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MENTAL HANDICAP PAPERS

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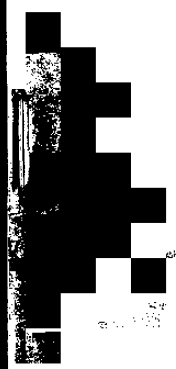

LOST SOULS

Services for mentally abnormal offenders

London 1975

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FOREWORD

This paper is about the service needs of mentally abnormal people who exhibit persistently anti-social behaviour of a kind likely to result in their appearance before a criminal court: a group of people we have come to describe as 'lost souls'.

It will be seen that people who have taken part in the discussions which led up to this paper come from a variety of professions and a wide range of service settings. To some extent the paper reflects the special interests of these members in particular categories of people: whilst one is visualising the needs of the homeless and rootless, another is concerned with the needs of the mentally subnormal, and another with the needs of prisoners: and so on. Yet these and other categories overlap in the body of people we have struggled to identify. Because of our different professional viewpoints, and different service settings, we might have tended to look for different remedies: yet we have in fact reached considerable identity of view both on the nature of the lost souls' group and on the shape of organisation which might give a better service.

But we have to make a special point about the prison population. A large number of the people in prison - possibly a half, according to the estimate of one of our members - can be classed as abnormal offenders. Our proposals in chapter 4 for a better co-ordination of present services, and those in chapter 5 for new measures, do not envisage the development of prisons as being within the purview of the Care Planning Team (para 50), or as part of our proposed assessment and rehabilitation campus (para 83). Far-reaching changes of this character we felt to be beyond our remit at this stage, but we are in no doubt that they will eventually have to be faced. We feel it necessary to point out that the treatment service cannot be regarded as complete unless some way is found to include within its remit a considerable number of prisoners: this could involve basing some parts of the treatment services on the prison.

Our work has involved us in a series of one-day meetings, and a residential seminar at the Oxford Centre for Management Studies. Not all those invited to participate could attend all the meetings, and not everyone participating necessarily subscribes to every detailed view expressed in this discussion paper. But the broad identification of the 'lost souls' group, and the dissatisfaction with hopelessly unco-ordinated services, represent the common view of all who have participated. There is substantial agreement on the recommendations for improvement, but we have not sought identity of view or complete consensus; instead we wish to share the ideas which have emerged from our discussions.

Services to 'lost souls' cannot be master-minded by one predominant service. To view this complex issue as being solely a medical or psychiatric problem would be as misleading as to view it as being mainly one for social services or penal services; or for education, or probation service; or for the Special Hospitals or for housing authorities. Services to the 'lost souls' group will not get better unless all these services, together, take a wide view of this complex problem and work out a common strategy amongst themselves.

We hope that this paper will enable the reader to take that wider view.

LOST SOULS

Services for mentally abnormal offenders

A report of the proceedings of a Working Party
convened by
King Edward's Hospital Fund for London

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The King's Fund is glad to have been able to facilitate the efforts of the Working Party, but wishes to make it clear that this is a discussion paper, and the views expressed are not necessarily those of the King's Fund.

1. LOST SOULS

1. Unknown to some people, there exists a group of men and women who live on the very fringes of society, if not outside it. They have been cast out by ordinary people because their antisocial behaviour makes them unacceptable; but they have also cast themselves out because they do not appear to accept the validity of standards of behaviour which are the mark of an organised society. They do not readily fit into any one defined category: they have certain common characteristics, but their antisocial behaviour shows up in different places and in different ways at different times: sometimes their need is for social support or education, sometimes for medical help. They are frequently homeless. Some may be psychiatrically ill, or mentally subnormal; sometimes they may be prisoner or probationer; alcoholic or petty thief. But they represent only a proportion of the total of people in each of these categories - those who are so inadequate as to be unable to benefit from the ordinary application of the various statutory services available to the other people in these categories.

2. They move around ineffectually, in and out of prison and mental hospital, of borstal and reception centre, sometimes residing on park benches, in shop doorways or in derelict houses. They get whatever help they do get from whatever agency the current manifestation of their condition has brought them into contact with. They are not usually abnormally aggressive, but are often seriously irresponsible. They have been described as a stage army of inadequate people who appear and reappear in different roles, the scene being first one agency and then another.

3. Such care as they do receive may come from prison, mental hospital, mental handicap hospital, reception centre, social services, probation service, or community home; or, very important, those shelters and homes provided by voluntary agencies. Whilst there exist some indicators of the possible numbers of such people, no-one seems to have identified or numbered them. They are a nuisance to the established services and tend to be passed on from one agency to another in the hope that they will somehow disappear from view. Even when there is a sincere intent to help this kind of person, or a desire to intervene early in his career so that social deterioration can be arrested, professionals in every agency are frustrated by the problems of organisation and management, by lack of knowledge of what the other agencies have done or will be doing, by lack of access to information held on file by other agencies; and by lack of any machinery to permit co-ordinated action. They see the problem as a product of modern society, and particularly urban society, over which they have little or no control. If they try to penetrate to root causes, they seem to be faced with the impossible task of reforming that society. The temptation is therefore to encourage such people to drift off elsewhere, out of sight and out of mind.

4. When a number of concerned professionals expressed their anxieties about this group of so-called 'lost souls', the King's Fund decided to bring together a small group of workers from a number of different agencies, in an attempt to identify the nature of the problem and its extent; to examine some of the reasons why the problem exists; to find out what services are at present available, and how they might be better used. In addition, it was hoped that the group would be able to make people more aware of the problem, and to make new proposals for the better, and more co-ordinated, use of the services which already exist. The outcome is this discussion document, which is published in the hope that it will give statutory and voluntary agencies a starting-point for joint planning of a more adequate service for this apparently unattractive, and certainly inconvenient, group of human beings.

5. Since Lord Butler's Committee on Mentally Abnormal Offenders is at present deliberating, and has recently issued its interim report (12), and since the Departmental Working Party on Security in NHS Psychiatric Hospitals has just reported (11), it might be asked whether the King's Fund Working Group was necessary at all. We think its value lies in its identification of the 'lost souls' group, some of whom may fall within the remit of Lord Butler's Committee and the Departmental Working Party, but some of whom are outside those considerations.

6. Let us consider more closely the concept of lost souls. We mean someone whose behaviour is socially unacceptable to current society, to such a degree that society then uses its forces of social control to identify the 'criminal'. But standards or criteria of social unacceptability relate to a particular society at a particular time. For example, a drunk who smashes a street light in a slum area may be accepted as part of that local scene, with little action being taken against him: the same man behaving in the same way in suburbia might be arrested at once.

7. Although the main part of this report deals with services for those lost souls who have appeared before certain courts, our story would not be complete without some account of those who may later fall into the offender category: those who, although aesthetically unacceptable are tolerated; those whose life-style does not accord with that of certain strata of society; who though they present many of the manifestations of the abnormal offender, have not so far been before the criminal courts. To illustrate the kind of people considered by the group, and the inadequacy of current services, we have included at Appendix D some examples culled from newspapers by one of our members.

8. Our working group was convened to consider "the abnormal offender". Yet our first definition was not restricted to offenders, but to people with persistent anti-social or asocial behaviour, whether or not they were technically offenders. The original definition ran: "a person with persistent anti-social behaviour which is serious enough to warrant action by social, educational, penal, or medical agencies".

9. But whilst our term lost souls covers offenders and non-offenders alike, we soon found that in order to produce meaningful statistics and practical proposals, we had to reduce the field. So the definition was narrowed down to "persons with persistent anti-social behaviour which results in their appearance before the courts".

10. We then considered what we meant by courts, and as a result we excluded the civil courts, but retained criminal courts. Even with this further narrowing of definition, the group thus defined is probably only the tip of the iceberg because it represents only those offenders who are caught and who are actually prosecuted.

11. Although we have deliberately narrowed our definition so as to be concerned only with lost souls who are offenders of a particular kind, we have still had great difficulty in producing meaningful statistics, and we admit that our efforts to do so have been largely unsuccessful.

12. To crystallise, we have described the existence and characteristics of a group of people we have termed lost souls; and whilst much of what we say applies to the entire group, whether offenders or not, whether caught out or not, whether tolerated or not, our main proposals relate to

persons with persistent anti-social behaviour
which results in their appearance before
criminal courts.

From this point on, when we use the term 'abnormal offenders' we mean only those abnormal offenders who fall within the above definition.

2. THE REASONS

13. We now outline some further characteristics of the lost souls group, and try to identify the causes of the individual becoming 'lost' in the first place.

14. A high proportion of abnormal offenders are classified as of no fixed abode, either at first contact with the force of law and order, or because prisoners who may have had some sort of fixed abode on arrival in custody (be it only bed-sitter or rented cubicle) find they have lost their room on release. Reports suggest that of those of no fixed abode, a high proportion tend to be male, and single, widowed, divorced or separated.

15. The age distribution of abnormal offenders is very skew and does not appear to follow the age distribution of all offenders. With some exceptions, the age of the abnormal offender with which the working party is concerned is 17+. In general, at younger ages, various agencies - educational, medical or social - identify and deal with potential lost souls who happen to be in trouble: possibly important exceptions would be West Indian teenagers, truanting schoolchildren some drop-outs. Within the 17+ age group, it is the young men - that is, those aged under 25 - who account for the largest number of normal offenders. There is evidence that in the abnormal offender group, there is a lower incidence of young men than would be expected and a higher incidence of those aged 40 and over.

16. A substantial number of abnormal offenders are found in local prisons or appearing before courts in the metropolis or large conurbations: this is particularly true of recidivists. It has been estimated by one of our members that at least half the present prison population comes within the lost souls category. The work-record of abnormal offenders is usually irregular or non-existent.

17. The causes which lead to the individual becoming an abnormal offender are many, all the following types of factor being present in varying concentrations: economic, genetic, physical, social, educational and medical. The outcome in any case, is an individual who is predisposed emotionally, experientially, intellectually, economically and socially, to deprivation. More than one of these factors may be present; they all interact; and there seem to be other, residual influences, difficult to identify.

18. One major manifestation which appears to be presented by the abnormal offender is that of mental disorder, covering in varying degrees, all those disorders legally defined in the Mental Health Act - that is, mental disorders, including mental handicap and personality disorders. But many present neither manifest mental illness nor mental subnormality, though they may be labelled 'disordered' as a convenience, yet they have become lost through other associated factors, some of which we list below. We are sure that there will be others.

