II PATIENTS WITH RESTRICTION ORDERS—THEIR PLACE IN PSYCHIATRIC OR "SPECIAL HOSPITALS"?

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Under the M. H. Act 1959, patients can be admitted to Psychiatric Hospitals with a restriction order. This provision is designed to protect the public from a mentally disordered offender convicted of a serious offence and considered likely to repeat it once he is freed from detention.

The purpose of this paper is not to question the validity or otherwise of the orders of restriction but to discuss some of the problems and difficulties that arise in course of implementation of the same in Psychiatric Hospitals, with special reference to a Hospital for Mental Subnormality.

My observations are based on the study of six patients, the particulars of whom are given in the appendix.

All the patients described are males. They compare favourably with the cross-section of Section 60 cases in this Hospital regarding their mental picture, offences and so on. In fact two patients were originally admitted to this Hospital under Section 60 and, as mentioned, were put on Section 65 following their offences since.

Those of us working in Mental Subnormality Hospitals who have to deal with a small number of Section 60 cases know only too well the difficulties we have to face, not only from the administrative angle but also from the angle of management with a view to rehabilitation. This problem is getting more acute and the number of cases are increasing, and many are already forming the opinion that probably Psychiatric Hospitals are not the best places for these patients. Patients admitted with restriction orders over and above Hospital orders certainly add to the problem.

Regarding numbers, I have to deal with between 35 and 40 Section 60 cases in a Hospital with a total beddage of 665 patients, and that certainly is not just a small number. The addition of six restriction order patients has not made the task any easier, and has added considerably to the already existing troubled atmosphere, and the object of this article is to consider this.

The vigilance and supervision already increased for Section 60 cases has to be further strained for these Restriction order patients, so much so that at times this becomes very individually pointed and amounts to the patient's behaviour being constantly observed. The patient naturally resents this and wonders if he is a prisoner. To support this extra degree of vigilance, his fellow-patients have got to be watched and supervised. They consequently become resentful and dissatisfied as they suffer through no fault of their own. This would not happen if they were on their own. This extra vigilance also calls for additional work on the part of the nursing and other staff concerned when they could be otherwise engaged. The atmosphere becomes vicious and, as a result, everybody suffers, the patients with the restriction order as well as the rest. One may question the necessity of this increased vigilance and supervision, and to get the answer, one has only to look at the clauses of the Restriction orders which automatically call for this.

Next in order of importance is the fact that the patient soon starts feeling the impact of restriction which, after all, is its intention. He does his share of work,

engages himself to the discipline of hospital life and activities and starts comparing himself with patients of other wards and villas. He knows that he has got to be confined to the four walls of the Hospital and that depending on his behaviour he would be allowed all the privileges and facilities possible inside the Hospital. Nevertheless he does not like to accept this difference in treatment. Why can't he get the same privileges as others for his good behaviour and work record? Why does he have to wait one or more years before getting any privileges outside? In the end his trust in the doctors, nurses, and all others is diminished. This type of patient tends to be emotionally unstable and loses control very easily. The thing he mostly resents is his confinement within the hospital walls. Very soon an ordinary hospital with its limited facilities and recreations becomes a dull and monotonous place. He quickly becomes unsettled, frustrated and even violent. A restriction order patient is expected to be in the best of behaviour for a considerable length of time before the Responsible Medical Officer could recommend the easing of the restriction. These points not only make the problem of day to day dealing with the patient difficult but also the ultimate improvement in their behaviour is delayed and rehabilitation made more difficult.

Needless to say this differentiation in treatment also has an adverse effect on his fellow-patients, especially those who become friends of these patients. There have been many occasions when a friend of a restriction order patient would ask to take him out e.g. to the cinema or shopping. To all these the answer has got to be in the negative and the other patients certainly feel it and become very upset over it. Sometimes even members of the staff would make such requests with a view to helping the patient, and when made aware of the restriction order get frustrated and require counselling for its justification as a therapeutic measure.

The restriction on going out also prevents some patients from taking up outside employment in which patients under Section 60 have been tried. Again in all instances, such patients have got to be content with the type of occupation that an ordinary Psychiatric Hospital, with its limited facilities, can provide, thereby further restricting him. The patient may well have to work for years in unsuitable jobs, and his former training wasted.

As we have already seen, the patient has not only to live a restricted life, being constantly watched, prevented from going out on all leaves, from activities outside the Hospital, from taking up a job outside, but saddest of all he sees others from his own wards or villas enjoying all these activities and coming back and revelling in them making him feel worse than a prisoner. In prison all of them are in the same boat but in a Psychiatric Hospital it seems discriminatory, distressing and frustrating. They come to believe that there is something grossly wrong with Authority and themselves. They express their feeling either in aggressiveness and resentment or in complete apathy and resignation. After a while they get depressed when they receive the same answer to their questions—wait and behave for one or more years before the Responsible Medical Officer will write to the Home Secretary recommending the easing of the restriction. Some develop an inferiority complex, and express it openly.

Two further problems can arise. One when the patient is in need of urgent treatment in a General Hospital outside the scope of the parent Hospital. When a patient is taken seriously ill, and has to be transferred to a General Hospital permission has got to be sought and obtained from the Home Office prior to the transfer, and this can be time consuming. Admittedly this can be done by telephone, but that has got its difficulties. The second problem concerns the patient who goes absent without leave when the Criminal Records Office and the Home Office have

got to be informed. Apart from the administrative side of the second problem, the question one is faced with is where does one go from here? In spite of the tightened vigilance and supervision a patient does absent himself without leave. What steps, if any, are to be taken when one keeps on absenting himself? One patient whom I thought might change his attitude towards absenting since being put on restriction order, nonetheless has remained a problem; he has gone absent a few times and at the time of writing is once again at large.

