Contemporary Themes

Solutions to the Problem of the Dangerous Offender

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In so far as the dangerous offender can be classified as mentally abnormal, the Mental Health Act of 1959 permits him to be transferred from court or prison to hospital. This solution has been a clear failure for two reasons. The hospitals (other than special hospitals and a few special units, usually of subnormality hospitals) do not want these patients; 150 transfers a year of psychopathic patients is scratching the surface of the problem. The fact that the administrative possibility exists of transferring the difficult prisoner to hospital removes therapeutic responsibility from the prisons and effectively retards the therapeutic capacities which they so obviously possess, and should develop.

Flexibility

It has been argued that if the needs of the dangerous offender lie between hospital and prison, then let him be in hospital when he needs treatment and in prison when he does not—that is, keep the custodial prison and the therapeutic hospital and shuttle the convict-patient between the two. This is the solution favoured by the Lord Chief Justice in Regina v. Horan and in his remarks when sentencing Ian Ball who shot four men while attempting to kidnap Princess Anne. He indicated that the time may be approaching when such dangerous patients, even though mentally abnormal, should be subject to an indeterminate prison sentence to secure the protection of the community, and that any requisite treatment should be through temporary transfer to a secure hospital. Since the establishment of new methods of reviewing discharge from special hospitals under the Aarvold Committee a hospital order—with restriction of release unlimited in time to a special hospital—thereoretically should and does provide just as effective protection for society as prison. But the scheme lacks an essential element in that it fails to stimulate therapeutic endeavours within the prison system.

The Department of Health and Social Security, after long cogitation, has produced its answer. Faithful to the philosophy of the Mental Health Act it proposes semisecure units in association with mental hospitals, at the rate of 20 places per million of population. These are to be staffed by forensic psychiatrists; they are to be small (50 to 100 patients), and they will be short term (18 months). It is recognized that they must be staffed very generously in "quantity and quality." Forensic psychiatrists, like any good parents, are expert at being firm without being retributive and would welcome such units, which would certainly be interesting and rewarding. Nevertheless, this Janus-like capacity to control and at the same time encourage is basic to all psychiatry, which may be emasculated if it delegates too far. Security is immensely expensive, materially and in staff. The hospital system is already desperately short of nurses. It is acknowledged that these units would need highly experienced and skilled grades of nurses, and these would be very difficult to find. Most important, the units, even before the first is open, are showing unmistakeable signs of selecting the nicer band of the psychiatric spectrum of patients—who are to be short term and requiring only intermediate degrees of security.

Disadvantages of Units

These units may go some way to meet the parochial needs of hospitals, but they will not relieve overcrowdings in special hospitals and they will do nothing for the mentally abnormal, long-term dangerous convicts who are so difficult to help in any constructive way in the prisons. The units will do nothing at all to encourage therapeutic developments in prisons and, indeed, are likely to retard any such effort. If the units ever succeed in opening in significant numbers (which is doubtful) they would only be repeating the same basic errors which led to their conception and would be a costly drain on the system. The fault was not in the Department's report but in its terms of reference. The problem should have been considered by a joint committee of the Prison Department and the D.H.S.S. and perhaps with lawyers and social service administrators as well.

The situation, then, is that the present discrete prison and hospital systems both fail to meet the practical requirements of dangerous persons. To shuttle the inmate between the two is impracticable and inefficient. To make the hospitals like prisons will not be tolerated. It remains to make the prisons more like hospitals, and thus to fulfill the requirements of the law and of the protection of society, while doing as little harm
Shigella dysenteriae and Shigella boydii in England and Wales during 1972 and 1973

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Summary

During 1972 and 1973 the Salmonella and Shigella Reference Laboratory examined 133 strains of Shigella dysenteriae and Shigella boydii isolated from patients in England and Wales. Of those infected 89 had recently travelled abroad and a further seven had been in close contact with travellers recently returned to this country. Though these subgroups were of little numerical significance they are of considerable epidemiological interest. The increase in tourism from the British Isles to North Africa and Asia is likely to lead to an increased incidence of infections due to these organisms, both in travellers infected abroad and in their contacts within the British Isles.

References

1 Craft, M., British Journal of Psychiatry, 1974, 124, 494.

Incidence of Sh. dysenteriae and Sh. boydii

Altogether 133 strains gave the biochemical reactions of Shigella* and serologically belonged to subgroups Sh. dysenteriae or Sh. boydii, which contain 10 and 15 serotypes respectively. Among the 133 strains isolated in England and Wales there were 16 isolates of Sh. dysenteriae serotype 1 (Sh. shiga), 17 of