

### III. THE CARE OF THE DELINQUENT SUBNORMAL

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The degree to which mental defect plays a part in the incidence of crime is difficult to assess. Early estimates of the number of prison inmates who were retarded were too high and clashed with the lower figures of later studies. The discrepancies were reconciled by the explanation that better ascertainment and the provision of more adequate hospital accommodation had removed many actual and potential delinquents from the penal system. All were satisfied that this was advisable and psychiatrists, prison reformers, and the public were united in approval that mental disability, even if it did not exonerate the offender, necessitated hospital care and detention rather than penal procedure. Thus the older institutions and those more recently built following the 1913 Act found themselves the recipients of all grades of subnormality from the helpless idiot to the borderline moral defective with criminal propensities. Though not completely irreconcilable the difficulty of dealing with such diverse varieties of mental disability within the curtilage of a small estate posed problems which became difficult to surmount. Because of this the assumption that the convicted delinquent of poor mental endowment requires hospital care needs reassessing and is certainly queried by many physicians working in subnormality hospitals who, without having available even nominal security units, are expected to detain, control, and treat an unruly rebellious group who tend to disrupt the therapeutic atmosphere of what should be a trainable hospital community.

#### **The position in the South West**

The percentage of delinquent patients admitted from the Courts to this typical psychiatric hospital group for the subnormal is disconcertingly large and grows year by year. The Royal Western Counties Hospital Group has 1800 beds and a catchment area comprising the four local authorities of Devon, Cornwall, Plymouth and Exeter. These have a combined population of approximately 1,200,000. The peninsula they comprise constitutes a relatively closed community and it is fair to assume that most subnormal offenders before the Courts who are considered to need medical care, are referred to the staff of this hospital. It would appear that the trend is towards an increase in Court admissions rather than a reduction as can be seen by comparing the figures of 1959 and 1965.

In 1959, 103 patients were admitted of whom 13 came under Section 8 of the Mental Deficiency Act, 9 of these were male and 4 female and the offences were 1 of buggery, 1 of indecent assault on young children, 1 of assaulting and beating females, 1 of assaults on young females, 1 of common assault, 1 of arson, 1 of burglary and unlawful wounding, 1 of fraudulently converting money to own use, and 5 of stealing. None was admitted under Section 9, i.e. on transfer from detention in penal establishments. Among 55 discharges during the same period were 14 men and 5 women who had previously been admitted under Section 8 (13 men and 1 woman) or Section 9 (1 man and 4 women). The offences for which these had been admitted followed a similar pattern and included 5 of indecent assault, 1 of unlawful carnal knowledge, 1 in need of care and protection and 12 of larceny or equivalent.

During 1965 of a total of 168 admissions, 23 patients came under Section 60 of the Mental Health Act, 1959, and in 2 of these cases a restriction order (Section 65) had been imposed. 21 of these were male and 2 female, 14 had been convicted of larceny or offences against property, 1 of arson, 1 of attempted murder, and the

remaining were for sexual offences including incest, indecent assault and exposure and gross indecency. During this period among 155 discharges were 17 men and 8 women who had previously been admitted under Section 60. Only 12 of these returned to the community. Of the other 13, 6 remained informally, 1 remained under Section 65, 2 were transferred to hospitals for mental illness, 3 were transferred to special hospitals, and in 1 the Order lapsed after absconding.

The extent to which the services of the psychiatrists from this hospital were utilised is interesting though it illustrates more an appreciation of their help in making disposals rather than any indication of deterioration in the mental status of prison inmates. In 1959 no visits were paid to H.M. Prison, Exeter, but by 1965 the number of requests to visit was 30. In 1959 only very occasional Court attendances took place, but by 1965, 12 appearances were called for at Magistrates Courts, Quarter Sessions and Assizes. Regular clinical visits were also paid by senior members of the staff to an Approved School and Remand Homes, many of which necessitated reports to the Juvenile Courts. It is gratifying to record this improvement in the ascertainment of the subnormal offender.

### **Restriction Order (Section 65)**

The number of patients admitted subject to Restriction Order is not large, but averages two or three each year. The periods for which the restriction is in force has varied from two to five years, and three patients have come subject to unlimited restriction. Initially it was customary to include in the psychiatric report to the Court, recommendations as to whether or not such a step was deemed necessary, but a memorandum in January 1963 terminated this, and suggested that by the wording of the report only an indication should be given to the Court. This rather fine distinction calls for considerable verbal ingenuity and at the hearing the Judge generally asks the opinion of the psychiatric witness before reaching a decision.

Such orders are advantageous to closing the gap open to absconding Hospital Order patients under Section 40 (3) (b), where liability to detention would expire after twenty-eight days, and afford the only effective means of continued detention. But, especially where the longer periods are imposed, they constitute a very real handicap in resocialising a patient when outings, holidays, and trial leave can only be granted with the consent of the Secretary of State. The combination of the functions of a penal establishment and therapeutic community in one hospital presents difficulties and complications which are accentuated when one has to cope with this extra imposition.

Patients admitted to this Group, and capable of responding, are subjected to a four months initial assessment with periods of training and observation in the Industrial/Occupational Therapy, Gardens, Farms and Domestic departments to elicit their needs, inclinations, attitude and potential so that they may be placed in the environment and type of occupation for which they are best suited. Obviously this scheme was applied to patients subject to restriction order but they had to be excluded from the visits to museums, factories, and places of public interest which formed an integral part of the scheme. Application was made therefore to the Secretary of State and was successful, provided certain precautions were complied with, in enabling these to accompany the others. Holiday difficulties were not insurmountable because the hospital has a holiday home and a summer camp at Brixham, and permission was granted for those recommended to have a vacation there. Thus, in practice, the difficulties have not been insuperable and most of our Section 65 cases have become reconciled to the restrictions imposed on them. Only two, who resented confinement and become recalcitrant, have had to be transferred to Special Hospital.

