Contemporary Themes

Transfers from prisons to local psychiatric hospitals under section 72 of the 1959 Mental Health Act

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The problem of finding places in local psychiatric hospitals for sentenced prisoners who become ill has been given some prominence in recent years.^{1,2} During the course of the 1959 Mental Health Act's operation the number of people being transferred from prison to local hospitals under the section 72 provisions of that Act has declined steeply (fig). The top line

Number of people transferred from prison to local hospitals under section 72, 1961-77.

in fig 1 represents the total number of orders made under section 72 since 1961, the first full year of the Act's operation, and the dramatic decline in the number of orders is accounted for by admission to local hospitals rather than to special hospitals. The most pronounced decrease in orders has taken place since 1966, and between 1975 and 1977; no more than 25 people have been transferred from prison and other Home Office establishments to local hospitals in England in any one year. This compares with an average transfer figure of 116 during the first five years of the Act. The average number of people admitted to local hospitals as being "insane after conviction" between 1949 and 1959 was 122, and indeed the number of people being transferred from prisons to local hospitals varied little between 1949 and 1966. If judged only by the criterion of hospital admissions the 1959 Act has not benefited the mentally ill prisoner.

We have recently completed a study of the long-term criminal behaviour of a large group of mentally abnormal offenders, and part of this project included collecting data on those prisoners transferred to local hospitals during the two years 1962 and 1964. During this study we noted the fall in the number of section 72 orders made and decided to carry out a subsidiary study to try to determine whether or not there were any obvious reasons for this change in practice.

Method

The population of people transferred under section 72 in 1975 was added to those cases that had been collected from the intake in 1962 and 1964. In addition the population of patients from prison that Professor Walker and Mrs McCabe had collected in a 12-month period in 1966-7 was made available so that three groups could be analysed. One of these came from the early years of the Act's operation, one from the middle, and one from the period towards the end of the Act's history. It was possible to obtain over 90% samples for each group. Practically all were men and only men have been used in the following analyses.

Data were collected on the psychiatric, social, and criminal backgrounds of these men, and information regarding length of stay in hospital and type of discharge was available for all but the 1966-7 group.

Results

Firstly, it was noted that there was a high failure rate for transfer applications made by prison medical officers in 1975. Although some 25 orders under section 72 were effected during that year, another 13 section 72 reports had been completed by prison doctors but had not resulted in a successful transfer. This represents a failure rate of 25% for transfer applications (if we include special hospital transfers made in that year) and compares with the very different failure rate reported by Walker and McCabe,³ who found that only 6% of transfer applications made between 1967 and 1970 were not successful.

Of the group of prisoners who were not transferred, slightly over half were psychotic, and half of this group had recovered before the transfer application was processed and the application was withdrawn; but the other members of this group could not be found a place in either a special or a local hospital despite the prison doctors describing them as being in a quite pitiable condition.

Table I lists the major psychiatric and criminal variables collected in relation to the total population—that is, including those men transferred in 1962, 1964, 1966-7, and 1975. Practically all of these men had a previous record (94%), and three-quarters had been in prison before. The distributions of these variables are very similar to those produced by the total population of prison receptions. The section 72 group is likely to differ from the general prison population in regard to the distribution of the variable "age at first conviction." Of the section 72 group, 16% were over 30 when first convicted, and it would be surprising if this group of prisoners did not contain some people whose criminality was secondary to mental health factors. Most were diagnosed as schizophrenic, 20% being described as paranoid.

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Affective illnesses accounted for one in ten of the transferred group, and slightly fewer were diagnosed as subnormal. The concept of psychopathic disorder was used to describe only six men, 2% of the population. Two-thirds had a record of previous psychiatric admissions, and this is likely to be an underestimate.

Table II summarises the demographic characteristics of the sample, details of length of stay in hospital, and type of discharge. The average age of this largely anomic group of men was 33. Almost three-quarters of them had never married, and two-thirds had been living alone when arrested. Slightly over half the total were described as being of no fixed abode. The overall picture is of a group who were heavily concerned in crime, were suffering from mental illness rather than any other form of mental disability, and were leading a socially isolated existence outside prison.

