment area (35/124 (28%) *v* 94/220 (43%)). Men on remand from Oxford region were significantly more often perceived as being disruptive or aggressive by hospital staff and more likely to be labelled as having psychopathic or personality disorders. These differences may have reflected different attitudes towards mentally abnormal offenders and the allowances in the services available in the two regions; in particular, Oxford region did not have a secure unit or a forensic psychiatrist.

If mentally ill prisoners do not receive the treatment that they need they run the risk of being criminalised. Most such men are best treated in general psychiatric units; only a few require secure conditions and staff with specialised psychiatric skills.

Introduction

Should regional health authorities continue to develop specialist services for difficult patients and mentally abnormal offenders? Most regions now have secure units or advanced plans for their introduction, but recently some regions began to waver in their commitment.¹⁻⁵ This study compared and evaluated the psychiatric services available to and received by mentally abnormal men remanded to Winchester prison for psychiatric reports over the five year period 1979-83 by the Wessex and Oxford Regional Health Authorities. During the study Wessex region had an interim secure unit and a consultant forensic psychiatrist whereas Oxford region had neither.

Methods

The method is described in the accompanying paper (p 1779). Briefly, I collected data retrospectively from the case notes of all men from Oxford and Wessex regions who had been remanded to Winchester prison during the five years 1979-83 for reports on their state of mind or fitness to plead and who fulfilled the criteria of the Mental Health Act 1959 (or the new act of 1983 for the later cases). The data were recorded on a check list and included demographic and diagnostic data, the most serious charge, the conviction and the sentence, the man's social circumstances at the time of reception into

prison, the response of the consultant psychiatrist for the catchment area, the final recommendation to the court by the psychiatrist and the prison doctor, and the outcome.

Oxford and Wessex regions have similar populations and demographic structures. I did not have any data on the practices of policing or on the practices of local courts in remanding prisoners for psychiatric reports. The Oxford sample was less complete than the Wessex sample as some of these men were remanded to Bedford or Brixton prison.

Results

Results were analysed by the χ^2 test. Of the 388 men remanded to Winchester prison who fulfilled the criteria for entry to the study, 220 (57%) were from Wessex region and 124 (32%) from Oxford region. No appreciable differences were found between the two regions in the men's age or race, their most serious index offence, and all categories of illness diagnosed by the prison doctors. There were no differences in the men's social circumstances at the time of the offence or in their mental state on reception to prison as judged by the proportion who were of no fixed abode, unable to care for themselves independently in the community, or had committed a crime for food, shelter, or monetary gain. Yet the Oxford consultants described 26 (21%) of the 124 men they examined as having been violent or highly disruptive during previous admissions, whereas the Wessex consultants gave the same description to only 28 (13%) of the 220 men from the Wessex region ($\chi^2=4.06$, *df*=1, *p*<0.05). The Oxford consultants diagnosed a personality disorder or psychopathic behaviour in 42 men (34%) whereas the Wessex consultants made this diagnosis in only 47 (21%) ($\chi^2=6.46$, *df*=1, *p*<0.01).

There were no differences between regions in the proportion of consultants who visited the men on remand for themselves, although there was a non-significant trend for psychiatrists in Oxford region to discuss recommendations for admission to hospital by telephone (31 (25%) *v* 37 (17%); $\chi^2=3.34$, *df*=1, *p*<0.07). A significantly higher proportion of men from Oxford region (36; 29%) than Wessex region (40; 18%) had their stay in prison extended to allow assessments or arrangements to be completed ($\chi^2=5.42$, *df*=1, *p*<0.05).

Table I shows the final recommendations made for the men from both regions. The Wessex consultants accepted a significantly higher proportion

TABLE I—Final recommendation for 344 men on remand in two regions, 1979-83. Values are numbers (percentages)

Recommendation	Wessex (n=220)	Oxford (n=124)	χ^2	p Value
Hospital order (sections 60, 73, 5, Criminal Procedures (Insanity) Act)	94 (43)	35 (28)	7.11	0.007
Special hospital (sections 60, 5, Criminal Procedures (Insanity) Act)	9 (4)	13 (10)	5.41	0.02
Probation order	26 (12)	13 (10)		NS
Informal admission, section 25	26 (12)	13 (10)		NS
Deportation, no recommendation	29 (13)	13 (10)		NS
Rejection	36 (16)	37 (30)	8.61	0.003

of men on hospital orders under section 5 of the Criminal Procedures (Insanity) Act or on transfer from prison for urgent treatment. The Oxford consultants recommended a significantly higher proportion for transfer to a special hospital and rejected a significantly higher proportion ($\chi^2=8.61$, *df*=1, *p*=0.003).

