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Mildly mentally handicapped offenders: an alternative to custody

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Concern is increasingly being expressed about the lack of provision for mentally disordered offenders, who by default end up within the penal system. Gunn *et al* (1991) in a study of sentenced prisoners identified a significant number who were mentally disordered to be in need of psychiatric treatment. Among these, 0.4% were considered to be mentally handicapped. Recent reports have emphasised the importance of diverting these individuals from the criminal justice system (Woolf & Tumin, 1991; Home Office, 1990; British Medical Association, 1990). However, the majority of such offenders do not fulfil the criteria for admission to hospital under the Mental Health Act 1983. Most are not overtly mentally ill and do not require treatment in conditions of medium security such as exist in regional secure units. However, it is not clear what provision there should be for such individuals. Smith (1988) described an open forensic unit for mildly mentally handicapped offenders (the Leander Unit). She concluded that there was a need for a specialised service to cater for these patients, who were neither appropriately nor adequately provided for by the general psychiatric services, the mentally handicapped services, regional secure units or special hospitals. Unfortunately, in practice there are very few facilities for this group of patients.

Since that study was performed, there have been fundamental changes occurring within the structure and funding of the National Health Service. The provider/procurer model has concentrated attention on the funding of placements and the cost effectiveness of units. The Health Service is the predominant procurer although social and probation services refer this type of patient. At the same time, the emphasis has shifted from in-patient to community based psychiatric facilities, leading to a reduction in the number of available beds.

In order to examine what impact, if any, these changes have had on the use of the Leander Unit, a further study of admissions to the Unit was carried out.

The Leander Unit

Opened in 1967, the Leander Unit provides a service for Devon and Cornwall, although referrals are considered from further afield. In 1983, the regional secure unit was commissioned on the same site. The unit itself is composed of an 18 bedded assessment ward, a 17 bedded rehabilitation ward and 6 + 3 places in self-care flats. In addition, there is a resource centre where the Departments of Psychology, Education and Social Work provide sessions as well as an occupational therapy unit and gymnasium. Group therapy, occupational therapy and industrial therapy play a major role in the work of the unit. The philosophy of the unit emphasises treatment, training and rehabilitation. Treatment options are varied and range from the pharmacological to the psychotherapeutic.

Strong emphasis is placed on developing the necessary skills to survive in the community and avoid further offending. The unit is seen as a medium term facility. However, for a small group of patients it is recognised that because of the severity of their problems, long-term in-patient care within the unit is unavoidable. Many patients are treated as a condition of a Probation Order and close co-operation between the clinical teams and the Probation Service is a pronounced feature of the unit's activity. The Liaison Probation Officer has a major input into the Leander Unit and plays an important role in the rehabilitation process.

The study

Patients who were admitted to the Leander Unit between the 1 January and 31 December 1990 were included in this study. All patients are initially admitted to the assessment ward. The case-notes were examined and standardised information recorded. In addition, details of referral source and permanent health authority were obtained.

Findings

Demographic data

Eighteen mentally abnormal offenders were admitted during this period. All were male. Thirteen patients (72%) were aged 17 to 24, three patients (16.8%) were aged 25 to 34, and two patients (11.1%) were aged

between 35 to 44. The average age on admission was 22.

Location at the time of referral

Nine patients were assessed while on remand in prison (50%). Three patients were on probation. Three patients were referred from NHS hospitals. Two patients were on remand on bail.

Health authority

The health authority responsible for funding was identified in each case and recorded as follows: Exeter 7 patients (38.9%), Plymouth 3 patients (16.7%), Cornwall 2 patients (11.1%), Somerset 2 patients (11.1%), North Devon 2 patients (11.1%) and Torbay 2 patients (11.1%).

Criminal behaviour

There was an average of two offences per patient (range 1–7). Of a total of 36 offences, 15 were property offences, eight were sexual offences, three were arson, and two were crimes of violence.

Psychiatric diagnoses

Twelve patients had a diagnosis of mild mental handicap associated with a personality disorder (usually anti-social), with three of these abusing alcohol and drugs, and one abusing alcohol alone. Three patients were diagnosed as personality disorder alone but with commensurate deficits in educational and social skills. Three patients were diagnosed as suffering with psychosis, and epilepsy was a feature in a further three.

Problem behaviours

Only three patients exhibited no particular management problems. Problem behaviours included verbal and physical aggression, and low tolerance of frustration. In general, patients tended to be threatening and disruptive prior to admission as an in-patient.