Individual

Inability to cope with the demands and limitations of everyday life, hence a retreat into avoidance of conflict and reality. Inability to accept that failure is not necessarily the end of the line.

Inability to make relationships

Continued low self-esteem as characteristic of that condition

Failure all through life - even as an offender, or patient - is itself a cause.

Family pathology

Illegitimacy

Very large families when accompanied by inadequate parents or physical overcrowding, bringing dilution of care and low-density of parental contact

Frequently-changing parental figures

Emotional chaos in the home

Parents having opposite ideas and the child being torn between them, thus fragmenting his identity.

Social

Social class 5

Social isolation of family

Early life in an institutional setting

Homelessness

Destitution

Poor cultural milieu

The drift to large cities of unskilled migrants, particularly from Ireland and Scotland to London

The quality of life in cities

The reduced number of really unskilled jobs increases the number of people who see themselves as failures

The operation of the courts may reinforce the tendency to seek shelter in the form of prison: the stage is reached when the subject can only succeed in one role, that of a successful offender.

Medical

Wrong diagnostic or prognostic labelling is often a self-fulfilling prophesy

In certain cases, physical factors appear to be relevant, e.g. brain damage, genetic conditions, epilepsy particularly if it involves the temporal lobe

The physical and intellectual deterioration caused by addiction to drink or drugs, or by having a drink problem.

Physical causes can lead to chronic hospitalisation that can lead to personality disorder: and that can lead to offence. For example, brain damage can lead to disturbed education and this in its turn can lead to personality disorder.

19. So much for causation. How many such people are there in Britain? Even with our narrowed definition, we were hampered by lack of hard information. We examined evidence relating to the number of people who were homeless, single, living rough, those in reception centres, those in common lodging houses, those in psychiatric hospitals and Special Hospitals, those in institutions for the mentally handicapped, those in custody. Out of the resulting total, and bearing in mind the stage-army effect which we have described in the first chapter, we made an attempt to identify the number of abnormal offenders in our lost souls category. We failed, but we have come to the conclusion that the nature of the group concerned is probably similar to that of the group affected by alcoholism: in other words, a hard core of people who are permanently drifting, and a larger group who wander in and out from time to time.

20. It must be remembered that these people represent only a small proportion of all offenders, and a small proportion of the total of all abnormal people.

21. We should make a special point about the problems of London. Just over half of the total problem of homelessness appears to be confined to the London area, whereas most of the rest of the problem is confined to the large conurbations, and only piecemeal in the rural or small-town situation. London's difficulties are compounded by the fact that the organisational problems, including the siting of mental hospitals away from the local populations they serve, are far greater than they are elsewhere. It has a greater share of lost souls than its population would justify, and this is because of the great drift of drifters to the metropolis. Half of all the people in reception centres are in London; and half of all the people detained under Section 136 of the Mental Health Act are detained in mental hospitals within the four metropolitan regions.

3. TODAY'S SERVICES

22. It must not be forgotten that a disproportionate number of the people we are discussing come from large families, living in overcrowded homes and in poverty. For them, social and cultural deprivation in childhood is probably normal. Since it is probable that the marked reduction in the population of vagrants and homeless people since the turn of the century has been due to general improvements in living standards and in the social services, then if these improvements continue, the problem to which we are asked to address ourselves may diminish: but we do not know that this will be so; indeed there are at present signs of an increase. At all events, research into the factors underlying the cycle of deprivation, and the direction of resources to remedy these factors is crucial. This statement underpins what follows, where we look at the institutions, services and agencies which could be associated with our defined population; they are described more or less in the order they are likely to be encountered during the career of the abnormal offender.

Services for children and adolescents

23. We hope that in future, delinquents will be recognised at school, that many will become known to the local authority social service department, and that joint action will result. Although there is awareness of the need to take action and to provide care and treatment for these young people, not enough is done. Newer developments such as Youth Treatment Centres may prove to be helpful for a tiny group of more seriously disturbed young offenders but it has to be accentuated that despite various kinds of help, a proportion are still likely to become chronic offenders. It seems that some youngsters are destined to fail, no matter what. Thus early collaboration between school, social service, and psychiatric service, is vital.

Adult employment

24. The men we are dealing with seldom possess useful job skills or education. A large proportion of them come from areas of high unemployment with few training facilities, such as Ireland, Scotland and the North of England. At present, a lifestyle built around unskilled, short-term or casual work is all too easily acquired, and may later prove to be ineradicable. The Department of Employment is said to be well aware of this problem but facilities are still not available: employment rehabilitation centres do not provide enough places for the psychiatrically handicapped, and the absence of a permanent address tends to exclude those people who are homeless and rootless.

The Armed Forces

25. We mention these because the attraction of service life to the socially-deprived young adult is now well-known: a disproportionate number of abnormal offenders have previously been regular servicemen, as the Camberwell study shows.(20) It must be said that the Armed Forces have now taken steps with their pre-release training programme to prevent immediate social deterioration after service.

The Courts

26. Although some lost souls may first come to official notice at a court appearance, it is likely that some are already well-known to one or more social agencies, well before their first appearance.

27. In our working group, criticism was levelled at the busy London Magistrates Courts, but rather less at the more leisurely courts in the provinces. It was suggested to us that in London, adequate social and psychiatric reports are available in far too few instances. This is mainly because of the sheer pressure of work, and also because, even with the best will in the world, information about the social circumstances of homeless drifters in London is difficult to obtain. In addition, remand for assessment is used too seldom and only the most serious offenders tend to be reported upon. The lack of adequate social and psychiatric reports hampers effective sentencing, the result being that fines and short prison sentences may be used inappropriately, rather than sentences which would entail more appropriate long-term support, care and treatment. Some sentencing is undertaken without adequate knowledge, but it would be unfair to blame the courts entirely, since they are limited by the sheer lack of facilities and personnel. This has led the working party to consider the other possible courses of action.

The Probation Service

28. The probation service has always provided a social work, counselling and care service at field level, for the mentally abnormal offender in the community. As there is no statutory requirement or charge upon social service departments to look after this group of lost souls, much of the social work support, when in fact needed, comes from probation officers. Whilst the powers of Criminal Courts Act 1973 allow the probation and after-care service to acquire after-care hostels for adults and to organise Day Training Centres, these facilities are as yet available for no more than a handful of clients. Both could be expanded to cater for mentally abnormal offenders within our definition. Probation officers bear a tremendous burden in dealing with such clients, and may lack sufficient support from the psychiatric services: without that more informed backing, they cannot be expected to cater for the more mentally abnormal type of client.

The Penal System

29. The penal system, in prison and borstals, has always cared for what is probably the majority of personality disorders amongst abnormal offenders. Whilst the removal of the offender from society is the main purpose of a custodial sentence, much time and money has been spent on promoting rehabilitation. After-care has been limited, owing to shortage of resources, but the situation is improving under the parole system set up in 1967. The prison medical service is aware of the rising number of disturbed prisoners (see also para 16); it also provides a service for the alcoholic or the drug addict in the withdrawal phase, and for epileptics and acute psychotics. There are now 36 prisons and borstals with psychiatric units, including Grendon. More than 50 Alcoholics Anonymous groups operate in prison service establishments.

30. Basic as the service sometimes is, we prefer it to the situation said to obtain in some States, where drunkenness is no longer a crime and where drunks are now perforce left to lie exposed to the elements.

31. Because, in London, psychiatric hospitals are less willing to accept or re-admit psychotic people who are offenders, the prisons are having to provide a treatment service for such people. This resurgence in demand is forced upon the prison service by alteration in hospital policy. Both for these cases and for other known but less florid mentally disordered people, psychiatric after-care in London is difficult to obtain, a situation made worse by the reluctance of social service departments to accept responsibility for offenders. But it has to be remembered that the London services have to face the problem of having a high proportion of all abnormal offenders. Inevitably the present service is unable to offer full psychiatric service and many prisoners who might need help remain unseen by a psychiatrist.

Psychiatric Services

32. The NHS mental hospital system has always been expected to provide a county and borough level outflow for Special Hospital patients. But it is becoming less and less possible to find conventional psychiatric beds for mentally abnormal offenders. This is due to a number of factors: the break-up of the old system of medical superintendents; the current open-door policy which so much benefits the majority of psychiatric patients; the policy of sectorisation which means that individual consultants each have a small number of beds; the increasing use of psychiatric units in district general hospitals; and similar advances in the field of mental handicap. Indeed in some districts, it is impossible to make the system of Section 65 and Section 60 of the Mental Health Act work because no-one can be found to take responsibility for such patients and it is difficult for a regional health authority to lay such responsibility on a particular psychiatrist. In some areas the situation is greatly helped by the appointment of consultant forensic psychiatrists who work jointly in the NHS and the prison services.

33. Since the middle of the nineteenth century, the Special Hospitals** have provided psychiatric care for the most seriously psychotic abnormal offenders, if necessary for a lifetime's duration. We see these hospitals as continuing to provide a principal maximum security care system for mentally abnormal offenders.

34. There is a sharp contrast between the mental handicap service, which has traditionally tried to provide its clients with lifelong care and support, and the service for the mentally ill. First aid treatment for people with personality disorders or who encounter some acute social crisis, and especially those who have threatened or attempted suicide, is relatively easy to obtain, but long-term intensive therapy is available only to a select few. We feel it to be evident that one bi-product of the combination of the current open-door policy and the official pressure to reduce overcrowding by taking down beds, and the lack of residential after-care facilities

for the people discharged from those beds, has been to increase the number of socially inadequate psychotic people who become homeless and drift to city centres. Lacking medication, their psychoses are liable to lead to anti-social behaviour. Hospitals often refuse to accept or readmit such patients, either from the courts after offences or from the streets under Section 136 or from common lodgings or from reception centres. Some of these people need treatment and care in a hospital setting, others need a refuge: something the asylum function of the old mental hospital took care of but which is now too seldom available. (This situation is well described in the interim report of the Butler Committee and in the report of the DHSS working party on security in NHS psychiatric hospitals.) We deplore the current lack of supervision for these disadvantaged people which every now and then comes to notice when some scandal or tragedy occurs (see Appendix D).

