

Focus: Current issues in medical ethics

When a serious crime—say a murder—is committed by someone who has been discharged or has absconded from prison the public reaction is extreme. And public anger is not appeased by psychiatrists and sociologists who argue in the media the case either for all mental disorders being capable of treatment leading at least to partial cure or that all crime springs from unfortunate social circumstances. In the two papers which follow the situation is described how psychopathic and other mentally abnormal offenders are dealt with at the present time, and how the Aarvold and Butler Committees were set up. The Aarvold Committee (Chairman, Mr Justice Aarvold) was to be concerned with tightening the provisions of the law as it now stands whereas the Butler Committee (Chairman, Lord Butler) was asked to look into and recommend changes in the law relating to these offenders. The Aarvold Committee reported swiftly and the Butler Committee made its final report in 1975. (An interim report was produced in 1974.) It is with the Butler Report that Dr Rollin and Dr Norton are principally concerned here. The fundamental aim of both committees was to maintain a balance between 'what is best for those guilty of dangerous offences and the right of the public to be protected'. Both writers describe the various forms of detention for psychopathic offenders in operation and proposed, and both conclude that the Butler Report offers wise and realistic guidance but fear that continuing official inertia will preclude the recommendations ever being implemented. Dr Norton deals particularly with the concept of 'dangerousness', and the controversial issue of the Butler 'reviewable sentences' for mentally abnormal offenders.

The care of the mentally abnormal offender and the protection of the public

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Historically speaking, the care of the mentally abnormal offender has alternated, according to the fashion of the time, between incarceration in prisons and treatment in mental hospitals. With certain exceptions, notably, on the one hand, Grendon Underwood, a psychiatric hospital within the prison service, and on the other, the 'special hospitals' - Broadmoor, Rampton and Moss Side -

the two systems have operated in a mutually exclusive way although, as will be shown, the clientele is all too often common to both. Since the implementation of the Mental Health Act 1959 in November 1960, however, the care of the mentally abnormal offender has been firmly vested in the mental hospitals.

Primary assumptions fundamental to the Mental Health Act 1959

The inspiration for this move springs, it would seem, from two primary assumptions which are in themselves fundamental to the 1959 Act. The first is that, therapeutically speaking, psychiatry has elevated itself to a position where not only can all mental illness be substantially ameliorated, if not cured, but whatever betterment is obtained will be permanent. (It must be mentioned parenthetically that this therapeutic optimism would appear to extend to psychopathic disorder. If this were not so it is difficult to see why it was included as one of the varieties of mental disorder as detailed in section 4 of the Act.) The second assumption is that all criminal behaviour in a mentally disordered person stems from his illness. Therefore, the argument seems to run, cure him of his illness and his criminality will cease. To my mind both these assumptions are fallacious and until such time as it is generally recognized that this is so and the relevant parts of the Act amended, the Act will continue to misfire and be brought into disrepute.

There is ample evidence to support my thesis. Criminal statistics show that the number of cases remanded for psychiatric report rose from 6366 in 1961 (Home Office Report, 1962)¹ to 11 912 in 1975 (Home Office Report, 1975),² a rise of nearly 100 per cent. It is known that 16 per cent at least of those remanded had been discharged from mental hospitals less than one year before their arrest. Furthermore, it is safe to say that if the period were extended to two years after discharge the number would be in the neighbourhood of 50 per cent.

However, the statistics quoted refer only to mentally abnormal offenders dealt with after prosecution (part V of the Act). But there has also been a steep rise in the number admitted, or readmitted, to mental hospitals without prosecution. Of special importance in this respect is the use of section 136 (part IV of the Act), a method whereby

the police in their wisdom can deal expeditiously with social crises occasioned by the mentally disordered by removing them to a place of safety, in practice almost invariably a mental hospital. For example, in the 12 mental hospitals administered before the reorganization of the National Health Service in 1973 by the then South-West Metropolitan Regional Hospital Board, the number rose from 308 (1.9 per cent) of all admissions in 1965 to 709 (4 per cent) of all admissions in 1972, an increase of well over 100 per cent.³