Legal status on admission

Bail assessment for patients with low motivation was used on eight occasions with three subsequently placed on Probation Orders with a condition of psychiatric treatment under the Powers of the Criminal Courts Act 1977, Section 3. Six patients were admitted directly on Probation Orders. Four patients were admitted under the Mental Health Act 1983: Section 2, Section 3 and two under Section 37. Overall, it could be said that nine patients were admitted for assessment (of whom four stayed), and nine for treatment (of whom six stayed). Non-compliance with the condition of the Probation Order led to proceedings being initiated by the Probation Officer.

Length of stay

The average length of stay was 20 weeks (range 1 day–58 weeks); if the population who settled in the unit are considered then the average length of stay was 32 weeks (range 17–58 weeks). This is a somewhat artificial figure owing to the number who were still in-patients at the end of the study.

Patients fell largely into two groups: those who failed to settle and stayed only briefly, and those who remained in the unit for several months.

Outcome

At the end of the period of study, eight patients (44%) remained on the unit (either in the assessment or rehabilitation wards), three patients had been transferred to NHS hospitals, two were in the community and two had been returned to prison. One further patient had absconded, one had been transferred to the regional secure unit and one patient was living in a hostel.

Comments

One purpose of the present study was to compare this population with that described previously (Smith, 1988). It can be seen that the annual admission rate had increased. It was more difficult to make comparisons between the average lengths of stay. The original study provided an average length of stay measured in months for all the patients admitted; however, as this study covered a three year period, it had been possible to follow 40 patients (80%) through to the point of discharge. In the present study, eight patients (44%) remained on the unit at the end of the one year period, and therefore the average length of stay was misleading.

The average age on referral showed a younger patient group having been admitted, although the predominance of males continued to mirror the general criminal population rather than the general psychiatric. The unit admitted fewer mentally ill patients, which was reflected in increased referrals from the penal system, and the reduction in use of the powers of the Mental Health Act: 60% of the patients in the previous study had been detained, compared with 22%, 11% of whom were detained under Civil Sections. No patients were admitted from special hospitals, compared with 18% between 1984 and 1986. Criminal offences showed a reduction in sexual offences from 36.7% to 21.6%, and an increase in property offences from 26.3% to 40.5%. One possible explanation for the changes was that the unit was now admitting similar types of offender, but at an earlier stage of their "career".

The selection of patients who might benefit from admission to the unit has not been straightforward. An assessment of suitability using the remand on bail

procedure was made in several cases, and thus an element of self-selection was implied by the results. Further research would be needed to clarify the characteristics of those who settled in the Unit compared with the eight of the 18 admitted who stayed relatively brief periods of time. The latter group included some of the most disturbed offenders who could not be contained in an open facility, and yet were unsuitable for treatment in the regional secure unit. They seem to have slipped through the provision net completely.

The question of funding is a subject of current debate, with government policy being to divert the mentally disordered offenders from the criminal justice system (Home Office, 1990). However, it is unclear where the responsibility for funding alternative provisions lies: whether with the Home Office or the Department of Health. The Probation Service and the Department of Social Services do not have the necessary budgetary allocation, despite often being the referring agents, and currently the district health authorities shoulder the financial burden by default.

The cost of such specialist provision is not cheap, and although the total numbers requiring such care are not large, it would seem that a facility of this nature is required at the regional level. The current cost per patient per year of residence at the Leander Unit is £40–45,000 (compared with a range of costs between £60–85,000 at alternative resources nationwide). It is certainly less expensive in the short term for an offender to serve a prison sentence, but the longer term implications in terms of re-offending and psychiatric morbidity are not known.

Two possible approaches are immediately obvious: either district health authorities remain responsible for the provision of regional units, or specialised units are developed within the penal system and comprehensive forensic psychiatric services are bought in. Both options have implications for manpower provision for professionals within forensic psychiatry and consequent implications for funding. In a regional psychiatric unit, consideration would have to be given to issues such as number of bed days required, and the cost effectiveness of particular parts of the service provided, for instant assessment and rehabilitation. If the Home Office were to procure forensic psychiatric services then the nature of their role towards the mentally abnormal offender could be substantially altered. The increased length of stay resulting from public policy as opposed to the clinical needs of the patient would have to be funded. During this time of considerable financial constraint, however, it may be that central health monies are required.

While the numbers of mildly mentally handicapped offenders requiring psychiatric services are undoubtedly small, especially in relation to other mentally abnormal offenders, their particular needs should not be ignored. Furthermore while specialist provision at relatively high cost does exist, it does not appear to be meeting the needs of the more severely disturbed.

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