The Special Hospitals: A Problem of Clinical Credibility

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The Special Hospitals arouse public interest only on occasions of disaster or scandal and there are widespread misconceptions concerning their role. The purpose of this paper is to examine the clinical functions of the Special Hospitals and to critically discuss their medical remit.

The Special Hospitals, of which there are four serving England and Wales and one in Scotland, are provided by statute for those mentally disordered individuals who 'require treatment under conditions of special security on account of their dangerous, violent or criminal propensities' (Section 97, Mental Health Act, 1959). Although managed by the Department of Health and Social Security, they are administered separately from any of the Regional Health Authorities or Scottish health boards. In spite of this separation from the mainstream of the National Health Service they are designated as hospitals and referred to as such in all documentation. The residents are patients (not inmates) who are admitted and discharged (not received and released), and each is under the care of a consultant psychiatrist. The resident population of approximately 2300 patients is detained under the same legislation that applies to compulsorily detained patients in any mental hospital. The distinction is that whereas about 5 per cent of the population in an average mental hospital is treated on a compulsory basis, in the Special Hospitals all the patients are detained under compulsory powers.

How are patients admitted?

The principal sources of admissions are the criminal courts and ordinary hospitals for the mentally ill and mentally handicapped, with a small number of patients being transferred from penal establishments. For legal purposes two conditions must apply for all admissions irrespective of their source. Firstly, there must be present a form of mental disorder which qualifies for compulsory treatment under the civil or criminal powers of the Mental Health Act, 1959, and secondly, the patient must be of dangerous, violent or criminal propensities. Since the legislation is enabling and not directive[1], discretion at various stages plays a large part in determining admissions.

This discretionary aspect of the process produces anomalies in respect of both criminal and civil admissions. Two million people are the subjects of criminal proceedings in England and Wales each year. In about 800 of these cases compulsory treatment in hospital is ordered by the court in place of imprisonment, and approximately 20 per cent of these Hospital Orders result in admission to a Special Hospital. Thus only 1 in 10,000 offenders receives a Special Hospital disposal. A sequence of judicial, medical and administrative devices determines this selection. The court, through defence, prosecution or the bench itself, may or may not seek psychiatric evidence.[2] The psychiatrist or prison medical officer may or may not recommend a Special Hospital disposal, and the DHSS, the final arbiters, may or may not make a bed available. These complex filtering mechanisms are erratic in their operation and the court disposal of many mentally abnormal offenders, particularly those designated psychopathic, is something of a random affair.[3]

The selection of patients referred from ordinary psychiatric hospitals also depends on non-clinical variables such as local facilities and tolerance for patients considered to be management problems.[4] Geographical factors are known to affect such referrals[5] and with the industrialization of the National Health Service, trade unions pressure may be a decisive influence in the referral of a patient to the DHSS for admission. Successful applications for admission fell from an average of 75 per cent of those referred in the early 1970s to 50 per cent by 1975. This fall in acceptance rates is doubtless attributable to DHSS policy aimed at reducing overcrowding in the Special Hospitals and developing regional secure units. Admission is thus dependent to a large extent on administrative manipulation and a substantial reduction in admissions has been achieved without apparent risk to the public.

How are patients treated?

Special Hospital treatment is characterized by the level of security and the assumption that patients will remain in hospital for a considerable length of time. While the statute suggests that the function of the hospitals is to provide treatment for dangerous patients, there can be little doubt that the public consider the purpose of the hospitals to be the containment of the patients behind a wall. It is by removal of the patient from society that the public expects the effects of the dangerousness to be ameliorated. It is disappointing that there have been so few accounts[6,7] in the medical literature of the clinical methods which render these hospitals special. Psychotherapy, behavioural approaches, milieu therapy and physical treatment are all ubiquitous in psychiatric practice, and it is doubtful if any of the treatments provided are unique in the sense that they are unavailable elsewhere. If the hospitals exist to treat mentally disordered individuals who are dangerous, then the wall treats the dangerousness by incarceration, and the mental disorder is treated by conventional methods that may be available in other settings. The physical and symbolic importance of the wall cannot be overstated, for only the prolonged separation of patients from society by a wall accounts for the Special Hospitals' uniqueness.

How are patients discharged?

