

SYMPOSIUM ON "HOSPITAL ORDERS"

I. RESTRICTION ORDERS IN OPEN HOSPITALS with an Appendix on Security and Closed Wards

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The humanitarian revolution in the early nineteenth century led to the widespread building of asylums. Some of these institutions began with the benign function implied by the literal meaning of the word "asylum", but enthusiasm waned, and soon their primary purpose became to protect the community from the supposed risks of the mentally disordered. Penal methods of care supervened, and even into the twentieth century it was still assumed that certification, detention, segregation and strict custodial rules were necessary. Such care represented almost the only responsibility accepted by the community.

The asylum doctor was known as an "alienist", indicating that his function was to remove out of sight and lock away those whose behaviour constituted a problem for the community. This attitude isolated the services for the mentally disordered from medicine, and helped to reinforce the prevalent belief that mental disorder had violence as its predominant feature. A corresponding isolation was also reflected in the legislation for the mentally subnormal, and in the resigned acceptance by the public of the inadequate standard of care and lack of treatment.

Not until after the second world war did public opinion alter enough to demand revision of the ancient, outdated legislation. Although people had tended to become more sympathetic and understanding, Thomas (1959) believed that it was the advance in diagnostic and therapeutic techniques which caused the fundamental change of attitude. Patients became able to return to the community, and this positive result secondarily influenced public opinion. In the field of mental retardation the advances brought the speciality back into the centre of many clinical areas of investigation.

In 1954 the "Royal Commission on the Law relating to Mental Illness and Mental Deficiency in England and Wales" was set up under the chairmanship of Lord Percy of Newcastle. It did not inquire into treatment, nursing or accommodation, but only into the legal and administrative machinery concerning the mentally disordered. Various witnesses, including the R.M.P.A. and the Magistrates' Association, criticised the existing legislation and its emphasis on protection of the community, rather than on treatment and rehabilitation of the patient. The Royal Commission's Report (1957) implied that mental disorder must be regarded primarily from the point of view of the patient's health and welfare, rather than from that of society's protection.

The Report was followed by the Mental Health Bill, which was closely examined and discussed in the House of Commons. Restriction orders came up as a

main topic on 19th March, 1959. The question was debated whether the power to be given to the Secretary of State concerning special restrictions on discharge might be in conflict with the new conception of treatment for mental disorder. Mr. Kenneth Robinson (St. Pancras North, Lab.) now Minister of Health, moved to delete the provisions in clause 64 for restricted discharge and the related authority of the Home Secretary. He held that these tended to confuse the function of a hospital with that of a penal institution, contrary to the spirit and aims of the Royal Commission.

On 24th March, 1959, Mr. Renton, Under Secretary, Home Office, explained that there should be no segregation of those patients subject to restrictions. The only differences would relate to discharge, leave or power to recall. He also said that it was the intention of the Minister of Health that cases under restriction should be reviewed periodically according to the provisions of clause 43, i.e. the Responsible Medical Officer would review these at the same intervals as those without restriction. This safeguard was never written into the Act, but was left as an administrative arrangement.

ORDERS RESTRICTING DISCHARGE (Mental Health Act 1959)

Power is given to a court of assize or quarter sessions, but not to a magistrates' court, to restrict discharge from hospital where a hospital order is made because of

- (a) the nature of the offence.
- (b) the antecedents of the offender.
- (c) the risk of his committing further offences if set at large.

Such an order, called an order restricting discharge, and referred to in this paper as a restriction order, may be made either for a specified period or without limit of time (section 65(1)). A restriction order cannot be made

- (a) unless a hospital order is also made.
- (b) unless at least one of the medical practitioners, whose evidence is taken into account by the court, has given evidence orally before the court.
- (c) when a guardianship order is made.

If a person over 14 years of age is convicted by a magistrates' court of an offence in respect of which a hospital order under section 60 could be made, but having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences, the court may be of the opinion that a restriction order is more appropriate. Instead of making a hospital order, or dealing with the offender in any other manner, the magistrates' court may then commit him in custody to quarter sessions (section 67(1)), which may

- (a) make a hospital order with or without restriction.
- (b) deal with him in any way that the magistrates' court might have dealt with him.