Table II compares the official reasons for rejecting men for admission to hospital in both regions. The Oxford consultants tended to dispute the diagnosis or point to the lack of a secure bed whereas the Wessex consultants tended to assert that treatment was inappropriate or that hospital staff would not cooperate, but in no case was the trend significant. No significant

Maudsley Hospital, London SE5 8AZ

JEREMY W COID, MRCPsych, DIPCRIMINOL, senior registrar in forensic psychiatry

Correspondence to: Department of Psychological Medicine, St Bartholomew's Hospital, London EC1A 7BE.

differences emerged when the men rejected by the Wessex consultants (36) and by the Oxford consultants (37) were compared except that, as expected, more of the men from Oxford had been described as showing psychopathic behaviour or having personality disorders (26 v 14; $\chi^2=6.04$, $df=1$, $p<0.05$).

TABLE 11—Reasons for rejecting treatment in 73 men, 1979-83. Values are numbers (percentages)

	Wessex (n=36)	Oxford (n=37)	χ^2	p Value
Failure or refusal of consultants to visit	2 (6)	4 (11)	0.15	NS
No secure beds	4 (11)	10 (27)	2.04	NS
Admission refused by staff	8 (22)	4 (11)	1.00	NS
Treatment not appropriate	11 (31)	6 (16)	1.37	NS
Diagnosis disputed	4 (11)	10 (27)	2.04	NS
Other	7 (19)	3 (8)	1.14	NS

Discussion

This study shows considerable differences between two regions in the provision and receipt of treatment to mentally abnormal offenders. Despite the similarities between the two samples prisoners on remand from Oxford region were more likely to be rejected for treatment, especially on a hospital order, and to be recommended for admission to a special hospital. This tended to contradict the region's official statement at that time that it could cope with all patients who did not require maximum security. The study also suggested that the men in this region were disadvantaged in terms of treatment. Admission to a secure unit permits greater flexibility of management, and the period of stay is rarely longer than 18 months; in special hospitals the average stay is around six years.⁶ The Oxford consultants were more likely to diagnose psychopathic behaviour or personality disorders and describe the men as disruptive or violent. Were the diagnoses of the prison doctors (and myself) incorrect or were the Oxford consultants using these labels as a convenient excuse to exclude these men?

Perhaps it was unfair to compare these regions as Wessex region has a particularly good record in dealing with patients who are offenders.¹⁷ The way in which I have presented the results also obscures the wide discrepancies among the different hospitals and among different units within the same hospitals. Although some consultants persistently refused to admit prisoners, a colleague could sometimes be found who would do so, and would take a special interest in them. Unfortunately Oxford region seemed to have fewer of these consultants and also did not have the benefit of a second opinion from a forensic psychiatrist. Neither region was immune from washing its hands of some patients. Indeed, one man in Wessex region became a media "folk hero" while living in a disused tunnel furnished with articles stolen from the wards of a hospital where he was no longer welcome and eating food stolen from the kitchens.

Overall I was unable to evaluate the effectiveness of the Wessex secure unit independently of the other general psychiatric units within the regions. The unit seemed to admit more prisoners on remand who had been rejected initially and probably reduced the number recommended for a special hospital. On the other hand, its presence in the region may have encouraged other hospitals to accept such patients, who could be transferred to its greater security if necessary. More positive attitudes towards mentally abnormal offenders and towards forensic psychiatry, however, may well have facilitated the development of the specialist services in Wessex region in the first place.

Snowden suggested that delays in organising regional secure units entailed complex processes.⁴ For example, Oxford region has

suffered from the lack of a doctor with a special interest in developing forensic psychiatry; it would be such a doctor's job to convert the "gatekeepers," who can permit or hinder the acceptance of innovation—in this case the regional medical officer, administrators, and clinicians in the region—and the "blockers"—those who may be affected directly by a change in their job, work philosophy, or environment—who may thus delay progress.

A survey in Oxford region showed a need for both a secure unit for the mentally ill and a secure training unit for the mentally handicapped.⁸ Unfortunately some doctors vigorously opposed these developments, and publication of the survey coincided with the widespread regional move towards community based facilities. After adverse media publicity and a "robust" exchange between the Minister for Health and the regional officers⁹ the health authority took a direct interest in patients who were offenders and patients who were difficult to place. This policy of closer monitoring coincided with the end of the period of my study, and a future study would probably not produce such dramatic results. It is now regional policy to develop two secure units for the mentally ill; a training unit has been opened, and a forensic psychiatrist has recently been appointed.

My study illustrates one method of evaluating the delivery of psychiatric care to patients who are offenders. A more detailed and refined evaluation would need to take into account other variables, such as populations of sentenced prisoners, patients in special hospitals, and highly disturbed and difficult patients requiring admission to hospital on civil orders. Without adequate facilities and the willingness of staff to admit such patients some of them will become "criminalised."^{10,11} In addition, persistent failure to provide adequate resources carries the risk of training a new generation of health care professionals who are more adept at avoiding their responsibilities for difficult patients than skilled in managing and treating them. The rapid expansion of forensic psychiatry may well have resulted from these unmet needs,¹² but most patients are best cared for in general psychiatric units; only a few require conditions of greater security or subspecialist skills for their management.

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