When a detained patient keeps on absenting himself and commits offences, the course sometimes left to the Responsible Medical Officer is to recommend admission to a Special Hospital. However, such requests are often refused as there is considerable difficulty in obtaining their admission to a Special Hospital.

There have also been occasions when the Responsible Medical Officer could not undertake to Quarter Sessions to prevent future escapes, despite vigilant observation in a Psychiatric Hospital, and has recommended the patient for admission to a Special Hospital but, as no place was offered, the Judge had no alternative but to send the patient to prison.

The type of patients who resent this restriction most are those who have been in-patients before and have been put on a restriction order for further offences, as they have experienced liberal treatment before. Admittedly, they were to blame for the fresh crimes and necessary steps would have been taken to curtain their privileges, but the imposition of the restriction with time limit of some years has not helped matters at all; on the contrary, it has made their management more difficult. To my mind the superimposition of an order on patients serves very little purpose; on the contrary it makes the patient more difficult to manage, treat and rehabilitate. It also throws doubt on the judgement of the Responsible Medical Officer, on whose recommendation at a future date a different course of action would be taken.

Once the patient has been sent to a hospital under restriction order or put on restriction order while in the hospital, the Responsible Medical Officer is faced with another problem in connection with recommendation to the Home Office for easing of the restriction. The words "after prolonged observation" mentioned in the letter from the Home Office that is sent to him makes him think hard before making a recommendation. Does this prolonged observation mean any particular arbitrary time limit? The onus is obviously left to the doctor. In a case where restriction order is placed say for 5 years, the term prolonged would mean 3-4 years, certainly not 1-2 years. In any case the Responsible Medical Officer in making his recommendation has to go by the patient's behaviour while inside the Hospital, howsoever prolonged it may be—he has not tried and cannot try the patient out. The doctor can truthfully say how he found the patient inside the Hospital and make his recommendation. Admittedly the Home Office having agreed to lift the restriction leaves the patient detained and treats this with caution. The doctor now has to treat the patient as a detained case and gives him privileges gradually. One obviously asks—What has the restriction order done to help matters? Of course we all know that patients who have committed arson or sexual crimes remain potential offenders till quite a late age in their lives, and the doctor would only give such patients liberties very cautiously, and also curtail them according to their needs. The restriction order *per se* has hardly helped matters, on the contrary as mentioned earlier it has made the management of these patients more difficult. Even when the restriction is lifted upon the Medical Officer's recommendation in so called "good" cases he had done so without really giving the patient a trial. In all cases he has more or less to start afresh the day the restriction is lifted.

In conclusion, it could well be said that a special unit with security could greatly alleviate the management of detained cases, with or without restriction, in a Psychiatric Hospital. One wonders if they would not be altogether better managed in a "Special Hospital" as long as the restriction was in force. In any event, the attitude to admission of such patients to a Special Hospital will need fresh evaluation.

Appendix: Case Notes:—

Case 1 W. F. D. Date of birth 10.8.41. Date of Admission 22.7.63.
Mental Condition: Subnormality, I.Q. 56.
Offence: Office-breaking and larceny (2 counts).
Sentence: Imprisonment for 2 years to run concurrently on each count.
Transferred to this Hospital under Section 72 after a year in prison.

Case 2 J. E. I. D. Date of birth 9.6.34. Date of admission 25.1.62.
Mental condition: Severe Subnormality. M.A. 6 years.
Offence: Arson (2 cases).
Verdict: Section 71(2) M.H. Act 1959 (like effect as a Hospital order with an order restricting discharge of indefinite time).

Case 3 F. R. Date of birth 2.11.05. Date of admission 8.12.61.
Mental condition: Subnormality. I.Q. 60.
Offence: Indecent assault on a girl aged 10 years.
Verdict: Section 71(2)—indefinite period.

Case 4 R. W. E. Date of birth 14.5.34. Date of admission 18.9.63.
Mental condition: Subnormal. I.Q. 61.
Present offence: Indecent assault on a boy aged 12 (buggery).
Previous convictions: Larceny, robbery with violence, assault occasioning actual bodily harm.
Verdict: Section 60 and Section 65—3 years restriction.

Case 5 A. J. M. Date of birth 30.8.39. Date of Admission 4.5.62.
Mental condition: Subnormal. I.Q. 70.
Offence: Removal of vehicle without the owner's consent.
Previous offences: Stealing a bicycle (Probation 2 years). Many other petty offences in the past.
Verdict: Section 60.
New offences and verdict: Larceny (2 counts)—Section 60 with Section 65 restriction —5 years.

Case 6 A. W. E. Date of birth 26.2.43. Date of admission 19.2.63.
Mental condition: Subnormal. I.Q. 71.
Offence: Larceny and house-breaking (3 offences).
Previous offences: Assaulting Police Officer, using obscene language, store-breaking. (Section 60 in another Hospital).
Verdict: Section 60.
New offences and verdict: Larceny (2 counts)—Section 60 with Section 65 restriction —5 years.