A magistrates' court, pending disposal of the offender by quarter sessions, may admit him to a hospital, with the latter's consent, and direct that the offender be produced at the quarter sessions (section 68(1)). The period of twenty-eight days, within which the patient must be conveyed and admitted to the hospital, does not apply and, until the case is disposed of, the offender must be treated as if he were subject to a restriction order (section 68(2)). In practice, if a considerable time elapses between the patient's committal and the hearing at quarter sessions, the latter may require a fresh medical report; also, if the patient's condition changes in any way the clerk of the peace must be advised by the hospital authorities.

In respect of a restriction order made by a court of quarter sessions, the patient may, within 10 days of sentence being passed, appeal to the Court of Criminal Appeal which may dismiss the appeal, reduce, quash or increase sentence, or even pass some other sentence e.g. that of imprisonment (section 69(2)).

Whilst a restriction order continues in force none of the provisions of Part IV of the Act, relating to the duration, renewal and expiration of detention, apply and the patient is detained until discharged by the Secretary of State either absolutely or conditionally (section 66(2)). If the Secretary of State lifts the restriction the hospital order continues in force. If the patient absents himself without leave and if the restriction order was made for a specified period, that period does not expire until the patient's return to the hospital (section 66(3)(o)). Power to grant leave of absence under section 39 or transfer under section 41 can be exercised only with the consent of the Secretary of State, but, where leave of absence is granted, the Responsible Medical Officer, as well as the Secretary of State, has power of recall.

No application may be made to a Mental Health Review Tribunal but the Secretary of State may refer the case there at any time for advice. The patient may also request the Secretary of State to do so after one year from imposition of restriction, at the end of the second year and then at two yearly periods. The patient's request must be acted upon by the Secretary of State within two months from the receipt of the request. If the patient, after being conditionally discharged, is recalled to the hospital, he may appeal from six to twelve months after his recall.

Under sections 72 and 73 prisoners in certain categories may be transferred to hospital if the Secretary of State is satisfied that they are mentally disordered, and under section 74 he may impose the restrictions of section 65 upon such patients. Under section 75 the Secretary of State can direct back to prison any patient subject to a restriction order on notification by the Responsible Medical Officer that further treatment is not required, provided that the period of the prison sentence has not expired. The Secretary of State may direct that a person unfit to plead, or not guilty because of insanity (Criminal Procedure (Insanity) Act 1964 section 5 (1)), be detained in a hospital under section 71 (1) (2), which is equivalent to a restriction order without limit of time (section 71 (4)).

RESTRICTION ORDERS IN PRACTICE

(A) DIFFICULTIES

The provisions for restricting discharge, together with the authority invested in the Secretary of State, suggest that when the Mental Health Act was still in the Bill stage the functions of hospital and penal institutions did become confused. This was contrary to the aim of the Royal Commission to complete the change of psychiatric hospitals from mainly custodial institutions into genuine hospitals.

The Act presupposes that a lawyer can be expected to predict both the duration of a patient's treatment and its outcome. Whilst detained under a restriction order a patient may only be discharged from hospital by the Secretary of State. Thus, he might continue to be detained even if the Responsible Medical Officer considers that he has recovered, or is no longer responding to treatment.

Section 65 may present the psychiatrist with a conflict between his direct responsibility for the health and welfare of his patient, and the interests of the society of which he is a member. If a fixed minimum period of detention is imposed arbitrarily the element of sanctions automatically creeps in, since the length of treatment required cannot be predicted accurately in advance. On the other hand, restriction orders of indefinite duration can only be beneficial to the patient in rare instances.

Patients, who might otherwise have received limited terms of imprisonment, sometimes feel trapped by this form of justice. The feelings of resentment and frustration aroused interfere with rehabilitation, and may lead to a vicious circle of rebelliousness, absconding and further offences. This all too frequent state of affairs tends to put back both locks and clocks. Incarceration is enforced as a sustained precaution, and undue pre-occupation with preventing absconding and possible crime obscures the original treatment aim of admission. Newer, humane methods are jeopardised if hospitals are expected to re-introduce restrictions which they had to battle for so long to abolish, and hospital psychiatrists should resist moves to make them assume responsibility for providing make-shift prison conditions. There is also the danger of the psychiatric nurse being invested with the unenviable role of gaoler, at a time when the introduction of counselling and group therapy methods into some prisons is tending to change the role of the prison officer.

It should be no part of a hospital's function to be a place of detention when medical grounds no longer exist. Therefore, in an attempt to get away from the idea of legal sanctions, if a patient's treatment is either completed or no longer of value, his discharge from hospital ought to be a psychiatric decision. The Royal Commission intended that no patient's detention should be unduly or unnecessarily prolonged, and so offenders should never be detained in a hospital for custodial purposes, as a legal expediency.