Mental Handicap Services

35. Some of us feel that the newer strategies of the mental handicap service, with the accent on reducing overcrowding, will give rise to the same kinds of problem as have arisen in the field of mental illness, if those who are discharged from hospital do not receive truly adequate social support. The move away from the custodial approach in mental handicap is strongly supported but even more strongly we must emphasise that without a proper network of community facilities we shall merely see an increase in our population of lost souls.

Services for Alcoholics

36. Services for alcoholics are as yet inadequate. Hospital units are selective and not generally orientated to our lost souls group. They certainly provide nothing like a proper service for the alcoholic offender. Neither the hospital services nor the embryo hostel service provide long-term support. In this field we think that when services expand, the practicability of compulsory treatment needs looking into.

Local authority social service departments

37. The recent re-organisation of these departments seems to have lessened their effectiveness in dealing with psychiatric patients, at least in the short term. Psychiatric after-care hostels are rarely available and when they are, the chronically and mentally disabled offender is seldom accepted in them. We feel that the boundary between the responsibility of social service departments and that of probation and after care services needs clarifying.

38. The social service departments are now responsible for community homes, formerly known as approved schools. Whilst this system has provided much help for the older teenager, the same criticisms apply as in the previous paragraph, viz. difficulties in providing sufficient varieties of care. Local authorities now have the responsibility for providing hostels for adults, with a further need to plan for a range of services; thus they need to be included in a more comprehensive service.

39. In London, the men in our defined population drift from borough to borough, and the demise of the London County Council Welfare Department has led to a situation in which responsibility for individual patients is difficult to apportion and is not always accepted. Once again, London's concentration of lost souls compounds an already difficult organisational situation.

Education Services

40. The education service offers some help with young unstable teenagers, with a rising number of schools for the maladjusted. We think this service is important and highly constructive as it places emphasis where it is needed, on full-time residential care for difficult young people. The existence of caring staff provides a remedial education which is usually much needed. For obvious reasons this system contributes less at the age when services become more needed, for after 15 or 16 it is the former approved school, now the community home system run by social services which has to take over care. Yet the contribution of the community home system is not likely to be as great as the previous approved school system of selective placement, if only for the reason that with the greater mixture of age and ability in local geographically-based community homes, bigger bullies can less often be prevented from harming the small or young. Careful selection has been sacrificed in favour of better community and home links.

Reception Centres

41. We consider that the reduction in the number of official reception centres has now gone too far: there are now only fifteen outside London. Those which have survived lack resources, trained staff, and contact with other services. They have extreme difficulty in persuading other services to take back their patients or clients once they have fallen to reception centre level. The stress of extreme destitution may well be the major cause of delinquency and the opportunity to prevent further offences is undoubtedly being missed.

Common Lodging Houses

42. The number of beds in common lodging houses has been allowed to fall faster than the need for them, so that the remaining accommodation is full and is turing people away. The present accommodation is often of too low a standard and should be replaced: the need for it is manifest. It seems that no government department or local authority is at present willing to finance an adequate building programme for this purpose. Yet the main need is a warm bed, a dry roof, and basic cooking and sanitary facilities. Although it is now known that perhaps the majority of those who live in common lodging houses have physical or psychiatric handicaps, few social service departments have provided social work support for their residents. And more often than not, service from general practitioners or the psychiatric service is very difficult to come by.

Voluntary Bodies

43. These range from large organisations such as the established churches, Salvation Army and Church Army, to the Cyrenians, Centrepoint and many other small groups. They are fulfilling a vital function and their willingness and ability to experiment is invaluable. There are a few probation hostels, though the number run by the probation service is now increasing. Those run by voluntary bodies are fairly selective of patients, and their staff work under great stress with little back-up service. The staff feel lonely and have nowhere to transfer patients when they become too difficult for them. They usually discharge difficult patients back to the community with a Court review for breach of the Probation Order, but this system cannot provide the swift protection for the public that is needed in the case of the highly unstable abnormal offender.

Co-ordination

44. Co-ordination between all the services we have described is sadly lacking. We are glad to see the rapid growth and confidence of the National Association of Voluntary Hostels and the appearance of the Campaign for the Homeless and Rootless. NACRO is working hard in this field. In London, we are surprised that more use is not made of the one organisation which does seek to co-ordinate policies, the London Consultative Committee on the Homeless, which has representatives from voluntary bodies, social service departments, reception centres, the police, probation service, Home Office and DHSS.

** Broadmoor, Moss Side, Park Lane, Rampton,
State Hospital - Carstairs, Scotland

Lost Souls

Mentally abnormal petty offenders who clutter up the courts and provide a recurrent headache for probation and social services and for all the caring professions were the subject of a King's Fund Centre conference earlier this month. The Centre has published the report of a working party on the same group, and this contains detailed and useful proposals for ensuring better professional provision for those at risk. But, as the conference made clear, professional ca is no substitute for a caring society. Alexander Kirby **reports.**

'THE greatest problem in the world,' wrote Mother Teresa of Calcutta, 'is not to be wanted.' All of us define ourselves, in large part, in terms of the relationships we have with other people, in terms of the degree to which we manage to persuade ourselves that we are in fact wanted. It is this I-thou confrontation that gives us the courage to be, if anything does. So, if we cannot form relationships, we face a far higher risk of disintegration.

The King's Fund Centre has published the seventh in its series of mental handicap papers, *Lost souls: services for mentally abnormal offenders,* which is a report of the proceedings of a working party it convened. It held a conference on December 3 to discuss the report and its recommendations, under the chairmanship of MIND chairman Christopher Mayhew. The report defines its subject matter as 'persons with persistent anti-social behaviour which results in their appearance before criminal courts,' and designates them for brevity's sake as lost souls, a label whose vividness should just about save it from being as patronising as it sounds.

That said, the definition chosen begs as many questions as it answers: it was an Australian participant who pointed out that 'before you can start talking of anti-social behaviour you have to define what your society is.' It is a criticism of the report and the conference to say that neither attempted any direct definition.

Fragmented society

A theme that recurred time and again, however, was the fragmented nature of this society, both organisationally and individually. According to one of the working party's members, Professor T. C. N. Gibbens, professor of forensic psychiatry at the Institute of Psychiatry, London, at least half of the total prison population may well be lost souls. There is research which shows that recidivists who break their pattern and cease to offend have been successful in forming satisfying relationships. And yet, said a prison psychologist, prison rules expressly forbid the formation of relationships between discharged prisoners and either staff or other ex-prisoners: 'I am not allowed to keep in contact with ex-cons, and prisoners are searched on discharge to make sure they do not take out of prison with them the addresses of any friends they may have made there.' Several speakers stressed the way in which the institutional setting of even a prison can provide a stable and happy life for the mentally abnormal and a rare chance to build relationships. As another speaker put it, 'The trouble with borstal kids is that they've been social worked for so many years. The only relationship they've ever had is with someone who tells them they've got problems.'

Low self-esteem

A common feature of most lost souls, according to many participants, is very low self-esteem, probably both cause and effect of inability to relate to other people. One speaker urged a greater tolerance by society of what it defines as failure in boys: this would result in less rejection and in fewer damaged, self-deprecatory personalities. Professor Gibbens cited the attitude of many developing countries in Africa, which cannot afford to hale petty offenders before the courts. Lost souls there are recognised as being no threat to society and are allowed to go their own idiosyncratic way.

If we could avoid bringing the mentally abnormal offender to court we should have made a start on breaking the vicious circle of dwindling self-esteem. But an issue which exercised the conference was how far it is legitimate to impose treatment on lost souls for their own sake and not for society's. This is hard enough, anyway, with people who lack any motive to change themselves. But treatment is made far harder by another sort of fragmentation, that which separates one service from another and effectively provides too many Indians and not enough chiefs: there is at the moment no single agency responsible for the lost souls, and this makes buck-passing not only easy but natural.

The report believes that the number of lost souls has risen in the last few years for several reasons: the diminution of the asylum function of the pre-1959 mental hospital; the very slight degree of social support for those discharged from mental hospitals; the reduction in the number of official reception centres; and the near-disappearance of the cheap common lodging-house. Ways of achieving a substantial drop in the numbers liable to become lost, it believes, include better educational services during the formative years (when an individual's patterns determining his self-esteem are laid down), sufficient overnight lodgings in every city and town; better social work support; and a general improvement in the quality of life for families caught in the cycle of deprivation.

But it recognises that there will still be many lost souls, and believes the only way they can be offered significant help will be through 'the co-ordination of the activities of the extremely varied range of existing services, so that in each area there is a composite team with a common philosophy.' Key features of the new service it proposes are new co-ordinating machinery, a new multi-disciplinary assessment mechanism for the formulation of service to the courts, and the creation of a new adult care order which would become an option available to the courts.

Why not use the existing provisions for making guardianship orders, some have asked. The answer seems to be that they have been used too rarely for anyone to know whether they would be effective if they were more widely used. In any case, whether present guardianship or future adult care orders were used for mentally abnormal offenders, no one appeared to think that their own service could accept responsibility for carrying them out.

. . . too easy

One depressing lesson of the conference was the overall impotence and the defensive mistrust of the services society has developed to cope with its lost souls. It's too easy to single out the professionals' shortcomings, whether of organisation or finance or ability to co-operate. We employ the professionals to shield us from the reality with which we refuse to cope ourselves. One conference member mentioned a child care department in which he had worked, where the number of staff equalled the number of children in care. 'At last it dawned on me: why didn't we each take a child home to live with us, and simply stay away from work?' Professional caring services are designed to let us amateurs off the hook. They are a step on the way to building a society where, in the end, nobody is wanted. So who's lost then?

4. BETTER CO-ORDINATION OF TODAY'S SERVICES

45. The previous chapter clearly indicates the disjointed nature of services for our defined population of lost souls. It is a situation in which various agencies look at the scene but see it differently, and assess separately; in which there is insufficient co-ordination of assessment and little joint planning between the various agencies involved; in which there is no clear allocation of responsibility for long-term prescription for the individual person in need; in which there is a shortage of facilities and of skilled staff. But over and above all this, the preceding chapter shows that all these organisations and agencies, try as they might, are lacking in a common understanding or strategy for meeting the problems which arrive on their desks separately and randomly, but which in fact stem from common origins.

46. In this chapter we are attempting to look at the existing facilities, not just as they are, but as they might operate if they were grouped and organised in a different way. We can consider them arrayed in several tiers or levels of security and treatment.