TABLE I—Criminal and psychiatric characteristics for total section 72 transferred population (local hospitals)

		No	%	NK	Mean	SD
Any previous criminal record	Yes	258	94	12		
	No	16	6			
No of previous prison sentences	None	69	27	29	4.87	6.07
	1-2	50	20			
	3-4	38	15			
	5-6	26	10			
	≥7	74	29			
Age at first conviction	13	5		29	21.44	9.13
	11-15	57	22			
	16-19	60	23			
	20-24	56	22			
	25-29	27	11			
	≥30	44	16			
Diagnosis	S	157	55	2		
	PS	58	20			
	AI	26	9			
	SN and SSN	21	8			
	Psychopathic	6	2			
Previous inpatient admissions	Other	16	5			
	None	101	64	129	1.06	1.95
	1	18	12			
	2	17	11			
	3+	21	13			

S = Schizophrenia; PS = Paranoid schizophrenia; AI = Affective illnesses; SN = Subnormal; SSN = Severely subnormal; and NK = Not known.

In terms of transfer procedure and hospital discharge two-thirds of these men had been moved within six months of starting sentence. Having been transferred to a local psychiatric hospital, the modal group, 41%, remained in hospital when their restrictions on discharge under section 74 of the Act ceased to operate at expiration of sentence. Of this group, over half (58%) were detained on section, 29% were returned to prison to complete their sentence, and 20% were discharged directly by the hospital as being better. This latter type of discharge normally occurred after a man's earliest date of release from imprisonment had passed but before his full term had expired. Only 7% of these men absconded and did not return to hospital.

Table III presents the major differences found among the three main groups in this study. As regards criminological variables, the

TABLE II—Social data and hospital discharge for total section 72 male transferred population (local hospitals)

		No	%	NK	Mean	SD
Age	20	30	11	0	33.50	11.24
	21-29	89	32			
	30-39	96	33			
	≥40	71	25			
Marital status	Single	200	73	12		
	Married	26	10			
	Separated	33	12			
	Divorced etc	15	5			
Living arrangements at time of arrest	No fixed abode	139	51	15		
	Relatives	61	23			
	Wife	26	10			
	Lodgings	37	14			
Type of discharge of order	Other	8	3			
	Return to prison	59	28	79*		
	Remain in hospital	85	41			
	Discharged hospital	10	5			
Length of stay in prison before transfer (months)	Section 47	18	9			
	Absconded	14	7			
	Other	21	10			
	3	126	45			
	4-6	56	20			
	7-12	48	17			
	≥13	50	18			

*No information for 1966-7 group.
NK = Not known.

1975 group had had considerably less experience of imprisonment than the other two groups, and also tended to be serving shorter current sentences. Furthermore, there was an appreciable decrease over the years in the number and proportion of men charged with breaking and entering offences, and, interestingly, it is here rather than in the broad larceny category that contains many petty offences that the group difference exists.

The main difference in regard to psychiatric variables is in the use being made of the diagnosis of subnormality. Local mental handicap hospitals received no patients from prison in 1975 and, indeed, only three such admissions were made in England in the two years before 1975, so that the overall picture is one of minimal or no movement between prisons and local mental handicap hospitals. Significantly more of the 1975 group were living with their wives at the time of their arrest, and significantly fewer members of this group had been born in the British Isles.

The average length of stay in hospital was much shorter for the 1975 men than for those transferred in 1962 and 1964—four months as opposed to eight months—and the likelihood of being returned to prison to complete sentence doubled, 20-40%, between the two periods.

Although all 15 regional health authorities admitted some patients from prison in 1962 and 1964, five received no such patients in 1975. Regional distribution is presented in table IV.

TABLE III—Section 72 transferred male group compared by year of transfer

	1962-4		1966-7		1975		F	p
	Mean	SD	Mean	SD	Mean	SD		
Length of present sentence (months)	24.31	24.67	19.85	22.46	13.68	13.27	2.42	0.09
Months spent in hospital after transfer	8.61	11.95	—	—	4.00	3.95	3.52	0.001
	No	%	No	%	No	%		
Type of offence at conviction								
Breaking and entering	63	36	27	30	2	10		
Other theft	63	36	34	39	7	37		
Other	46	29	30	31	10	53		
Diagnosis								
Schizophrenia	102	58	46	51	9	47		
Paranoid schizophrenia	34	19	21	23	3	16		
Affective illnesses	13	7	9	10	4	21		
SN and SSN	11	6	10	11	0	0		
Psychopathic disorder	5	3	0	0	1	5		
Other mental illness	10	6	3	3	2	10		
	1962-4 + 1966-7		1975		NK		χ ²	p
	Yes (%)	No (%)	Yes (%)	No (%)	No (%)			
Any previous prison experience	183 (76)	58 (24)	7 (44)	9 (56)	29	6.47	0.025	
Whether born in UK	244 (91)	23 (9)	13 (68)	6 (34)	1	7.90	0.005	
Living with wife at time of offence	21 (8)	232 (92)	5 (28)	13 (72)	15	5.27	0.025	

SN = Subnormal.
SSN = Severely subnormal.