Approximately 300 patients leave the hospitals each year,

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some departing for conventional NHS hospitals and others proceeding directly into the community. Over 10 per cent of the resident population have been declared suitable for discharge but remain longer than is considered necessary owing to the difficulties in obtaining alternative hospital or community placements. The reasons advanced by local hospitals for refusing to accept these patients is a sad reflection of their unpopularity in NHS circles.[8] There has been no clinical study of the decision-making process leading to the transfer or discharge of patients from the Special Hospitals, but Dell noted two non-patient variables which affected the process. One was a high turnover of consultant staff in some Special Hospitals which made the doctors reluctant to recommend transfer of patients unfamiliar to them. The second was a wide variation in doctors' attitudes whereby the transfer of a patient 'could depend less on him than on his doctor'.[8]

For nearly two in three patients the power of discharge rests, not with the hospital, but with the Home Secretary (or the Secretary of State for Scotland). The manner in which the Home Secretary reaches his decision in any individual case is not made public and the patient has no right of appeal to a judicial body with executive authority. Following the conclusion of the European Commission on Human Rights that such detention was a breach of Article 5 (4) of the European Convention of Human Rights, legislative change in the United Kingdom is expected.[9] When the power of discharge rests with the hospital authorities, the patient may also be discharged on appeal to a mental health review tribunal.

Decision-making, whether by psychiatrists, tribunal or Home Office, is hampered by the vexed problem of considering not only clinical condition but also the likelihood of further dangerous behaviour. There is naturally public and political concern when former Special Hospital patients reoffend. This induces in some psychiatrists a cautiously defensive attitude which may be disproportionate with the clinical situation. Moreover, although the assessment of mental disorder is a legitimate psychiatric task, the prediction of dangerousness is not.[10] Discharge might depend less on clinical evidence than on an appraisal of what may be considered publicly and politically acceptable. Entreaties from the patient to the hospital authorities usually elicit a stereotyped and somewhat tautological reply explaining the need for continued detention as unreadiness for discharge. This is usually amplified with a reference to the requirement for further treatment, thus justifying on medical grounds the continuing loss of freedom.

Discussion

The Special Hospitals care for a group of disadvantaged and unattractive patients generally ignored by the public, shunned by other psychiatric facilities and frequently rejected by their families.[11] Their detention under conditions of maximum security is a seriously invasive form of psychiatric treatment and it would be indefensible if any patients were inappropriately admitted or detained. However, many admissions are determined by idiosyncratic processes unrelated to clinical need, and non-patient variables may be powerful determinants of continued detention.

The establishment of the Special Hospitals was a worthy attempt to treat under humane conditions a group of mentally abnormal offenders for whom imprisonment was inappropriate and deleterious. Handing over the hospitals to the Department of Health has failed to modify their strong cultural links with the prison system; the DHSS continues to recognize the Prison Officers' Association as the official negotiating trade union for the staff of these hospitals. Thus the hospitals are a complex hybrid. The patients may be partly mad and partly bad. The staff are both nurses and wardens. The DHSS, which manages the hospitals, is required to defer discharge decisions for the majority of patients to the Home Office, which manages the nation's prisons. In this tangled administration, psychiatrists are required to accept clinical responsibility for a cohort of patients whose admission and discharge often lies outside their control.

Psychiatry's critics refer to it as a method of social control, and in certain countries the well-documented political abuse of psychiatry illustrates the vulnerability of its practitioners.[12] Psychiatrists in the Special Hospitals have no political mission, but their role as medical underwriters of preventive detention is crucial. They confer medical legitimacy on the patient's continuing loss of freedom and by implication they medically sanction the discharge. Their attitudes will simultaneously be regarded by some as too custodial and by others as too libertarian.

Underlying this invidious position is the failure to reconcile public expectations of the Special Hospitals with the realities of contemporary psychiatric practice. In 1968 a Parliamentary Committee concluded that the Special Hospitals were 'performing more than satisfactorily the functions Parliament entrusted to them'[13], although the Committee did not attempt to define these functions. Within a decade events in two of the Special Hospitals prompted Governments of the day to set up full scale inquiries into each of them.[14,15] Their findings, of major deficiencies in security at one hospital and of grossly substandard treatment at the second, symbolize the conflicting demands made on these hospitals. If the perceived public need is simply for institutions which put away certain people for lengthy periods, then the medical aspect is irrelevant and the use of mental health legislation for this purpose is unjustified. However, if the Special Hospitals are really in the business of dealing with dangerousness, where is the theoretical and practical evidence to support the premise that dangerousness has a medical component which can be reliably identified, medically treated and accurately predicted?