At level A we include maximum security prisons and the special hospitals. This level is rarely relevant to the lost souls group.

At level B there is a gap; there are closed prisons and borstals; there should also be regional secure hospital units (as recommended in the interim Butler Report) for people who require hospital treatment but who are neither suitable for an open hospital nor need the maximum security of a special hospital. Existing NHS hospitals have to meet this need with their locked wards, or so-called security units.

At level C there are the ordinary open facilities at NHS hospitals, with here and there, more specialised but still open, units. There are also open prisons and borstals.

At level D there are a few community homes, hostels, homes, boarding houses and remand hostels, some run by voluntary societies, some by local authorities.

At level E there may occasionally be those who live at home and who use non-residential facilities, and with level D use walk-in psychiatric advisory clinics (day and evening); day centres, industrial therapy units, and recreational facilities.

47. How can all those services be better co-ordinated? We recognise that each separate agency has to take into account constraints on development and also the fact that developments may take place which relate more to that general service (e.g. hospital, probation, prison) than to the specific problem of the lost soul. We have looked for ways in which existing services may be co-ordinated better and be enabled to co-operate more fully, enabling a forensic service to develop, the major components of which would be social services, probation, health, prison and educational services, together with some voluntary bodies.

48. The people who were described in the opening chapter need a network of services which are designed to help those who want to be helped, and also those whose persistent anti-social behaviour is so unacceptable to the community as to warrant the community directing help upon them. This network should include penal services which are of course limited to offenders; and it should include a range of health and social services which are neither limited to a defined group nor limited to offenders. A network of this kind seems to call for a forensic care planning team and for planning to take place at a variety of levels, so that there may be better use of existing resources and joint forward planning of new developments. The remainder of this chapter suggests a way in which activities might be co-ordinated.

49. It will be apparent that the existing services are insufficient in quantity and quality, and lack a co-ordinating system or network. We feel that a new look has to be taken at the system which must be provided within any state for the rising numbers of mentally abnormal offenders who are no longer catered for in our modern society. The system we are discussing must combine an element of protection of the public with care for the individual, aid to help him understand the reasons why he behaves as he does, and above all a through-put system so that when the individual requires lesser degrees of security, trial at work and living in the community, these chances are provided for him under lessening degrees of supervision. Moreover we are anxious that the many offenders who know of the nature of their disability and have not been convicted, are allowed care on a voluntary basis.

50. We feel the best model to carry this system through is a Care Planning Team operating at area level. Such a team should be a joint enterprise: although it could be initiated by any one of the concerned services. It should be provided with a comprehensive brief, and be specifically required to have representation from each social service involved. The forensic psychiatric brief will have to be planned at regional level, because although the majority of mentally abnormal offenders can be cared for in their entirety by an area forensic psychiatric team operating through a network of hostels, lodgings and open psychiatric units designated for the purpose, there will be a few who will have to be transferred to regional units with security: furthermore, the NHS region is the authority responsible for planning new systems of care, and resulting from the recent Glancy and interim Butler reports, is required to provide medium security units for diagnostic, assessment and treatment purposes at regional level.

51. Since the Special Hospitals provide national centres for maximum security, we visualise a forensic psychiatric system which provides some security at area level where the vast majority of work is done, with those few patients needing greater security being transferred on a voluntary or compulsory basis to a regional unit giving medium security, and the yet fewer patients needing maximum security being transferred on a compulsory basis to the five national Special Hospitals. The flow would also run the other way, following successful treatment, and the regional planning authority would designate at area level who on a part-time, or full-time basis would be expected to take responsibility and leadership to persuade local authorities and voluntary bodies to provide health care facilities for mentally abnormal offenders. Parallel to this, the briefs for educational, social and probation services would need to be worked out at the area level.

52. At the operational level whether it be area or district, we see the team comprising such people as:

Representatives of
- Prison medical service
- Probation service
- Social service
- Education service
- Police
- Area Health Authority

- Consultant forensic psychiatrists (full time or part time)
- Psychologists
- Nurses
- Hostel staff
- Centre staff

53. The object of the team would be to help the process of assessment for the Court in sentencing; and to establish a planned rehabilitation programme. This should be supplementary to the sentencing of the Court - Judges, JPs, and Clerks of the Court. Depending on personality and local needs, any member of the team could take the chair and/or provide the main leadership. Some degree of leadership would be expected from the forensic psychiatrists who would not only run conventional out-patient clinics for voluntary or compulsory patients or those on remand, but would provide the group therapy sessions and counselling so much needed by residential staff fraught with the anxieties and responsibilities of care. Other members of the team would play differing parts within differing areas or districts depending on how they saw their needs ahead. In any one district or area it is likely that three or four of the team would meet two or three times a month to discuss individual patients, staff idiosyncrasies, and the nuances of night or morning for those concerned with hostel patients; whilst the main team would meet at less frequent intervals. Since there is such disparity in incidence and numbers of mentally abnormal offenders from one area to another, we could see that, for example, staff serving a population in rural Wales would need to allocate less time than staff serving a population of the same size in London.

54. Indeed, big cities like London provide intractable problems of organisation because of the way such individuals cross boundaries or appear under different names on different lists. Because four English regional health authorities are responsible for different sectors in London, the areas are numerous and districts more so. It would probably be necessary to set up a central co-ordinating agency, or agencies, to help in some of the myriads of needs for preventive counselling, shelter and treatment, possibly using the resources of the London Probation Service with whom many of our problems overlap.

55. This is the kind of solution we would advocate if we are to be limited to using the existing range of resources, within the existing statutory system. The following chapter considers what might be achieved given the possibility of certain desirable statutory changes.

5. TOMORROW'S SERVICE: A NEW CONCEPT

56. We have considered what might be achieved tomorrow, in the shape of a new type of service, given the possibility of statutory or legal change, and of some degree of new building. Before proceeding to outline our proposals we need to list a number of our underlying statements and assumptions.

57. The present provision for lost souls is inadequate, because there is:

no clear allocation of responsibility
no co-ordination of information
no proper assessment
no treatment plan
no recognition of existence of this group
no hope for future
no incentive to change

58. No-one should be admitted to NHS or Special Hospital service except for treatment: he should not be admitted solely to meet security or accommodation needs. But treatment cannot be enforced. The primary purpose of

prison	is	custody and training
home/hostel	is	accommodation
hospital	is	special treatment

but all should be for treatment in the broad sense. The inference is that for abnormal offenders, prison, hostel, boarding house, hospital and special hospital should all be part of an all-embracing service.

59. It follows that if both prisons and hospitals are provided, a new type of Court Order, such as the Adult Care Order proposed in paragraph 86, would enable use to be made of both sets of facilities with maximum flexibility.

60. The present health service is run on health-care lines; the present prison service is run on rehabilitation and training lines. It would be an economy if so far as the mentally abnormal offender is concerned, the two could combine their efforts, together with probation, social and educational services.

61. The custodial security service should be based on prison buildings; treatment with security should be based on regional secure hospital units or special hospitals, or even on prison hospitals with appropriate new orders; treatment without security should be based on ordinary NHS hospitals (including hostels, boarding houses, etc.) The Court should have power to remand to any of the above sectors for purpose of assessment.

62. The planning team at area level might include people in a position to control resources or deliver services, for example:

Director of Social Services	Area Medical Officer
Director of Education	Forensic Psychiatrist
Chief Probation Officer	Forensic Psychologist

The operational team would be as outlined in paragraph 52.

63. Whilst security facilities are necessary for the few, for the vast majority of lost souls dealt with by the medical services, we endorse the emphasis of the interim Butler Report on interpersonal relationships, sometimes with a nurse-patient ratio of one-to-one. Services and back-up facilities are more effective than incarceration.

64. The inadequate drifter, whilst he does not fit in with society, does not actually threaten it: he needs help rather than punishment. Is there any hope of changing him by what we do? Some might be changed by treatment or by social and educational strategies. Or should the effort be to improve that quality of life which is possible within his own limitations? Some are beyond aid: others will not accept it. The relative demise of the reception centre, and of the common lodging-house, has added to the problem, which has been further compounded by the liberalisation of mental hospitals and the accent on discharge under the 1959 Act.

65. Psycho-social abnormality is not a category with a sharp cut-off point; there is a continuum between the socially viable and independent at one extreme, and the socially inadequate and dependent at the other. The lost soul is in the blurred area somewhat between these two extremes, well towards the socially inadequate end of the continuum.

66. The aims of sentencing are as follows:

(a) Deterrence, though this is hardly an issue with the lost souls group. Deterrents are only relevant for people at the socially-viable extreme of the normal/abnormal continuum: these people are sensitive to normal social sanctions: but this does not hold good the further one goes along the continuum towards social inadequacy.

(b) The protection of the public

(c) The main object, within the limits of resources, is to improve the quality of life for the lost soul - that is, to provide a decent level of accommodation and work tolerable to himself and the public. This is a form of support which is seen as likely to help delay the commission of further offences.

Sentencing should be constructive and remedial although with the lost souls group whose behaviour is by definition persistently anti-social, a therapeutic aim may be remote, this group being highly likely to recidivate.

67. Such persons should be deprived of their liberty in the interests of public safety, or for their own need, but not for punishment. Deprivation is for the Court to decide. Punitive measures rarely work with the lost souls group.

68. We support the following alternatives to prison for which provision was made in the Powers of the Criminal Courts Act, 1973:

(a) Hostels for adults
(b) Day training centres
(c) Community service orders
(d) Deferred sentences
(e) Supervised suspended sentences
(f) Bail hostels

69. There are at present three ways the Courts may handle the abnormal offender to obtain custodial care and treatment.

A Probation Order with a condition of residence (under the new Powers of the Criminal Courts Act, this may be up to three years)

A Section 60 Order under the Mental Health Act 1959

A Section 65 Restriction Order (also under the Mental Health Act 1959) added to limit powers of discharge to the authority of the Secretary of State.

70. The advantage of a Probation Order is that the voluntary acceptance by the offender at Court appearance offers possibilities of establishing a "contract for treatment with the offender", its scope is not limited to the mentally disordered, and the individual can also be brought back to Court again if probation fails or he becomes beyond the control of a named after-care agent.