Discussion

There has been a steady and fairly rapid decline in the number of people being transferred to local psychiatric hospitals since 1961 and in particular since 1965. An analysis of a recent year's intake of section 72 transfer patients suggests that, even when the section operates and a man is transferred to hospital, he is less likely to be criminally experienced and is less likely to have served previous prison sentences than his counterpart during the early years of the Act's operation. It would be tempting to conclude that the 1975 population was less criminal than that of the group transferred in 1962 and 1964, but any interpretation of these results is confounded by the fact that sentencing policy has changed between these two periods and more specifically by the fact that suspended sentences have been introduced. This will probably have affected the chances of some members of the ill/offender population ever having had prison experience. In 1964 almost 19% of people found guilty of indictable crimes were sent to prison, while in 1975 the percentage of those given prison sentences was only 10%, and almost 9% of the total population received suspended sentences.

As regards diagnostic category, about eight out of every ten

TABLE IV—Regional distribution of section 72 transferred population by year of transfer

Region	1962 + 1964*		1966/67		1975		NK
	N	%	N	%	N	%	
Northern	11	7	6	7	0	0	14
Yorkshire	15	9	12	14	2	11	
Trent	8	5	2	2	1	5	
East Anglia .. .	9	5	6	7	1	5	
NW Thames .. .	2	1	3	3	1	5	
NE Thames .. .	9	5	3	3	2	11	
SE Thames .. .	15	9	7	8	3	16	
SW Thames .. .	37	22	19	22	1	5	
Wessex	2	1	1	1	0	0	
Oxford	4	2	1	1	0	0	
South Western ..	13	8	5	6	3	16	
West Midlands ..	14	8	6	7	1	5	
Mersey	10	6	6	7	0	0	
North Western ..	9	5	7	8	0	0	
Wales	9	5	2	2	4	21	

*The raw number in this column represents two years' intake.

men transferred from prison was deemed to be suffering from mental illness, usually schizophrenia. There is no evidence that hospitals were being asked to accept difficult or unmanageable people who were not disabled by illness or mental handicap. Only 2% of men were labelled as being psychopathically disordered. By 1975, the number of men being moved from penal establishments to mental handicap hospitals had dwindled to one or two a year, but numerically it is patients suffering from mental illness who have been most affected by the decrease in use of section 72 provisions. The fact that the average length of stay for patients transferred in 1975 was half that of those patients transferred in the earlier years of the study and that the 1975 group were twice as likely to have been returned to prison to complete sentence suggests that there has been a serious breakdown in goodwill between prisons and local psychiatric hospitals. Even when a man is transferred, the hospital regards his stay very much as a temporary measure, and he is returned to prison as soon as possible.

If the low level of transfers from prisons to hospitals is maintained the relevant section of the Act may come to be regarded as an allowable rather than as a practicable clause. Indeed this would seem to have happened already. In a parliamentary written reply to Mr Kilroy-Silk in June of last year it was stated that, "... places have not been found for four sentenced prisoners recommended for transfer to NHS hospitals." The reply also said that 461 prisoners were considered suitable for transfer to either special or local hospitals. It must be assumed that prison doctors have not even attempted to find places for most of the men who were considered suitable but were not on a hospital waiting list.

Why is it now so difficult for prison medical officers to obtain admission for the mentally ill men in their care? There was no reason to suppose from the results of the present study that most, or even a significant minority, of men transferred under section 72 were unsuitable for local hospital confinement. In the group of patients in this study we found that only 7% of the total absconded from hospital and did not return and that ten men committed offences while they were inpatients. These statistics reflect external security, of course, and it is not known to what extent patients from prison presented problems for hospitals in terms of their internal security. Most of the men were habitual thieves, and some may well have continued to steal when in hospital. It is known that 47%, almost half the group from 1962 and 1964 were not discharged from hospital at expiration of sentence and of this group, 41% remained as informal patients. The average length of stay after expiration of sentence was more than two years. It could be reasoned that had these men provided a considerable management problem for local hospital authorities they would have been discharged as soon as the law allowed under the terms of section 74 of the Act, or, more probably would have been returned to prison to complete their sentences. More probably most men transferred from prison did not cause significant problems for the authorities of those hospitals. A detailed search of the notes for comments

about a patient's unsuitability showed that 24 (13%) men in the 1962 and 1964 group had either offended while in hospital, absconded and did not return, or were transferred to a special hospital.

