MEDICAL PRACTICE

Contemporary Themes

Disasters, Asylums, and Plans: Forensic Psychiatry Today*

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British Medical Journal, 1974, 3, 611-613**Three Disasters**

About a year ago three disasters occurred in my clinic all within a short space of time, and they made a considerable impact on my view of the modern psychiatric scene.

The first story concerned a man in his early 30s, who for many years had harboured paranoid, hypochondriacal ideas. He had had repeated admissions to his local mental hospital, without much effect, though he always maintained that in hospital he felt "safe" and relaxed. But when hospitals were no longer prepared to keep him he said that if we didn't get him into hospital soon he would "have to do something"; "I won't commit suicide," he said, "or if I do, I will take someone with me." I agree with MacDonald,¹ who urges us to take such threats seriously, and I referred him urgently to another local mental hospital for possible admission. The consultant who saw him regarded his problems as more social than medical and once more not suitable for admission. At this news he set fire to the curtains in the outpatients' department and ran off. Later he was found by the police—after he had started a more serious fire in the nurses' home of the hospital concerned. It later transpired that he had previously started other fires—two in churches, and one in another outpatients' department where admission had been refused.

The second case was a man in his mid-50s. An impulsive, violent, and lonely man. Under stress he tended to become paranoid and to lash out in a brutal manner, and he had spent most of his life in prison. At the time I saw him he was charged, yet again, with a vicious assault on an old woman. To pay off an old score he decided to burgle a house but was alarmed to find, when he got there, that an old lady was at home. He threw her down the stairs and ran off. At his trial the

judge was very reluctant, in view of the uselessness of the procedure, to send him back to prison. I was asked, therefore, to try and find him a bed in a hospital. This I failed to do but offered the court the option of his attending my outpatient clinic. To my surprise this was accepted with a special five-year binding over order.

Though he was somewhat afraid of me and never entered treatment in any active sense he remained cheerful and contented for some time largely because he found a place in a good hostel. Unfortunately this had to be closed after some months and once more he was back on the street. He became tenser and tenser and pleaded for help with accommodation which I, a voluntary society, and two probation officers were unable to supply. One Saturday evening he attacked and robbed an old lady. This time the same judge that had bound him over sent him to prison for seven years.

The third disaster concerned another single man, this time in his mid-40s, with a long prison record for violence which mainly occurred when he was drunk. He had attended my clinic for five years. Occasionally I would have him admitted for a month or two to an alcoholism inpatient unit but usually he would run off after a while and return to drinking. During one of his periods in hospital he met a disturbed but beautiful young woman patient. They became very friendly and he went to live with her in her mother's house. Inevitably, however, things went wrong and he terrorized the whole household. After a terrible scene, during which he was rejected by his girlfriend, the police were called, he was brought to hospital, and admitted as being potentially homicidal and suicidal. After some weeks a social worker tried unsuccessfully to find him some hostel accommodation, and so he was discharged to his usual lonely bed-sitter. He soon found himself out of work and unable to pay the rent. His landlord gave him notice and one week later he took a massive overdose and killed himself.

In each of these cases the crisis was precipitated by actual or impending homelessness. It would be naive to argue a direct causal link between ill-health and violence or between social stress and violence.² Nevertheless, three propositions are worth considering. Firstly, these disasters need not have occurred; secondly, if, as a society, we are serious about reducing crime and protecting our citizens then we will take steps to see that these social pressures do not bear down on people who are unable to carry them; and, thirdly, maybe the only really effective treatment which could have been made available to these men (and wasn't) was old-fashioned voluntary asylum.