Conclusion

The Special Hospitals will remain vulnerable because their vague terms of reference are out of phase with current psy-

chiatric thought, and because their regulation by the DHSS owes more to political expediency than it does to medical wisdom. They must be unshackled from direct Governmental control and brought under the management of a specially constituted health authority. Its first task must be the re-defining of function in a form that is clinically realistic. Their national catchment areas must be sectorized so that units within each of the Special Hospitals can integrate with the various local secure facilities for mentally abnormal offenders which are slowly developing. Finally, it must be acknowledged that an institution does not automatically become a hospital because the sign over the door says so.

References

[1]MacCulloch, M. J. (1977) Some problems of placing psychiatric patients. *Health Trends*, **9**, 59–62.

[2]Gibbens, T. C. N., Soothill, K. L. & Pope, P. J. (1977) *Medical Remands in the Criminal Court*. Maudsley Monograph No. 25. Oxford University Press.

[3]Walse-Brennan, K. S. (1978) Classification inconsistencies in defining the criminally mentally abnormal. *Medicine, Science and the Law*, **18**, 283–86.

[4]Editorial (1977) Inhumanity to man. *British Medical Journal, ii*, 591–92.

[5]Brown, C. T. (1973) *Assessment of Regional Differences in Rates of Referral for Special Hospital Placement: Special Hospitals Research Report No. 7*. London: Special Hospitals Research Unit.

[6]Greenland, C. (1970) The three Special Hospitals in England and patients with dangerous, violent or criminal propensities. *Medicine, Science and the Law*, **10**, 93–103.

[7]Macphail, D. S. & Cox, M. (1975) Dynamic psychotherapy with dangerous patients. *Psychotherapy and Psychosomatics*, **25**, 13–19.

[8]Dell, S. (1980) Transfer of Special Hospital patients to the NHS. *British Journal of Psychiatry*, **136**, 222–34.

[9]Department of Health and Social Security, Home Office, Welsh Office, Lord Chancellor's Department (1981) *Reform of Mental Health Legislation*. Cmnd. 8405. London: HMSO.

[10]Shah, S. A. (1975) Dangerousness and civil commitment of the mentally ill: Some public policy considerations. *American Journal of Psychiatry*, **132**, 501–55.

[11]Vaughan, P. J. (1980) Letters and visits to long-stay Broadmoor patients. *British Journal of Social Work*, **10**, 471–81.

[12]Bloch, S. & Reddaway, P. (1977) *Russia's Political Hospitals*. London: Gollancz.

[13]Estimates Committee (1968) *Second Report from the Estimates Committee: the Special Hospitals and the State Hospital*. London: HMSO.

[14]Scottish Home and Health Department (1977) *State Hospital, Carstairs: Report of Public Local Inquiry into Circumstances Surrounding the Escape of Two Patients on 30 November 1976 and into Security and Other Arrangements at the Hospital*. Edinburgh: HMSO.

[15]Department of Health and Social Security (1980) *Report of the Review of Rampton Hospital*. Cmnd. 8073. London: HMSO.

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Trials of An Approval Team Convener

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I have been a member of the Southern Division Approval Panel since its inception in 1972. Thereafter I visited, with other panel members, two or three hospitals per year. I became Convener in 1978 and in my four years in office I visited over 35 hospitals, although these were not all separate visits. I look after a catchment area in South-East London, with all the in-patient services at Bexley Hospital. It is entirely my personal opinion that if I was not involved with a district service I probably would not have accepted the invitation to be a convener. I do not think I would necessarily have been a worse convener, but I might have been rather less credible.

There have been occasionally muted remarks on visits about 'those from ivory towers', although this has referred to the South-East of England as often as it has been intended to refer to London Teaching Hospitals. Interestingly, it has been the unanimous view of all my colleagues from the south who have joined me on visits to northern hospitals, that as regards fabric and general decoration, psychiatric hospitals in the north are perceptibly superior to those in the south. Can it be that RAWP is succeeding? Equally, the quality of trainees, especially around major teaching centres in the north has usually been as good and better than that of those in most psychiatric hospitals around southern London.

As the Approval visits developed, it was very satisfying to see training programmes improving, and rotations being slowly built up, offering wider experience to junior doctors, often together with more effective teaching opportunities for consultants. Obviously, these developments were not specifically brought about by any special excellence shown by the Southern Division Approval Panel. Rather, they are signs of the general success of the Approval Exercise.

Communication, both to and from the hospitals visited, was of crucial importance. Also very important was the general dissemination of ideas from the various rotating members on the visiting team. In addition, the Convener will