The White Paper on the Review of the Mental Health Act 1978 contains proposals that the section 74 restriction order that usually accompanies a section 72 transfer order should cease to have effect at a man's earliest date of release from prison—that is, after two-thirds of his sentence given full remission—and not at expiration of his sentence as at present. While this is to be welcomed it will do nothing to ease the lot of those prisoners who are ill and who cannot obtain treatment in a local psychiatric hospital. If such relief is to be obtained there will have to be a change of attitude on the part of medical, nursing, and ancillary staff in local hospitals. In recent years the practice has developed whereby a senior member of the nursing staff accompanies a consultant when a prisoner is being assessed for admission. Blanket bans on patients from prison now operate in many areas, however, and the practice has not resulted in an increase in admission rates. If, as is expected, a new mental health act is presented to Parliament within the next few years an intensive public relations exercise should be carried out at the level of local hospitals to introduce the new Act, and this ought to have the plight of the mentally ill prisoner as one of its central themes.

The problem of finding places for patients from prison has been characterised in recent years by statements about the "hundreds" of people in prison who are awaiting places in mental hospitals. Such statements are likely to frighten local hospital staff rather than encourage them to reopen their doors to the acutely ill prisoner in need of special care. The figures quoted in this connection have ranged between 450 and 900 on occasion but it would surely be better if the size of the potential population was described in terms of what it has ever actually been. Between 1949 and 1966 the number of people transferred from prison to local mental hospitals varied from 116 to 184, the average being around 140. Even allowing for the increase in the size of the prison population, it is unlikely that, in practice, the annual figure would be more than 180, and as a percentage of the total intake of local mental hospitals this would hardly be measurable. In 1964 the section 72 population accounted for 0.002% of local hospital admissions. For the individual local hospital the figures mean that many such establishments would either never be asked to accept a patient from prison or would be required to do so perhaps once every four or five years. A few hospitals, the larger metropolitan ones, would be asked to accept a patient from prison three or four times a year. Most patients sent from prisons to local hospitals seemed to settle there, and only a small minority were unsuitable.

Of the men in this study, 81% had been admitted to a psychiatric hospital on occasions other than on their admission from prison. (This figure includes admissions that were known to have occurred during the course of the follow-up project.) This is a minimal estimate of the number of people who had a record of (other) psychiatric admissions, but even if the figure is accepted it means that local hospitals are not being asked to treat people for whom they do not provide care on other occasions. It is difficult to understand what medical or management criteria are being used to exclude these men from local hospital care. Is it simply that they happen to be in prison when they become ill?

It is thought that some measures might be taken to ensure that the transfer procedure is as speedy as possible. Although the 1959 Act states that transfer must be effected within 14 days of an order being made, the real delay in transfer procedure occurs between the writing of the prison doctor's report and the order being effected. In the population under review only one-quarter of orders were made within a week of the doctor's report being completed. In slightly under half the cases the interval was more than two weeks, and the process took more than one month to complete in one out of five occasions. Most of the men concerned were mentally ill, and the delay between

request and completion of transfer is likely to have caused considerable and unnecessary suffering. Such delay may also have caused some ill feeling and distrust to arise between prison and local hospital medical authorities as a number of the men concerned would no longer have been in the acutely ill condition described by the prison medical officers in their reports.

The patient from prison has never been popular in mental hospitals. Referring to a Bill introduced in 1840, Walker and McCabe³ state that, "... it did nothing to improve either the prisoner's chances of transfer or the procedure for arranging it. There was still too much scope for inertia on the part of prison doctors and for resistance on the part of asylums." More than 100 years later the asylums are still resisting and so effectively that many prison doctors no longer even attempt to transfer their ill patients to appropriate hospital care. We found several severely subnormal men who were being refused admission to a hospital for the mentally handicapped. Public knowledge of the condition of these men would surely cause public scandal. It is unlikely that there are many such men in prison but that they are there at all is indefensible.

We suggest that there are several ways in which the present unsatisfactory situation might be remedied and that the introduction of a new mental health act could provide the opportunity for many local hospital authorities to modify their approach.

We thank Mrs Sarah McCabe and the members of the Home Office who helped us with this work. The study was carried out while we were in receipt of a grant from the Home Office but the views expressed are our own and do not necessarily represent official Home Office opinion.

References

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MATERIA NON MEDICA

Vandalised

The very word is symptomatic of the age. The Vandals swept across Gaul, Spain, and North Africa to Rome in the fifth century like an exanthem. Today the process is endemic. Few of us can have escaped its annoyance, from useless telephone kiosks to scratched car bodies or slashed tyres.