Besides finding himself manoeuvred into the position of a gaoler the responsible psychiatrist has to accept a considerable administrative burden in connection with his section 65 cases. The requirement that he must seek Home Office approval and permission for even trivial and routine decisions may lead to psychologically favourable moments in rehabilitation being missed, whereas the Mental Health Act was designed to ensure early and appropriate treatment, care and training, and to encourage the use of measures aimed at preventing maladjustment and delinquency. Staffing difficulties, both in the hospital service and at the Home Office, can delay correspondence and hamper flexibility of treatment. Even with rigorous control, a hospital treating restricted patients alongside others is likely to find itself, unwittingly, in breach of these regulations from time to time.

Patients are sometimes received for admission and are found, unexpectedly, to be subject to section 65 restrictions. This is bound to create difficulties, and on 12th December 1961 Mr. Kenneth Robinson raised the problem in the House of Commons. The Minister of Health replied that "the decision whether to make a hospital order with or without restriction rests entirely with the court, whose conclusions may not be known when the patient arrives under such order at the hospital".

Often in such cases the psychiatrist who has written the section 60 recommendation during remand will have examined the patient without full knowledge of his previous antisocial record. McDiarmid (1963) pointed out that the psychiatrist may well over-identify with the patient's own feelings and that, unless he is called to attend, he may never get to know the story as put by prosecution and police in court.

It has also seemed that for certain serious offences (e.g. arson) section 65 is applied "automatically" by some courts, perhaps under the mistaken assumption that the hospital will then be bound to apply special conditions of security. The paramount consideration for the doctor, however, must at all times be the patient's welfare, and the Royal Commission believed that treatment in isolation from the family or the community should be used as little as possible.

The section 68 procedure, by which a magistrates' court may commit the offender to a hospital pending his appearance before the quarter sessions, likewise inter-

feres with the hospital's scope for rehabilitation, because of the restrictions imposed, and it can put an unreasonable strain on the understaffed hospital service.

(B) ADVANTAGES

In spite of these difficulties, there remain some circumstances in which restrictions upon discharge may be applied beneficially in local psychiatric hospitals for subnormals.

Restriction orders of short duration can sometimes benefit younger patients, already known to the hospital, who may have shown promise of responding to treatment, yet have failed and perhaps offended more seriously. Some compulsive absconders are able to accept section 65 for one or two years as a brake and a general indication of the seriousness of their position and the urgent need for sustained co-operation. Restriction orders may be a necessary and helpful expedient with certain patients under 21 who have re-appeared in court soon after discharge by operation of the law as an automatic consequence of twenty-eight days' absence without leave (section 40). This group has been studied by Woolf (1966).

Occasionally, patients are able to accept that discharge in the foreseeable future must not be contemplated. Examples include some who have made the hospital their home over the years, but cannot curb dangerous compulsive sexual propensities outside. These, and other social derelicts, may live peacefully under supervision in the sheltered hospital environment, and it can be kind and humane to allow them to remain, even under restriction orders without limit of time.

Patients may be helped by the presence in court of the psychiatrist prepared to undertake treatment. During the diagnostic examination he will normally have tried to explain the nature of treatment under section 65, in an effort to bring the patient towards understanding why such a drastic measure might have to be considered. If the psychiatrist subsequently participates in the court proceedings there is a continuity of experience shared with the patient, which may play a significant part in cementing the therapeutic relationship planned to help him to modify his previous attitudes towards authority. Afterwards, during the early phases of treatment, before parole and leave are recommended, the psychiatrist can, where necessary, reinforce his role as the good, understanding figure by letting the patient project some of his resentment against authority upon the remote official figure of the Home Secretary. Later, the psychiatrist will help the patient to overcome this primitive splitting of authority figures into good and bad, until an intermediate stage is reached when the special restrictions are no longer necessary. Eventually, some patients may develop sufficient insight for the last stages of rehabilitation to proceed on an entirely informal basis, as a partnership between the patient and the psychiatric staff of the hospital.

SUGGESTIONS (*Nos. 2 and 4 would require amendments to the Mental Health Act).