71. A Section 60 Order is restricted and limited in its scope by being attached to abnormal mental conditions and a total medical model. It has also the disadvantages of having no subsequent association with the Courts, having only six months compulsory after-care which is the responsibility of a diffused social services department. On the other hand, Section 65 offers indefinite after-care to a named after-care agent. The previous licencing system under the 1913 Mental Deficiency Act at least had the advantage of providing an on-going and definitive support system for the very inadequate.

72. It is not possible to return a dangerous custodial problem back to Court again for reassessment without the full procedure of the law. Hospitals are very loth to take their own patients to Court under these circumstances. In addition, the safeguard of backing admission prospects to Special Hospitals is now limited by their overcrowded conditions. Hospitals may thus from time to time be left holding dangerous patients who are, or who are potentially, beyond their control. It is likely that the new regional secure hospital units will ease this problem when they arrive, but probably not totally.

73. Informal guardianship schemes exist in a number of places: for example, the North Wales Guardianship Scheme wich permits guardianship on a voluntary basis, providing sheltered lodgings and sheltered work to allow people of sub-normal intelligence and/or personality damage the opportunity to live in the community within their handicaps.(3) But compulsory guardianship under the Mental Health Act has never really established itself on a national basis, as a means of effecting help for the inadequate. It would seem that the local authorities require more definitive legislation (for example at the level of a Child Care Order) in order to establish a responsibility concept appropriate for guardianship.

74. On the basis of the above statements and assumptions, we now make a series of recommendations, several components of which can be applied within the framework of the present situation, and some which indicate the necessity of a different kind of service for lost souls.

75. Clearly greater diversity is necessary than is currently represented by the division into, on the one hand penal, and on the other hand, hospital care. Punishment is regarded as irrelevant to the care of the abnormal offender, whilst the hospital concept of treatment, although important, is by no means the only form of adult care. Furthermore, flexibility has been stressed in our proposals so that offenders can be moved from one kind of facility to another as the need arises. Our proposals would enable disposal to conventional prison to be avoided in many cases. Prisons are overcrowded and expensive and they do not effectively achieve rehabilitation. We propose that an alternative service for assessment be offered to the Courts; and we suggest a new type of court order which overcomes the disadvantages of previous court orders and which also offers a wide variety of facilities in management, rehabilitation and treatment.

A NEW CONCEPT OF SERVICE

76. Although much of the development of the various services to date has been haphazard, accidental, unco-ordinated and unrelated, a great deal could even now be accompished simply by the more effective organisation of facilities that already exist (forensic psychiatric services, social services, prisons, probation and educational facilities) or which may shortly come into existence (medium security units, bail hostels, detoxification centres, drug addiction centres). Even better results could be achieved by the introduction of certain new measures, to which we now proceed.

New Co-ordinating Machinery

77. The first consideration therefore is to set up an executive group at area level to co-ordinate and relate all these varied services. A very senior officer should be appointed to this executive with the specific role of acting as a co-ordinator between the various services, agencies and facilities available.

78. The range could include prison after-care service (including voluntary organisations such as NACRO); probation services (hostels, day centres, day hostels); social services (group homes, training centres, industrial rehabilitation units, employment organisations); voluntary organisations; educational services (adult education and training courses); forensic psychiatric services; hospital facilities (out-patient clinics and centres, medium security facilities, forensic units, detoxification centres, drug addiction centres).

79. The executive group should include the Director of Social Services, the Chief Probation Officer, forensic psychiatrists, a senior prison Home Office representative, the Director of Education, the Area Medical Officer and other relevant staff such as the Director of Psychological Services.

80. The task of this executive should be to plan and direct an overall service to include facilities under the following headings:

Residential	a roof above the head; housing; group homes; hostels; hospital places; lodgings
Work facilities	sheltered workshops; employment rehabilitation centres; a system of sympathetic employers
Education	to include remedial teaching and towards developing latent talents in the individual
Counselling and treatment	allocation to a particular person along probation lines, with backing forensic psychiatric services, as and when necessary.

A new assessment mechanism

81. At present the assessment of the offender is limited to assessment on remand in prison and to assessment on remand on bail. We have seen that the level of social enquiry by the probation service is particularly limited in the metropolitan area and there are similar limitations in psychiatric reports whilst on remand in the London prisons. A further problem that the courts face is the considerable limitation on alternative residential facilities at present available to imprisonment, whether in the provinces or in the metropolis. The demise of the common lodging house and restriction on psychiatric hospital admissions has already been noted.

82. It is thus recommended that assessment facilities outside prisons should be developed at a sophisticated level in addition to the prison assessment system. These assessment facilities should be:

at a custodial level for the potentially dangerous, for a serious crime and for the inadequate who wanders off. This could be developed in association with the new medium security facilities being planned on the advice of the Butler Committee;

in open forensic psychiatric units, possibly in association with mental or subnormal hospitals;

on bail at forensic psychiatric out-patient centres or residential assessment on bail at psychiatric hospitals, bail hostels, etc..

The new concept of an assessment/rehabilitation campus

83. There would clearly be certain advantages if the above three variations of assessment could be carried out on the same campus, and a diagram illustrating a possible campus to include assessment, treatment and residential support is included. Such a campus might be called an Adult Care Unit, although facilities might be geographically scattered between different places whilst a total functional concept is still being maintained by management links. Indeed, the concept of a functional Adult Care Unit is essential to the concepts about to be propounded.

84. In order to assist the courts in assessment, it is recommended:

(a) that each court have its own multi-disciplinary assessment board associated with it and consisting of psychologist, psychiatrist or prison medical officer, social workers and probation officers

(b) that each assessment board be available to the court to advise on sentencing and have legal advice available from a qualified person in appropriate cases

(c) that the assessment report be made by one person as co-ordinator for the whole team. We make no stipulation about the professional discipline of the co-ordinator

(d) that the assessment team report on each case indicating a possible line of action and listing the factors which should be considered before sentence is passed by the court. The assessment team would have a direct responsibility both to the court and to the area executive committee. In this way the facilities available would be extended to include total facilities under all the various services.

85. It is essential that a professional relationship is established with the courts so that advice given is seen by the court as sensible and helpful. If a contractual relationship is to be established with a client (contrast the voluntary element of a Probation Order) it is important to set this up at the point of assessment with a reasonable level of prediction on the court's likely attitude to the case, whilst at the same time in no way usurping the functions of the court as the absolute authority on sentencing.

A proposed, new Adult Care Order

86. There is a need for a legal Order for the inadequate offender which incorporates some of the concepts of a Probation Order and avoids the disadvantages of Section 60 Orders under the Mental Health Act as already indicated. We therefore propose the introduction of a new order - Adult Care Order - aimed at both substantially reducing the penal population and providing an additional facility for lost souls.

87. It should be stronger and more definitive than a Probation Order, to the point where there can be variable direction on residential placement according to the needs of the situation as it develops - that is, to enable residential transfer between differing residences under the direction of a responsible officer, designated by the court. In addition to residential control, the designated officer should have authority to control the work situation or employment training as appropriate. When necessary this may be supported by designated psychiatric in-patient or out-patient treatment.

88. It should be possible to build treatment and rehabilitation advice into each Order. Clearly it would also be necessary to build in various safeguards in terms of civil liberties. Preferably the Order should be allowed to have a voluntary contractual element along the lines of a Probation Order, but to cover certain cases of non-co-operation it would probably be necessary to build in a coercive clause.

89. A time limit of three years - similar to that of a Probation Order - is advised, with the possibility of a return to court at the end of the time if it is found - we hope only in exceptional cases - that the Order should be renewed.

90. The Order would be supervised by the original assessment/therapeutic team, consisting of psychologists, educationalists, social workers, probation officers and forensic psychiatrists. The team would work in conjunction with a representative of the court who could indicate the court's likely intention in terms of custody or liberty as well as to protect the client from an overzealous team!

91. It would be vital that the various public services provide the facilities required in an Adult Care Order - flatlets, lodging houses, hostels, group homes, sheltered workshops, employment organisation, educational facilities, etc..

92. Finally, we would like to see the opportunity for the client to opt out of the Adult Care Order and choose conventional sanctions instead. Conversely a client undergoing conventional sanctions would be able to request and be considered for an Adult Care Order.

93. The way in which the Adult Care Order would work is shown schematically in diagram A. The recidivist goes to court to be tried. On a finding of guilt he is assessed by an assessment/therapeutic team, either at a clinic in the community or at a residential centre which would include secure facilities, bail hostel, detoxification centre, etc.. The number and situation of clinics/residential centres would depend on the population needs. The client would then present at court again for sentencing with the assessment advice available. The court would have the same powers as at present, for noncustodial, penal and psychiatric disposals, but with the radical addition of the proposed Adult Care Order.

How the new campus concept and the new Adult Care Order would combine in operation - See Diagram B

94. The concept of an assessment and rehabilitation campus has some bearing on original suggestions put forward by the Ministry of Health's Working Party on Security in 1962, but which sadly seem to have been lost in limbo. The medium security aspect refers to regional security units as suggested by the Butler Interim Report and the Report of the Glancy Working Party. Detoxification units and bail hostels were suggested under the recent Criminal Justic Act (The Powers of the Criminal Courts Act 1973), and it is felt that in particular, detoxification units might not get off the ground against local mental health service resistance unless there is comparable central funding and central pressure for units based on the medium security unit concept of the Interim Butler Report.

95. An open male forensic unit is suggested on the grounds that there are a number of cases who require to be housed during their remand period and require hospital assessment, but who by no means necessarily require security. This also applies to a treatment concept. In diagram B, the two houses of five beds each are suggested as a training concept towards transferring groups of people into self-care, or group-home housing in the community.

96. Further arguments in favour of collecting an adult care unit on one campus include:

(a) it makes possible a viable self-contained unit with its own services

(b) support facilities such as workshops, work assessment, recreation, physical exercise (gymnasium) would be needed

(c) it would facilitate the working of other support services provided by psychologists, social workers, forensic psychiatrists, etc..

(d) it would enable a tighter organisational service control and concept

(e) it would attract good staff, of all disciplines, because of the constructive nature of the work.

97. The alternative concept of scattering facilities between different hospital/social services/probation campuses would perhaps have an advantage in dispersing the service in relation to the general public and in preventing an over-identification as a prison/Home Office concept.