For me the attack came, unusually, at 8.45 am. Three boys ran into the garden and mercilessly toppled one of my hibernating beehives. Running out in consternation and inadequately protected, I was badly stung by the irate colony. Due perhaps to internal adrenaline, the effect of the 30 or so stings was minimal. I was able to put the hive parts quickly together around the central core, where with any luck the indomitable queen still lives. If not the colony will die. As it was one or two thousand bees lay lifeless on the cold ground.

The culprits were caught by very efficient detective work at school and later I had an apologetic mother on the phone. I suggested the docking of pocket money as a suitable punishment. As to the psychological trauma, philosophy came to my rescue. "Forgive, as I forgive" assumed a new and relevant healing function. It was reinforced by numerous solicitous inquiries from anxious patients who read of the incident in the local paper. Thus an act of mindless hooliganism flowered into a neighbourliness strong as the propolis with which the bees sealed their damaged home. It provided me with a parabolic answer to the whole problem. Meanwhile only time will tell whether the hive itself will survive.—S L HENDERSON SMITH (general practitioner, Huddersfield).

Garden fauna in Queensland

The quiet of Sunday morning was disturbed by a continuous, repetitive, high pitched screeching somewhere in the uppermost branches of the tall gum trees that soar and spread within our garden. Visible in the morning sun was a large but obviously young bird opening its beak frequently and noisily, at the same time flapping its immature wings. Fluttering around busily was one of our resident peewees. Was it attacking this stranger to the territory? On closer inspection, the large newcomer was demanding to be fed and was succeeding. It had not seemed very long ago that two large birds had floated in with huge wing span, zebra-striped undercarriage, and hooked beak to be swooped upon and dive-bombed by the local bird population, the same peewee in the van. These large birds, which were later identified as a pair of crested hawks, realised they were not wanted and moved on. Yet here was the peewee, dwarfed by the new baby, busily putting delicacies into the ever-opening beak. Was this revenge? Or was the crested hawk trying to outcuckoo the cuckoo?

It was the magpies that brought our notice to another visitor to our eucalypt establishment. Again, all the action was in the higher branches. This time the dive-bombing victim was that silent, Australian, leaf-eating equivalent of Paddington Bear—the koala. He had wandered in during the night looking for his special gumleaves. No amount of magpie attack would make him move again until dark.

But these are the extras. Our garden is full of interesting varieties of Australian fauna. An ear-piercing entrance heralds the daily visits of the rainbow lorikeets. Noisily, they feed on the new buds and flowers. Every morning the kookaburras laughingly tell us that they are still around and happy. Busy in the smaller trees are the various types of honey-eaters, different shapes and sizes, but all with a long beak which enables them to get at the nectar in the brush-like flowers. At ground level, the large resident frilly lizards stand dragon-like, with mouths open, feeding on the passing insects. Bright green tree frogs come to life in the evening, their disguise so good that only careful inspection allows them to be seen. Naturally, these frogs have all been renamed "Kermit," but unlike their famous counterpart, they find it's easier being green. At dark, the ugly cane toad appears. He sits with his companions, staring silently in a fairy-like ring. Any thoughts they keep to themselves.

There are other less desirable residents. Like the friendly ones, they are with us all year round—grasshoppers, snakes, mosquitoes, and the biting midge—it takes all kinds.

None at all seem to mind that they have to co-exist with our dog and six cats.—J P COLQUHOUN (Cleveland, Queensland, Australia).

When the north wind doth blow

One of the minor side effects of the Clean Air Act was that it abolished everyman's do-it-yourself weather forecasting. A glance out of the window at the neighbour's chimney told you not only which way the wind was blowing, but whether it was going to be wet or fine according to the inclination of the smoke. Though I am no expert at forecasting the weather I am a keen observer of what the encyclopaedias call the natural world. To me, observing the smoke from a cottage chimney was a crude indication of the severity of the weather; rather like looking at a patient's tongue—it does not make the diagnosis but it does indicate whether or not the sufferer is really ill.

With no smoke to observe I decided I must at least know which way the wind was blowing—otherwise how could I know when the swallows might be coming in the spring or the mayflies be about to hatch in the summer? And so I decided to buy a weather vane. Like books or pictures a weather vane reveals a little of the character of the occupants of the house to which it is fixed. For that reason I rejected the traditional rooster as being too ecclesiastical, and Father Time with his scythe I hoped was too premature. We are not a horsey family so the mounted equestrian was inappropriate and I settled for a fisherman sitting contentedly rod in hand. With the aid of a compass the angler was fixed to the gable of the house and accurately aligned. Now everyone else in the neighbourhood can see which way the wind is blowing without going out of their houses—except us. But our house is now different from all the others in the village and we can describe it to visiting strangers with a superior air—"You can easily recognise it—it is the one with the weather vane."—R A F COX (medical director, London).