But this is not the whole story by any means. In a series of investigations, I (Rollin, 1969)⁴ was able to show that 71 per cent of the prosecuted and 67 per cent of the unprosecuted offenders admitted to local mental hospitals had had multiple admissions to mental hospitals and could be legitimately labelled as chronic psychotics, or more precisely, in the majority of cases, as chronic schizophrenics. Equally important is the fact that 62 per cent of the prosecuted and 36 per cent of the unprosecuted groups had had previous convictions, whilst 43 per cent of the former and 28 per cent of the latter had served prison sentences. What is more, in a follow up of between 24 and 48 months, the number of readmissions to mental hospitals, not via the police, was 7 per cent in the prosecuted group and 18.6 per cent in the unprosecuted. In the same period 46 per cent of the former group and 26.6 per cent of the latter had committed further criminal offences.

A picture, therefore, emerges of a stage army of hopelessly inadequate chronic psychotics who express their pathology in part by offences against the criminal law, and who as a result, spend a goodly period of their lives being shunted between the prison and the mental hospital systems. It is fair to say that in terms of one system they are reckoned to be incorrigible and in terms of the other incurable.

The concept of the 'open hospital'

What complicates the issue even more is the fact that the switch in the care of the mentally abnormal offender to the mental hospital coincided with the flowering of the concept of the 'open hospital'. Security as a result became a thing of the past, and as a corollary, abscondences rose dramatically. Included amongst those who chose to leave the 'open' hospitals virtually at will are mentally abnormal offenders who were committed there under a variety of compulsory orders of the 1959 Act. The scale of the abscondences and the resultant problems are illustrated in an investigation at my own hospital (Rollin and Day, 1971).⁵ We showed that during 1968 there were 202 male abscondences by 85 individual patients under compulsory orders. Of these, six were under Restriction Orders (section 60/65) and five had been transferred from prison under section 72. Experience has shown,

indeed, that the more disturbed and, therefore, more potentially dangerous a mentally abnormal offender may be, the more likely he is to abscond from hospitals that offer at best only token security. And yet Lord Justice Parker in 1966⁶ gave a direction to judges and courts throughout the country to use their powers under the 1959 Act to impose restriction orders (section 65) to ensure that criminals guilty of violence or sex crimes are not released too soon from mental hospitals. In justifying his direction Lord Parker cited two patients admitted to mental hospitals under section 60, ie, without restriction, for crimes of violence who had been discharged after relatively brief periods and shortly thereafter had been guilty of further acts of violence.

Although these days it is recognized that, in effect, it is the right of the mentally abnormal offender to abscond virtually at will from an open hospital, it must equally be recognized that the public has a right to be protected from his offences when he is at large. It is true that the petty thefts, indecencies or disturbances of which in the majority of cases he is guilty, do little harm. But there is a minority, and by no means a negligible minority, whose offences include personal violence or sexual molestation. It is for this type of offender that the open hospital is manifestly unsuitable. A tragic example is the case of Barry John Stringer,⁷ aged 20, who in late 1973 attempted to kill three innocent and unsuspecting women in Oxford Street, London, with a carving knife he had deliberately bought for the purpose. Stringer had been committed to a mental hospital in Epsom, Surrey, presumably under section 60 of the Mental Health Act 1959 in August 1973, for possessing an offensive weapon, namely, a bread knife. He was stated at the time to be suffering from paranoid schizophrenia. Since his admission to hospital he had absconded on no fewer than five occasions and it was on the last of these that the terrifying assaults took place. All the warning lights were on, but it would have been futile as things were to have attempted to transfer him to a 'special hospital'.