*Based on a lecture given to the Northern Counties Psychiatric Association on 3 November 1973

Asylums

Since the war there has been a remarkable change in the facilities offered to the mentally disturbed. Perhaps this is no surprise for it has coincided with enormous social upheavals of other types, and in any case mental health facilities have been in a state of flux for about 150 years.³ One of our proudest boasts in this country is that we have reduced compulsion and admission to hospital for the mentally sick to the absolute minimum. The theory is that we have replaced these ingredients with community care. A D.H.S.S. publication told us in 1971⁴ that between 1954 and 1969 there had been a fall in the psychiatric inpatient population of this country by 31%. Nevertheless, as the *British Medical Journal* has suggested in a comment on that report,⁵ quite possibly the reduction by half of the inpatient population in the 25-44 age group could, at least in part, be accounted for by the increase in the number of offenders remanded in custody for a psychiatric report. The latter went up from 6,366 in 1961 to 14,232 in 1970, and in 1972 still stood at almost 12,000.⁶ The same report provoked correspondence in the *British Medical Journal* at the time.⁷⁻¹⁰

In their analysis of a Birmingham mental hospital in 1966 Berry and Orwin¹¹ found that the proportion of patients admitted to mental hospitals with no fixed abode was increasing steadily, and that half of such patients (mainly men) had a criminal record. They suggested three possible factors which may have contributed to the problem: mistaken mental hospital policies, inadequate community service, and reduction of accommodation facilities for the single man.

Plans

I have tried to advocate¹² that one solution to some of these problems would be to set up specialized clinics within the large concentrated urban areas. Such clinics would be multidisciplinary and cross the gulf that currently exists between psychiatry as practised within the Home Office, and psychiatry as practised within the Health Service. Such clinics could become the natural first port of call for the magistrate or judge seeking medical advice about an accused man, and so reduce the number of medical remands in custody. This would release valuable therapeutic facilities in the remainder of the prison system. These clinics could also become the nerve centre of the community care facilities which exist and could stimulate the provision of more facilities—for example, sheltered workshops and hostel accommodation.

CLOSER INTEGRATION

A natural extension of this idea is that, so far as the medical services are concerned, even closer integration between the Health Service and the Home Office facilities should occur. Scott¹³ has argued that the prison medical service should be amalgamated with the National Health Service, and that the excellent hospital facilities which are being developed within the prison system should be recategorized as N.H.S. hospitals recognizable as such under the Mental Health Act. Such a step would, of course, bring tremendous advantages to almost everybody concerned. Courts and doctors could move offending patients through a range of different security levels, according to need. Prison hospital officers would, at long last, have their skills recognized by the N.H.S. and nursing organizations. Pressure would be taken off the special hospitals. Prison doctors would have wide opportunities for training, research, clinical experience, and promotion within the Health Service as a whole. Senior prison hospital jobs would be open to competition.

Another, and perhaps complementary solution also currently being considered, is the regional security hospital. This title may be a bit of a mistake as it could trap some administrators into believing that what is required up and down the country is a series of mini-prisons which will have locks, bars, and high

walls. In fact such a bald venture would be a disaster. As Scott puts it,¹³ "security is a highly-skilled process; like medicine, it is something of a science and something of an art. It is by no means a mechanical process but very much concerned with group inter-relationships." Nevertheless, the three cases quoted at the beginning point to the urgent need for facilities of one sort or another for disturbed past or potential offenders at a moment of crisis.

Specialized forensic psychiatry units including both inpatient and outpatient services with security as one important element may form an essential part of a service which the N.H.S. can offer to a disturbed and disturbing end of the community. The security would come from a high staff ratio with a high degree of skill, and a high degree of involvement provided by that staff. Furthermore the units should be closely linked to a whole network of other facilities. In physical medicine we have overcome the naivety of assuming that the hospital is all-important. Certainly it is central for many areas of treatment but what goes on after the patient has left hospital is usually even more important. It is not much use taking, say, an alcoholic into prison or hospital, putting every effort into the period he is in an institution, and then discharging him to the same marital disharmony, the same social stresses that he received before, without fundamental assistance in the community. We could trap ourselves into seeking a new panacea, the security unit—in which we will put a lot of capital and material resources but all too few human resources—which will stand in splendid isolation, and of which we shall ask too much.

Highly dangerous patients for whom maximum security is required should continue to go to the special hospitals (or to prison hospitals if an amalgamation should take place). Nevertheless, the special hospitals are at present coping with some patients who are not particularly dangerous but who tend to run away or be disruptive in other ways; patients such as these would be suitable for the new units and would relieve some of the pressures. Dangerous patients could be led back into the community as they got better by accepting some admissions from special or even prison hospitals. Other patients could be accepted from other psychiatric facilities, courts, and from the remainder of the community forensic service. In other words the forensic inpatient unit would be one aspect of an integrated network of medical and social facilities. Movement to conventional hospitals, outpatients, special hospitals, hostels, and sheltered work, should always be possible.