#### **Section 4 Criminal Justice Act, 1948**

During 1965 14 patients who had been placed on probation were admitted for treatment during the first twelve months from the date of the order. This was the greatest annual number ever received in this manner, and because of certain difficulties and imperfections is likely to diminish in the future. In general it is fair to say that patients admitted by this method had been guilty of more trivial offences than those who entered under Sections 60 and 65 of the Mental Health Act.

Prior to the 1959 Mental Health Act only hospitals for the mentally ill could receive such patients, and it was not till after that date that hospitals for the mentally subnormal became eligible to admit under Section 4 of the Criminal Justice Act.

In its favour can be adduced the fact that the patient is received informally and any serious breach of the conditions is dealt with jointly by reference to the probation officer whose responsibility it is to take appropriate action. It has contributed to a close and helpful relationship between the hospital and probation services which must administer those so dealt with by discussion and conference together. The Court requires only one medical report instead of two; and some judicial authorities, perhaps influenced by outmoded misconceptions, prefer to sentence an offender for a definite time rather than entrust him to our care for an indefinite period.

But while Section 4 is well suited for those suffering from mental illness, often briefly episodic or even ephemeral, who have been guilty of misdemeanour, its help to the subnormal has a more limited application. Rehabilitation, reformation and resocialisation of the subnormal, as a rule, requires a period of years rather than weeks or months, and the time afforded is too short to effect dramatic change. On their return to the community most of such patients would benefit from the after-care of a mental welfare officer rather than a probation officer and possible duplication of their services is not desirable. Many probation officers agree that, except in a very limited number of subnormal offenders, action under the 1959 Act is preferable.

It is worthy of note that the number of cases coming under Section 60 and 65 of the Mental Health Act and Section 4 of the Criminal Justice Act, large as it is, does not represent the total of delinquents admitted. No police action is taken against certain offenders when it is agreed that they will come to hospital, informally, or under Section 26.

#### **DISCUSSION**

It cannot be maintained that penal procedure is never justified because the offender suffers from some degree of psychiatric disability. To commit to hospitals every subnormal delinquent who may previously have spent many years there is not always a good thing. Those who have volition and understanding and whose crime is not typical of, or dependent on, their mental defect, may benefit from, and even prefer, a period of ordinary detention within the penal code.

Equally it is unwise and unrealistic to adopt a policy whereby all subnormal offenders dealt with by legal process are excluded from the benefit of treatment in hospitals for the subnormal. Many make a first class response, become socially viable, and are not again involved in trouble after completing their period of residence.

The special hospitals cater for the persistent criminal and the grossly aggressive and play an invaluable part by receiving patients who require a measure of control and supervision greater than can be afforded in an ordinary hospital. The only criticism which can be levelled at them is that their criteria for reception are sometimes difficult to understand and even appear arbitrary to the psychiatrist making the recommendation. This may be inevitable in dealing with a branch of an impersonal

Ministry and could be improved if one could discuss each case with the arbiter, who is presumably psychiatrically experienced. Now that the Hospital and Specialist Division responsible for the management of special hospitals has removed to a separate establishment an opportunity to rectify the position may be available. The advice of the Working Party, mentioned in H.M. Circular (61) 69, that consideration should be given to transferring a patient elsewhere in the Region before recommending him to special hospital, has not proved efficacious in practice.

There remains an intermediate group whose own future welfare, not to mention the protection of the public and the smooth running of the hospital, would best be served by the provision of some type of special unit. Experience has shown that the success of a special security unit does not depend on physical measures such as high walls and locked gates but on the close supervision and observation of an adequate nursing and medical staff.

Alternative proposals for these units discussed over a period of time in this Region were:—

- (a) That each of the four large subnormality groups should provide its own. This is not ideal as the expense involved would be great, the number of patients in each small, and suitably qualified specialist staff difficult to obtain.
- (b) That one of these hospitals be chosen for the purpose. Each medical superintendent, probably unjustifiably apprehensive of being saddled with the others' misfits, was coy and reluctant to be the one selected.
- (c) To build one or two separate Regional units, possibly associated with an establishment for psychopathic offenders, where they could be received and treated.

The present position is that "until special security units can be provided, hospitals are expected to deal with patients from their own catchment areas requiring a degree of security. Failure to do so on the part of any one hospital at the present time would only mean diverting patients from its catchment area to neighbouring psychiatric hospitals who are in no better position to cope with these patients".

It would appear therefore that experiment and research is required before any final recommendation can be made. Each region may have individual problems and nothing but good can emerge from a variety of approaches. Only in this way can any national policy be formulated.

### SUMMARY

During 1965 one hundred and sixty-eight patients were admitted to the Royal Western Counties Hospital Group. Of these 37, or 22%, were under some form of Court Order. If other offenders had not entered informally or under Section 26 the percentage would be even higher. Some delinquents caused trouble and difficulty within the hospital and also, when they absconded, committed crimes and depredation outside. Only the forbearance and understanding of the Police and the Courts prevented undesirable publicity and enabled us to continue to care for them. Various methods of dealing with these subnormal delinquents are advocated and discussed.

### CONCLUSIONS

1. The provision of maximum security should be the responsibility of the Prison and not of the National Health Service. Psychiatric facilities could be made available.
2. Near maximum security is already afforded by the special hospitals.
3. Lesser degrees of security can be provided in a variety of ways depending on local circumstances, and experiment and research is needed to determine the most suitable methods.