Dilemmas of the 'special hospitals'

It is now almost 17 years since the implementation of the Mental Health Act 1959. Experience has shown that there are two overlapping groups for which the conventional mental hospital has little or nothing to offer. The first is that referred to as the stage army of incurable/incorrigible chronic psychotics who are shunted between the mental hospital and prison systems in an almost arbitrary way. The other is composed of the more overtly dangerous mentally abnormal offenders who qualify for restriction order (sections 60/65). In both groups, particularly the latter, it has become increasingly difficult to find consultant psychiatrists willing to accept them in their hospitals. An additional

obstacle these days is the demand of nurses through their unions to have a say in who may, or who may not, be admitted. As a result of both these factors the demand for beds in the 'special hospitals' has steadily increased. The 'special hospitals', it will be remembered, are establishments for persons subject to detention under the 1959 Act who require treatment under conditions of special security, 'on account of their dangerous, violent or criminal propensities'. It follows that if admission to a conventional mental hospital of those deemed eligible for a restriction order is blocked then the only alternative, within the spirit of the 1959 Act, is admission to a 'special hospital'. But the overcrowding in these institutions is acute. Living conditions in them have been described by the Butler Committee⁸ as appalling. The report of that committee says: '... 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 18 inches apart'. In these circumstances it is understandable that the criteria for acceptance to the 'special hospitals' have become more and more stringent. It is equally understandable why it is that Her Majesty's judges feel angry and frustrated when they have to impose inappropriate prison sentences, not in keeping with the spirit of the 1959 Act, on mentally abnormal offenders because there is no vacancy in the 'special hospitals'.

The difficulties under which the hard-pressed 'special hospitals' have to work have been compounded, however, by the public alarm occasioned in recent years by the infamies of Graham Young and Terry Iliffe who repeated their crimes and murdered while on conditional discharge from Broadmoor. It became politically expedient for urgent action to be taken to prevent further dramatic failures of this sort.

Two committees were set up, one under the chairmanship of Sir Carl Aarvold, and the other under Lord Butler. The Aarvold Committee was concerned with tightening the law as it now stands. They made their recommendations known with exemplary expedition,⁹ although they were accepted with some reservations. It was felt, indeed, that there had been an overreaction and that the recommendations might disadvantage those patients in 'special hospitals' who pose no threat to society after discharge.¹⁰

The Butler Committee and after

The Butler Committee was charged with recommending actual changes in the law. In April 1974 they saw fit to publish an interim report.¹¹ The most important recommendation by far was the 'provision as a matter of urgency of secure hospital units in each regional health authority area' to be financed by a direct allocation of central government funds.

The final report was published in 1975.⁸ Its fundamental aim, as it was of the Aarvold Report and of the interim report, is the maintenance of a balance between what is best for those guilty of dangerous offences and the right of the public to be protected. This is difficult enough in the dangerous offender not deemed to be suffering from mental disorder who is serving a determinate sentence and must eventually be released, although he may still be regarded as dangerous. Even more difficult is the case of the dangerous offender who is suffering from mental disorder. If his dangerousness is related to, for example, a paranoid psychosis then logically if this can be cured he ceases to be dangerous. But to what extent, even with the help of modern psychotropic drugs (whose efficacy is probably exaggerated) can such illnesses be cured? And if he is discharged from whatever custody he may be in and relapses, does he again become dangerous? Then there is the mentally abnormal offender whose dangerousness is not at all related to his mental illness: is he ever safe? Furthermore, the difficulties are compounded in the psychopath, an individual, such as Graham Young, who has a gross personality disorder characterized by abnormally aggressive and seriously irresponsible behaviour. When, if ever, may he be proclaimed safe?

THE NEED FOR SECURE HOSPITAL UNITS

Again, as in the Interim Report, great emphasis is placed on the provision of secure hospital units. The Report gives details as to how and for what purpose the units will be constructed. They are seen as operational day centres for all the forensic psychiatric services in the region, including the existing hospital and community mental health services. There will be links with the 'special hospitals' with which there will be not only an interchange of patients, but they will also assist in the training of prison personnel—medical and other—on secondment to them.