Bricks, mortar, and money will be easier to come by than staff. The unit I have described will need nurses, social workers, psychologists, and occupational therapists, and they will all have to be skilled at managing impulsive, disruptive patients—mainly men—in group situations. Fortunately in Britain we have had many years of experience in coping with this task even if only on a limited scale, and I have no doubt in my own mind that the models we shall borrow will come from the Maxwell Jones philosophy¹⁴ (which has been developed at Henderson and Dingleton), from the prison service, especially Grendon, and other similar facilities. To achieve anything like the result required on a national basis specially trained staff in considerable numbers will be required as a matter of urgency. Training schemes are not yet available except on a small scale, and they will have to be established. There may well be a case for a forensic nursing service. Ideally, therefore, one or more of such new units should be attached to teaching hospitals so that a large component of training of all professional skills is built in and a steady flow of competent personnel is assured. If we throw all our energies into providing new plant without reorganizing and increasing the manpower skills required we will fail in most of our aims, we will waste a lot of money, and we will produce an emotional reaction of disillusionment.

UNIVERSITY CO-OPERATION

We ought I believe go even further and link one or two of these

units to university departments. We need, for example, one or two departments of forensic psychiatry to stimulate interest in the subject, to inquire scientifically into the problems, and to foster the required skills in new recruits to the field. Scotland has made a small beginning with a chair at Edinburgh University. England has no department of forensic psychiatry at all, though Professor Trevor Gibbens holds a personal chair at London University. It was not until 1973 that Britain acquired its first chair of child psychiatry. Criminology has begun to develop as an academic discipline in a few centres and is well ahead of forensic psychiatry. Psychologists are beginning to find a role in this widespread discipline as therapists, as advisers to prison managements, and all too infrequently as assessors of individual cases. There is no unit for forensic psychology in this country. Medical schools and universities provide the backbone, the nervous system for the whole of medical practice. Unless we are prepared to face the growing problems in the area where psychiatry and penology overlap, and are prepared

to develop new clinical and academic facilities, the disasters will grow apace.

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Occasional Survey

Hypothalamus as an Endocrine Organ*—II

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In view of the findings concerning LH/FSH-RH discussed in part I¹ it is evident that the gonadotrophin-releasing hormone might be of value in the treatment of hypogonadotrophic infertility, especially since the alternative gonadotrophin therapy is complex and expensive. We have investigated this problem cautiously, partly because we have been using a new product and partly because supplies of it are short.

Therapy with LH/FSH-RH

We have initially concentrated on treating men with LH/FSH-RH since it seemed likely to be intrinsically more difficult to produce the necessary cyclical stimulation required to produce ovulation. We have so far treated 10 such impotent and infertile male patients, four with isolated gonadotrophin deficiency, one with isolated GH deficiency but delayed puberty, two with pituitary tumours (one apparently functionless and one acromegalic), and three with hypothalamic tumours. We have established that doses between 500 µg and 1,000 µg LH/FSH-RH given subcutaneously every eight hours are required, but we hope that newly developed analogues of greater potency^{2,3} will enable us to give it less frequently. The material is well tolerated and we found it devoid of side effects over six months of therapy. All patients have had improved potency with in-

creases in testicular volume and (except in two who have been treated for less than five weeks) good secretion of LH, FSH, and testosterone.

If after the start of therapy the dose of LH/FSH-RH was reduced or substituted with clomiphene clinical and biochemical deterioration occurred. Most of these patients have had treatment for less than three months, but three who have been treated for longer have evidence of continuing spermatogenesis, maximum levels so far achieved being total accounts of 2.7, 13.6, and 112 million, in the latter two cases with good motility (greater than 40%). One case is shown in the diagram.

Plasma 17-OH androgen (17-OHA) and spermatogenic responses to long-term therapy with LH/FSH-RH 500 µg given subcutaneously every eight hours in hypogonadal man with craniopharyngioma. Plasma 17-OHA measures predominately circulating testosterone and dihydrotestosterone with a small adrenal androgen component.

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