DIAGRAM A

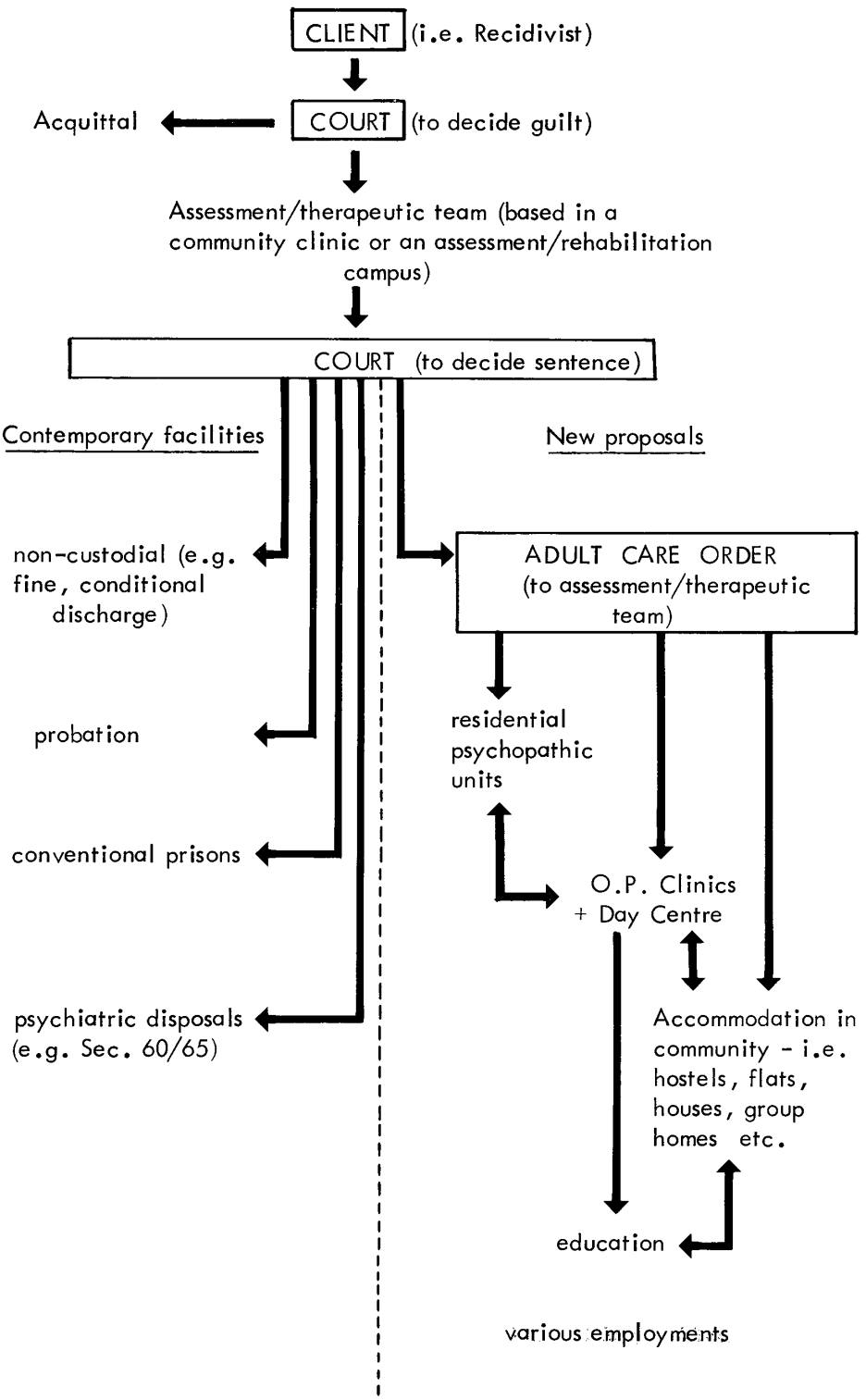
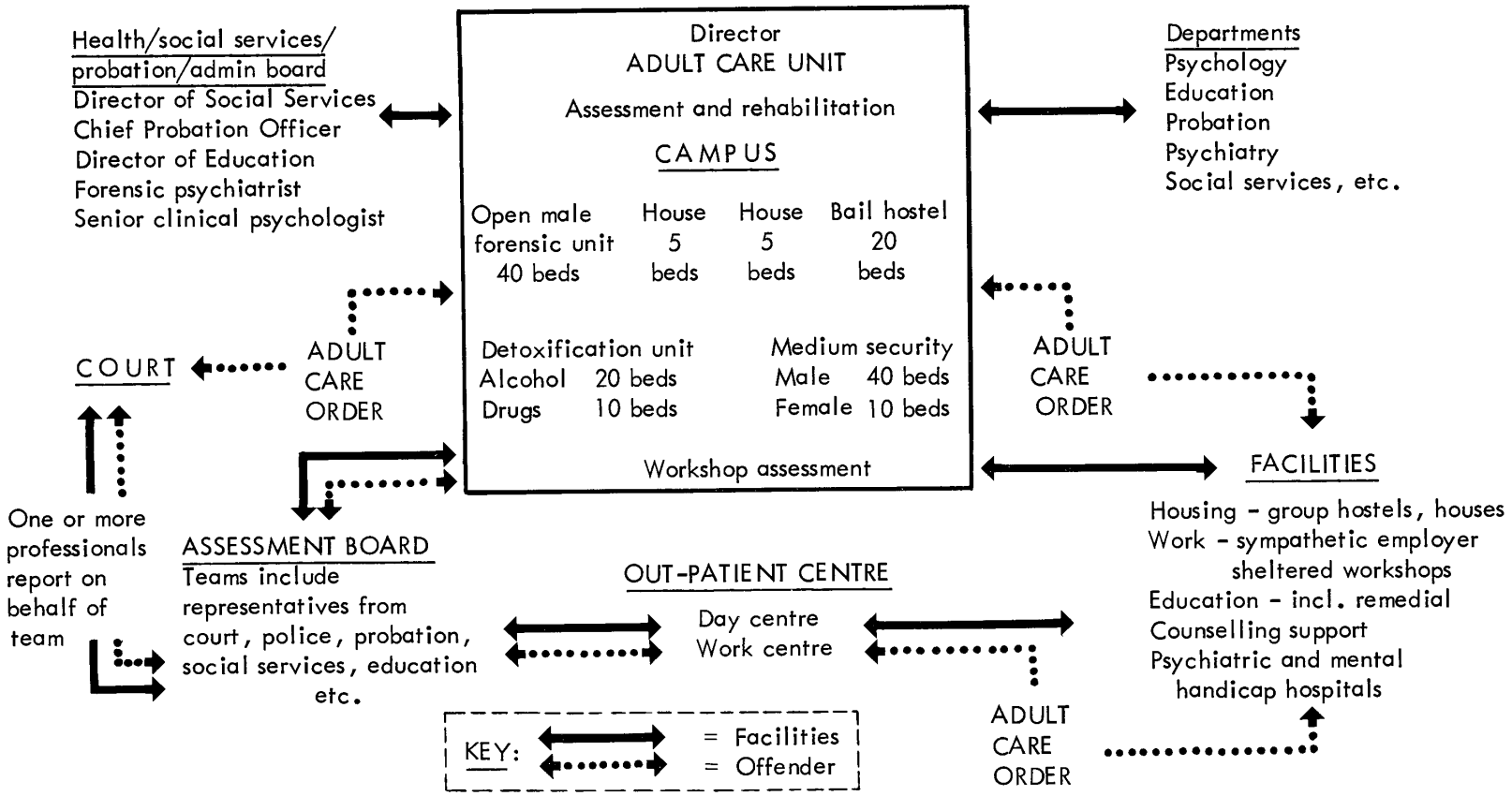

CLIENT (i.e. Recidivist)
Acquittal
COURT (to decide guilt)
Assessment/therapeutic team (based in a community clinic or an assessment/rehabilitation campus)
COURT (to decide sentence)
Contemporary facilities
New proposals
non-custodial (e.g. fine, conditional discharge)
probation
conventional prisons
psychiatric disposals (e.g. Sec. 60/65)
ADULT CARE ORDER (to assessment/therapeutic team)
residential psychopathic units
O.P. Clinics + Day Centre
Accommodation in community - i.e. hostels, flats, houses, group homes etc.
education
various employments

DIAGRAM B

Example of assessment/rehabilitation campus together with development of residential/treatment facilities



SUMMARY

1. There exists a considerable number of mentally abnormal people in Britain whose persistent antisocial behaviour, rather than their mental abnormality, brings them into contact with the criminal courts: we have described these people as 'lost souls'.

2. They are to be found in many places, including prisons, borstals, hospitals and lodging houses: many live on the open streets or in derelict houses in our great cities.

3. They have become 'lost' through a combination of factors: their mental abnormality combined with, or arising from, genetic inheritance, physical disability, and/or a whole group of social, psychological and educational factors.

4. The number becoming 'lost' has increased over recent years due to a number of factors: these include the diminution of the asylum function of the pre-1959 mental hospital; the paucity of social support for those discharged from mental hospitals; the reduction in the number of official reception centres; and the near-disappearance of the respectable but cheap, common lodging house.

5. The existence of this sub-group seems hardly to have been recognised in official planning, and such medical, social or educational services as do reach lost souls are inadequate and unco-ordinated.

6. The numbers becoming 'lost' could be substantially reduced by the availability of:

better educational services whilst potential lost souls are in their formative years;

cheap, clean, overnight lodgings in every city or town;

better social work support

a general improvement in the quality of life for families caught in the cycle of deprivation.

7. Even so, it is recognised that there will remain in circulation, many thousands of these lost souls who at present receive, at best, patchy and unco-ordinated support and help.

8. An immediate improvement in the quality of service delivered could be achieved by the co-ordination of the activities of the extremely varied range of existing services, so that in each area there is a composite team with a common philosophy. Proposals for the composition and operation of such teams are made in Chapter 4.

9. Far greater improvement is likely to flow if this formation of composite teams at regional and area level is associated with the entirely new concept of service outlined in Chapter 5.

10. Key features of the new service would include:

new co-ordinating machinery

a new multi-disciplinary assessment mechanism for the formulation of advice to the courts

a new Adult Care Order to be available to the courts

the concept of an assessment and rehabilitation campus, including facilities for residence and treatment. The campus would have an important part to play in the development of the new assessment system and the use of the new Adult Care Order.