1. When only one medical witness is required, the psychiatrist, rather than the prison medical officer, should normally be asked to attend in court to provide the oral evidence necessary for section 65. Many prison doctors agree that this is desirable because
 - (a) attendance of the psychiatrist offering to undertake treatment ensures that the views of the hospital concerned can be available to the court, and that the hospital is likewise fully in the picture before a restriction order is imposed.

- (b) the psychiatrist is better able to discuss treatment facilities at particular hospitals and prevalent security arrangements, if any.
 - (c) he is able to advise on the suitable duration of restriction, drawing upon his knowledge of how patients at his own hospital have felt about restriction orders and responded to treatment under these conditions.
- *2. The public interest might be served sufficiently if certain restriction orders were solely restrictions upon discharge, without the accompanying regulations which may interfere with treatment and rehabilitation.
3. Whenever the officer acting for the Secretary of State or the Minister of Health cannot readily agree to a measure proposed by the Responsible Medical Officer, there should be easy access to an independent psychiatrist, who would be available to come and examine the patient and discuss the case with the hospital psychiatrist. This need might arise with recommendations to relax or terminate restrictions, or in the case of a recommendation for transfer to Special Hospital.
- *4. The Responsible Medical Officer should have the power to discharge a patient, no longer in need of treatment, into the care of the Secretary of State, who would decide whether he should be released or further detained in a penal institution.

CONCLUSION

In certain circumstances there can be a conflict of interests between the legal and medical professions, which are jointly involved in the administration of justice and the treatment of offenders. A lack of full understanding and co-operation may result, because lawyers are concerned with the safety of society and with matters of reason, free will and conduct under conscious control, whereas psychiatrists are trained to give greater weight to the health and welfare of the patient and to emotional and instinctive forces, which may not be fully conscious.

Only by broader training in both professions, and by ceaseless research and pooling of experiences, will one arrive at the situation where sentences will never any longer be imposed arbitrarily, and instead there will always be strenuous efforts to collaborate in finding the most humane and most effective way of dealing with each mentally disordered offender.

APPENDIX: SECURITY AND CLOSED WARDS

The issue of security is related to that of restriction orders, but it must be remembered that secure accommodation may be needed for informal patients, and also that patients under restriction are often model citizens within the enclosed hospital community.

In a local psychiatric hospital, a closed ward typically consists of one or two rooms offering limited space for the patient and his belongings. Yet it is now realised that the "ward" should be a complex of rooms and outside areas, reflecting the basic physical, psychological and social needs of each individual patient, and providing for occupation and recreation, indoors and out. The patient's well-being demands as much freedom of movement as possible, within an overall security shell. Most of the older open psychiatric hospitals are still quite unsuited to this requirement. Paradoxically, the Special Hospitals can often offer better facilities, and greater freedom, to patients who need prolonged security, and the prison service may

rapidly overtake the hospital service in the provision of modern accommodation designed according to these generally accepted principles.

In the community adults normally work, play, eat and sleep in different places. In a typical closed ward all these activities may take place in the same confined space and according to a rigid schedule. Such anachronistic methods in hospital care and treatment seem to be based on ideas of retribution and deterrence which are often totally inappropriate. They must eventually give way to rehabilitation aiming to remove the causes of seriously deviant behaviour.

Admission or transfer into a closed ward is inevitably felt as punishment and a patient, incarcerated as a bad security risk, cannot pursue meaningful occupations such as are available outside the locked door. This undermines the aims of treatment and makes it harder to create a therapeutic atmosphere. Only with small groups, and specially picked staff, can one hope to prevent and overcome resistant attitudes, which hinder rehabilitation and social training. A proper balance between security and active therapy, with preservation of the dignity of each patient as a person, often cannot be achieved in existing circumstances. To combine the facilities of the Special Hospitals with flexibility of treatment and rehabilitation, customary in district hospitals under the National Health Service, will require the provision of special purpose-designed security units on a regional basis. Such units will only do their job really well with lavish expenditure on buildings and staff.

References

- McDiarmid, N. B. (1963). The Criminal in the Mental Hospital, *Lancet* p. 1371.
- Thomas, D. H. H. (1959). The New Bill and the Mental Deficiency Services, *Mental Health* p. 14.
- Woolf, P. G. (1966). The Back Door, *Brit. J. Criminology* p. 59.
- Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency (Cmd. 169) *H.M.S.O. London* (1957).
- Mental Health Act (1959). (7 and 8 Eliz. 2 ch. 72) *H.M.S.O. London* (1959).