THE 'TREATMENT' OF PSYCHOPATHS

Another relevant and most important chapter in the Report is that concerned with psychopaths. The Committee grasped this particular nettle with commendable courage. Although they say that it is outside their remit to suggest that 'psychopathic disorder' should be removed from the definition of mental disorder in section 4 of the Mental Health Act, it seems evident that this is what they would wish. There can be few practising psychiatrists who would not applaud the suggestion. Nor would they, as the result of bitter experience, be in the least bit offended by the Committee's categorical statement that, 'psychopaths are not, in general, treatable in medical terms'. The Report puts forward a bold proposal for the training and treatment of dangerous antisocial psychopaths on a voluntary basis in special units within the penal system. In these units,

some at least of the offenders, instead of being admitted to Broadmoor, would be given prison sentences which could be the proposed new 'reviewable sentence,' 'designed to enable the offender to be detained only until his progress under treatment . . . allowed him to be released under supervision without serious risk to the public.'

THE CARE OF THE INADEQUATES

At the other end of this particular spectrum are the inadequates, a heterogeneous group of rootless, homeless persons suffering from a variety of personality disorders, chronic psychoses, alcohol and drug addiction. These the committee place very firmly on the doorstep of the local psychiatric hospitals aware, as they are, that it is from these institutions that, in many instances, they have been quite recently booted out. There is an almost quaint, antique ring to the suggestion that one of the roles of mental hospitals, is, or ought to be, sanctuary, or asylum.

Official inertia following the Butler Report

Whether all, or indeed any, of the recommendations made, particularly those involving bricks and mortar, will ever come about remains to be seen. As long ago as 1961 the then regional hospital boards were asked to provide secure units by the Ministry of Health. Not a single one has materialized. The dangers of this continuing inertia cannot be exaggerated. Unless and until the secure units materialize both the spirit of the 1959 Act and the work of the Butler Committee will be frustrated, and as a result, the welfare of the mentally abnormal offender will be jeopardized, and the safety of the public will be put at risk.

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The concept of dangerousness

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For a few people—the staff of the special hospitals, for example, the staff of Grendon Psychiatric Prison, half perhaps of the full-time prison doctors and the slowly growing band of forensic psychiatrists—the publication of the Butler Report was a major event. The professional *raison d'être* of these people is to take decisions on the mentally abnormal offender. For many more—judges, magistrates, probation officers and the police, social workers, psychiatrists and the staff of psychiatric hospitals—contact with these patients may only be occasional and perhaps for that reason less practised, less skilled and more awkward and unhappy. The mentally abnormal offender forms a very small proportion of the total number of either offenders or of the mentally abnormal. The Butler Report itself says that psychiatric disposals account for less than half of 1 per cent of the 736 860 convictions for non-motoring offences; of the 197 000 admissions to all psychiatric hospitals (including the special hospitals) in England and Wales in 1973, fewer than 1 per cent came from courts and prisons. But they have an importance in the public eye quite out of proportion to their numbers. Professional people who have only an infrequent need to be concerned might value a reappraisal of the recommendations in the Butler Report, particularly as these will certainly weigh heavily in the review of the Mental Health Act 1959 now in progress.

The Butler Report is long and comprehensive, and a short article can only deal with a few points. In an Interim Report published in April 1974, some 18 months before the full report, the Committee recommended as a matter of urgency the setting up of secure hospital units in each region. These are needed because 'custodial requirements cannot be reconciled with the "open door" therapeutic policy now practised'. And they are needed for offender and non-offender alike. They form a vital part of the suggestions the Committee makes for coping with 'dangerousness', a concept that receives a chapter to itself and a very thorough discussion. One of these proposals is that the functions of the advisory board on certain patients detained under section 65, set up on the advice of the Aarvold Committee, should be extended. The Butler Committee also proposes that the existing safeguards about discharge, supervision and recall should be extended and modified. Most controversial of all is the proposal for a new form of indeterminate sentence for dangerous offenders who have a history of mental disorder that cannot be dealt with under the Mental Health Act and for whom equally a sentence to life imprisonment is not appropriate. Such an open-ended sentence would be subject to a mandatory review every two years, release being dependent entirely on the issue of