* * *

APPENDIX A

MENTAL ABNORMALITY AMONGST PRISONERS

M. Faulk

An attempt has been made to assess the incidence of mental abnormality amongst men who spend their sentence at a local prison (Category B men). There are between 40 and 50 such men per month released from the prison. The figures are presented in Table III, showing initial findings.

Method

Men who had served their sentence in the prison were interviewed one week before their release consecutively. 72 men were thus surveyed. Prison records and any social reports were examined at the same time. Information from the interview and data from the records were used to complete a questionnaire for each man. An attempt to make fine diagnostic judgments was avoided but note was taken of those aspects of the man's life which pointed to personality disorder. Only men who had sentences longer than one month were examined.

Results

The results are shown in Table III. The population is principally of recidivists who have failed to respond to previous penal experience. Personality, social and domestic difficulties are mirrored by the incidence of alcohol abuse, drug abuse, marital failure and occupational history.

Conclusions

The incidence of disorder in prison populations from other surveys is shown in Table I and Table II. One of the principal problems in psychiatric surveys in this area is that of definition. This is seen particularly under the heading of personality or psychopathic disorder. Walker has demonstrated how the term psychopathic has become restricted to an ethical meaning associated with personality disorder and he has demonstrated how, in practice, the legal definition, which is an extremely broad one, has been interpreted in a very restricted way by clinicians for reasons of expediency. How it is interpreted perhaps accounts in part for the differences in the findings of the investigators as shown in Table I, where the incidence of psychopathic disorder is seen to vary from 8% to 66%. My own view is that the incidence in a modern prison population of men with severe personality disorder, including psychopathic disorder, is in the region of 80% although not all may be suitable for treatment and certainly less may be in need of specifically psychiatric treatment. In my opinion, any attempt to get to grips with this problem must involve the penal system completely. Experience has shown that whilst psychiatrists have a contribution to make, they can only be one of a team which must involve many disciplines to contribute to a solution of this problem.

TABLE I: Incidence of mental disorder in different prison populations

Name of Investigator and Prison	Psychotic	Organic Epileptic	Neurotic	Personality Disorder	Psycho-pathic	Alcoholic	Drug Addict	Subnormal Borderline Subnormal
Glueck (1918) Sing Sing Prison	12.0%	-	-	-	18.9%	-	-	28.1%
Roper (1948) Wakefield Prison (Star Prisoners)	-	-	10.0%	-	16.0%	-	-	18.0%
Roper (1949) Wakefield Prison (Mixed population)	-	-	12.0%	-	8.0%	-	-	45.0%
West (1963) Study of recidivists in Wandsworth Prison	10.0%	-	-	Inadequate 52% Aggressive 48%		-	-	-
Robinson (1965) Belfast Prison	-	-	-	-	-	55.6%	-	24.0%
Bluglass (1967) Perth Prison	1.9%	2.5%	2.2%	13.3%	-	11.2%		14.2%
Gibbens (1966) Pentonville	2.0%	-	-	-	-	47.0%	8.0%	6.0%
Eastchurch Open Prison	0%	-	-	-	-	17.0%	3.0%	9.0%
Ex Juvenile Offenders	-	-	-	-	66.0%	-	-	-
Late Onset Offenders			60.0%		16.0%	-	-	-

Where figures are not given in the original papers, this space is marked with a hyphen.

TABLE II: Overall incidence of mental abnormality in the prison population

Name of Investigator and Prison	Normal	Mental Abnormality	Recidivism
Glueck (1918) Sing Sing Prison	41%	59%	66.8%
Roper (1949) Wakefield Prison	25%	75%	-
West (1963) Study of Recidivisits in Wandsworth Prison	12%	88%	100%
Bluglass (1967) Perth Prison	54%	46%	97%*
Gunn (1973) unpublished South East Region Prisons	One third of inmates suitable for psychiatric treatment		

* One or more previous convictions
Where figures are not given in the original papers, this space is marked with a hyphen.

TABLE III: Incidence of behaviour disorder in men serving a sentence in a local prison

Indication of behaviour disorder	Percentage
Six or more previous convictions	65%
Previous penal experience (including establishments for young persons)	78%
Previous imprisonment	68%
Previous psychiatric contact	40%
Serious alcohol abuse	50%
Serious drug abuse	10%
Vagrant at time of arrest	30%
Separated or divorced	44%
Less than one year's employment in the two years preceding arrest	46%
Unemployed at time of arrest	47%

APPENDIX B

INCIDENCE OF PATIENTS REQUIRING A SPECIAL OR PSYCHOPATHIC UNIT

M. Faulk

An attempt was made to assess this number in the Wessex Region (population 2 million). Every consultant in adult psychiatry was circulated and asked to indicate how many patients he had seen in the preceding nine months who would benefit from a psychopathic unit. The consultants were asked to indicate numbers in the following categories:

1. Young persons with severe personality problems requiring some degree of control
2. Unco-operative psychotic patients
3. Older men with severe personality problems
4. Ex-patients from prison or Broadmoor who might be considered dangerous

Results

Seventeen of the thirty consultants replied and reported a total of 125 patients that they had seen and who required special care. The cases were distributed in the following way:

Category 1	60 patients	Category 3	36 patients
Category 2	21 patients	Category 4	9 patients

Conclusions

From informal discussions with consultants who did not reply, I have no reason to think that they saw a substantially different number of patients to the ones who did reply. From the figures, therefore, it seems that in this population some 300 to 400 such patients may well present each year to psychiatric hospitals in a region of this size. This would not include however, drug addicts and alcoholics who already have services catering for them in this region. Whether patients are referred to particular psychiatrists will, of course, reflect the interest of the psychiatrist in this type of problem. The total number of cases will also reflect the urban or rural nature of the area considered. Gunn * from a study of the Camberwell register of psychiatric cases concluded that in that region there would be 1228 such patients (including addicts and alcoholics) per million per year.

* Gunn, J. (1971), British Journal of Hospital Medicine, 6, 260

APPENDIX C

THE EXTENT OF ABNORMALITY AMONG OFFENDERS

T.C.N. Gibbens

The extent of mental abnormality depends very much upon the type of population surveyed, as well as upon the type of abnormality and the very variable criteria adopted by psychiatrists. Among the various samples studied are:

(a) Remands for medical reports

(b) Borstal population

(c) Prison population

Remands for medical reports

Offenders before the courts are selected initially by laymen (probation officers and magistrates) to be the subject of a medical report. Some 14,000 reports yearly are prepared by prison medical officers on people in custody and an unknown number on people on bail. In 1969 we studied the medical reports - whether on bail or in custody - for 18 Inner London courts (4000) and for courts in the Wessex Regional Hospital Board area (500), in much greater detail. Only about 1%-2% of all offenders are the subject of a report, but this rises to 8% for indictable offences and reaches 20% for some offences (e.g. sex offences). Of those examined, 8% of males and 10% of females in London received a medical disposal (3% on probation and 5% hospital orders under Section 60); but in Wessex 22% of males and 21% of females received a medical disposal (14% on probation and 8% Section 60 for males; 18% probation and 3% Section 60 for females). The difference is probably due to the fact that 90% of London reports are made in custody compared with 65% in Wessex. If the NHS consultant sees the case on bail initially he is more likely to select those he feels he can treat than is the prison medical officer, who is more reluctant to make the choice for the NHS consultant, especially in minor optional out-patient cases.

In Wessex the doctors filled in a questionnaire about each case; 21% males and 47% females had had contact with a psychiatric hospital in the last year (14% more in both sexes had contacted a psychiatric hospital in the last five years). The probation service plays a key role, for in Wessex nearly all offenders are interviewed before conviction (and no doubt the psychiatric history is obtained), whereas in London very few are interviewed and much depends upon magistrates' impressions in court. Abnoramlities present in either severe or moderate degree in the Wessex study were anxiety states (9% M, 18% F); depression (6% M, 16% F); other neurotic symptoms (12% M, 14% F); psychosis (7% M, 0% F); dementia (2% F); mental retardation (7% M, 16% F); chronic alcoholism (8% M, 12% F); drug problems (7% M, 14% F); physical disorder (4% M, 14% F).

Borstal population

In 1952 I examined 200 London Borstal boys and concluded that 27% were mentally abnormal; 14% were problem or doubtful cases, often involving physical handicap or possible brain injury etc; and 59% were normal.

Each group, however, contained individuals with good, fair, poor or bad prognosis. Among the 'abnormals' 12% were considered to have a good or fair prognosis for avoidance of crime but required individual or group psychotherapy; 8% had both abnormality (severely inadequate or aggressive psychopaths) and very poor prognosis; 5% were considered to have bad prognosis but to show no psychiatric abnormality. Further criminal behaviour depends upon underlying personality (what the American psychologists now refer to as "levels of maturity in interpersonal relations") rather than on psychiatric abnormality. A 20-year follow-up has shown considerable error in the original prognosis: 65% of all cases have been in no recorded trouble for 10 years. The Borstal population has been deteriorating steadily since then, as courts have become more and more reluctant to commit to Borstal.

Prison population

Unless care is taken these are heavily biased according to type of prison. The population of any prison on any day contains a misleadingly large proportion of long-sentence prisoners.

In 1962 we interviewed (for aftercare purposes) 306 prisoners in three London prisons, carefully stratified to represent the output of the prisons by number and by length of sentence (106 for Brixton, 35 for Eastchurch, 165 for Pentonville). Even then those serving their first prison sentence in Brixton were far from being first offenders - 12% had six or more previous convictions or findings of guilt. In Pentonville 60% had served three or more previous prison sentences; under half were born in London or the Home Counties; 43% were born in Ireland or Scotland; nearly a third were living in hostels, or were of no fixed abode at the time of conviction.

Among the many characteristics of the whole 306 prisoners the most important factor was the age of onset of criminal behaviour - under 17 for 36%, 17-21 for 22%, 21-30 for 25% and over 30 for 17%.

No great emphasis was placed upon the diagnosis by the interviewing PSW, but 2% were regarded as psychotic, 2% epileptic, 35% neurotic, 51% psychopathic, and only 10% as normal. Psychopathic diagnosis was used especially frequently in the ex-juvenile delinquents.

A more objective factor was that 10% of all had been in mental hospital at some time, 2% in hospitals for subnormals, 3% with previous out-patient treatment or suspected in-patient treatment. The incidence of previous breakdown increased with age.

Among the 44 with mental hospital experience, half were depressive alcoholics whose admission had been caused by short-lived suicidal attempts; though some were not alcoholic. Six had had a previous schizophrenic breakdown and now suffered from schizophrenic defect states; six had been in subnormality hospitals and often involved in sex offences; six were grossly psychopathic middle-class prisoners of the 'non-sane-non-insane' type whose families had struggled repeatedly to provide them with psychiatric treatment for their fraudulent, fire-setting, promiscuous or perverse behaviour. The manifestly psychiatric cases however were (1) rather few, (2) rarely showed clinical symptomatology but did show much personality disorder, and (3) represented little risk to the public.

No less than 17% were not convicted until they were thirty. A number were first offenders (sex or fraud especially), but many were recidivists after the first conviction; a third of these were alcoholic or non-alcoholic depressives whose social adjustment had collapsed after the death of parents, wife, or similar calamity. Some 45% of the total population studied were considered to have a serious drink problem, and this proved to be closely related to the number of previous prison sentences and also to the speed of reconviction in the year following release. Those in prison for drunkenness itself, however, were excluded from the sample, which did not include those serving 28 days or less.

In 1965 Bluglass examined every fourth prisoner received in Perth. He concluded that 46% were psychiatrically abnormal (psychosis 2%, neurosis 2%, psychopathic 13%, alcoholic or drug addicted 11%, borderline subnormal 12%, subnormal 3%, epilepsy 1%, organic 1.5%).

Gunn has recently had an unusual opportunity to add a psychiatric component to a Home Office survey of a 10% sample of the prison population in South East England. He issued a mental health and other questionnaire to all those in the survey and arranged standardised and tested psychiatric interview of a 10% sample of these (i.e. 1% sample of all) by eleven psychiatrists trained in the use of standardised interview technique. Sophisticated methods were used to compare the validity of each method. A primary diagnosis was made of schizophrenia 1%, affective psychosis 1%, neurosis 9%, personality disorder 16%, sexual deviation 1%, alcoholic 5%. Total 33%. It was pointed out however that such terms have little value. The diagnosis of a "psychiatric case" depends upon symptomatology, the nature of the offence, the level of social function, previous psychiatric illness, and above all, motivation for change or treatment. Desire for treatment has a marked effect upon assessment. Using a variety of checks and methods, Gunn concluded that 35% were psychiatric cases (30% for short-termers, 35% medium-termers and 41% long-termers).

No attempt was made by Gunn to assess "borderline subnormality" and if these cases are deducted from Bluglass' total of 46% the resultant figure of 34% is very close to Gunn's finding that 35% of the prison population studied were psychiatric cases.

References

Bluglass, R.S. MD Thesis (Birmingham) unpublished

Gunn J, Robertson G, Dell S. and Way C. Psychiatric aspects of imprisonment. To be published. Academic Press, London

APPENDIX D

PEN PICTURES

To illustrate the kind of people considered by the group, and the inadequacy of current services, we give below some examples culled from newspapers by one of our members. The names of people and places have been deleted.

"Judge gives health men a rocket

..... And Judge X at Y Crown Court hit out again at the lack of semi-secure hospitals for the mentally subnormal. Z, aged 20, was before the court for sentence after being convicted of two offences of attempted burglary on public houses. It was his fourth appearance in the case. It had been put back while the court waited to hear what kind of hospital was available for Z, who has repeatedly absconded from a mental hospital. But, the Judge heard yesterday, no reply had been received from the Regional Health Authority or the Department of Health and Social Security. "So the policy seems to be that if you just do nothing for long enough you get away with it. And if you don't even answer letters, I suppose that saves a little trouble too", said Judge X."

"No place but gaol for loner

The Home Office last night refused to make any official comment on the case of X, aged 24, said to be unemployable, pathetic, and lonely and thought to have an IQ of 54. He was sent to prison at Y Crown Court yesterday because there was "nowhere else" for him to go. Mr. X was imprisoned for 12 months after admitting causing £29 worth of damage to a public-house in ..... He was told by Judge Z "You would like to go to hospital but the doctors say you are not suitable for hospital. There is nowhere else I can send you other than prison". Mr. X's barrister .... said there was no hostel available which would allow Mr. X to work in society and added: "It seems to reflect a gap in the social services that there is no means whereby this man can be allowed to live in society in a hostel and work in a workshop for disabled persons". ....."

"Sick man sent to prison

A teenager in need of psychiatric treatment was sent to prison yesterday because a mental hospital was short of staff. Dr. X of ..... mental hospital agreed that Y, aged 19 was in need of treatment but said he was violent. The defending solicitor told magistrates: "It is not the doctor's fault but if that's the position of the mental health service we are in a very sorry state". Mr. Y had pleaded guilty on July 29 to a charge of indecent exposure. He has two previous convictions, one for violence, and has been a patient at a mental hospital in the past."

"Ex-patient's crimes were 'cry for help'

A man discharged from a mental hospital after 15 years as a patient was dumped on the streets like an abandoned child, Mr. X, defending, said at ..... yesterday. Y (37), pleaded guilty to smashing a £165 plate glass window at a car show-room in ..... and the double glaze of a window at ..... police station. Sentence was deferred for 12 weeks. Mr. X said: "He is not a vicious criminal but a pathetic unfortunate whose action was a cry for help". After 15 years in a mental hospital this was his first time out and he was frightened. No help was available, Mr. X went on, and although he knew he still wanted treatment he was turned away every time he went to a hospital, a police station, or a welfare agency. ....."

* * *

APPENDIX E

BACKGROUND PAPERS

It will be seen that one of our difficulties has been to define and quantify this sub-cultural group, which seems to change shape, break into parts, and rejoin in a different shape, like a blob of mercury on a laboratory bench. In our search, we collected a number of papers and references, usually relating to different local settings: a particular prison or hospital or borstal or reception centre. Sometimes, as in the case of official statistics, they related to people classified under various Acts: Sections 60 and 65 of the Mental Health Act, for example. We found that our lost souls moved in and out of all these figures, now here, now there. We do not believe it possible, unless it be by some major survey, to count heads with any degree of confidence.

However, such papers as we have used have had to be searched for, and to help those who we hope will follow us, we list the whole of the papers involved.

1. BALDERTON HOSPITAL. Analysis of patient population on 1.3.74. Balderton, Balderton Hospital, 1974. p.1

2. BLACK, D.A. A decade of psychological investigation of the male patient population of Broadmoor: (1) General demographical information. London, Special Hospitals Research Unit, 1973, pp.35. Special hospitals research report no.8.

3. CRAFT, M.J. A new community forensic psychiatric service. London, King's Fund Centre, 1973. pp.5. KFC 73/430.

4. FAULK, M. Incidence of patients requiring a special or psychopathic unit. Paper circulated at a meeting on The Abnormal Offender held at the King's Fund Centre on 4 March 1974. pp.6.

5. FAULK, M. Mental abnormality amongst prisoners. Paper circulated at a meeting on The Abnormal Offender held at the King's Fund Centre on 4 March 1974. pp.6.

6. FAULK, M. and HALL, C.L. Report on a study tour in Holland and Denmark to investigate the services in those countries for mentally disturbed offenders and other patients with severe behaviour disorders. Winchester, Wessex Regional Hospital Board, 1973. pp.35.

7. FELTHAM BORSTAL. Feltham receptions - breakdown of problem areas. Paper circulated at a meeting on The Abnormal Offender held at the King's Fund Centre on 4 March 1974. June, 1971, pp.6.

8. GIBBENS, T. The extent of abnormality among offenders. Paper circulated at a meeting on The Abnormal Offender held at the King's Fund Centre on 4 March 1974. pp.5.

9. GRAY, W.J. The therapeutic community and evaluation of results. International Journal of Criminology and Penology, vol.1 1973. pp.327-334.

10. GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Report of the working group on residential provision for offenders within the community. London, DHSS, 1973. pp.(23) plus appendices.

11. GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Revised report of the working party on security in NHS hospitals. London, DHSS, 1974. pp.24. Appendix to HSC(IS)61.

12. GREAT BRITAIN. HOME OFFICE AND DEPARTMENT OF HEALTH AND SOCIAL SERVICES. Interim report of the committee on mentally abnormal offenders. (Chairman, Lord Butler) London, DHSS, 1974. pp.9. Cmnd.5698.

13. HEALTH CARE EVALUATION RESEARCH TEAM. Analysis of incidents of restraint occuring during April, May and June 1973. Winchester, Wessex Regional Hospital Board, Health Care Evaluation Research Team, 1973. pp.4 plus appendix.

14. H.M. PRISON. GRENDON. Survey of Grendon admissions for 1969. Grendon, H.M. Prison. Paper circulated at a meeting on The Abnormal Offender held at the King's Fund Centre on 4 March 1974. pp.10.

15. The homeless offender in the south-west of England: a report prepared for the south-west regional group consultative committee for after-care hostels. South-West Regional Group Consultative Committee for After-Care Hostels, 1969. pp. viii 62.

16. KING EDWARD'S HOSPITAL FUND FOR LONDON. THE HOSPITAL CENTRE. Strategies for the mentally handicapped security patient. London, The Hospital Centre, 1972. pp.21. Mental handicap papers No.2.

17. LANGDON HOSPITAL. PRENTICE UNIT. Some facts and figures concerning the Prentice Unit since its opening. Exeter, Langdon Hospital, 1974, pp.3. Paper circulated at a meeting on The Abnormal Offender held at the King's Fund Centre on 4 March 1974.

18. Memorandum of evidence to the Butler committee on the law relating to the mentally abnormal offender. Bulletin of the British Psychological Society, vol.26 1973. pp.331-342.

19. OXFORD REGIONAL HOSPITAL BOARD. Report of a working party on individuals requiring security. Oxford Regional Hospital Board, pp.26.

20. TIDMARSH, D. and others. Camberwell reception centre: summary of the research findings and recommendations by D. Tidmarsh, S. Wood and J.K. Wing. London, Department of Health and Social Security, 1972. pp.41.

21. TREVES BROWN, C. Assessment of regional differences in rates of referral for special hospitals placement. London, Special Hospitals Research Unit, 1973. pp.75 Special hospitals research report no.7.

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The following people were involved from time to time in the various stages of our discussions: see paragraph 4 of Foreword.

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We were also helped in our discussions by officers of Government Departments who attended as observers. Those who did so at various times included:

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* * *

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