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Audit in practice

The impact of the Mental Health (Amendment) Act 1983 on admissions to an interim regional secure unit for mentally handicapped offenders

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The management of mentally handicapped offenders has long been problematic. Three misconceptions of the relationship between mental handicap and criminality have been widely held since the turn of the century, despite there being no conclusive evidence in their support (Jackson, 1983). These are: that mentally handicapped people are more likely than others to commit antisocial acts in general; that they have a particular predisposition to commit serious crime, especially sexual crime (Robertson, 1981); and that they are unlikely to be deterred by normal sanctions. Misunderstanding breeds misapprehension. Sadly, in the past, many mentally handicapped people were admitted to hospital after committing only trivial offences. Moreover, one Special Hospital study (Parker, 1974) found that most "severely subnormal and subnormal" detained patients actually had IQs above the category to which they had been assigned.

Of the many reforms brought in by the Mental Health (Amendment) Act 1983, two are central in addressing these issues. Firstly, "subnormality" was replaced by "mental impairment", a term which includes by definition "abnormally aggressive or seriously irresponsible conduct". Secondly, the treatability criteria were introduced, although not for severe mental impairment. By these two means the basis on which people with mental handicaps can now be compulsorily detained is at the same time more explicit and more exclusive. Also, the additional machinery of the Act – particularly the Mental Health Act Review Tribunals – should now ensure that the more stringent criteria are followed, and that no patient is inappropriately detained. Now, with several years' experience of the 1983 Act, it is important to know whether these changes have had their desired effect.

The study

The aim of this study was to assess the impact of the 1983 Mental Health Act on admission practices to an interim secure unit for mentally handicapped offenders. We were particularly interested to determine whether those admitted under the 1983 Act differed in any way from those admitted under the 1959 Act.

The subjects of the study were all patients admitted under a court order (sections 60, 65 of the 1959 Act and 35, 37 of the 1983 Act) to one mental handicap interim regional secure unit over a ten-year period, consisting of five years before and five years after the introduction of the 1983 Act (1 October 1978 to 30 September 1988). The unit chosen for the study very rarely admits any patients voluntarily, a practice which has persisted since the implementation of the new Act. A precoded structured schedule was used to collect the data, which included age, sex, IQ, recorded psychiatric diagnosis and details of index and previous offences.

Findings

The total number of admissions to the unit over the ten years of the study was 38: 27 in the five years before the 1983 Act; 11 in the five years after.

In many respects admissions under the two Acts were similar.

(a) *Age*. Both groups were young. Sixteen, nearly half of the total group, were under 21 years.

(b) *IQ*. IQs ranged from 45 to 100 on the WAIS. Twenty (53%) scored in the mildly mentally handicapped range (50–70), 16 (42%) in the borderline range (70–90). One patient had an IQ of 100: only one had an IQ under 50. These IQ scores were evenly distributed over the two groups: there was no trend towards more mentally handicapped people in the 1983 Act group.

(c) *Diagnosis*. Most patients (36: 95%) had diagnoses of either mental impairment or subnormality. Ten had additional diagnoses, of mental illness (4: 10%) or psychopathic disorder (6: 16%). Two (one

from each five-year group) had a recorded diagnosis of psychopathic disorder alone, and no mental handicap diagnosis.

(d) *History*. Most of the subjects (30: 79%) had a history of previous hospitalisation, or were in some way known to the mental handicap services. Again, this was constant over the two groups.

(e) *Offences*. All but one of the sample had been convicted of previous offences. The types of offences showed some constancy across the two groups, as shown in Table I, but also some differences, as further elaborated below.

Admissions in the two five-year periods show certain contrasts, in addition to the fall in number.

(a) *Sex*. No women were admitted to the unit in the five-year period following the 1983 Act.

(b) *Offences*. As Table I shows, admissions to the unit after the 1983 Act are characteristically for more serious offences. No patients were admitted on account of arson after 1983: in other respects, the numbers of offences against property in the two groups were in line with the different total numbers of admissions. All admissions for offences against person after the amendment Act were for assault or wounding, whereas under the old Act there were five admissions under compulsory detention for "threatening/insulting behaviour". There were few admissions for sexual offences after the 1983 Act.

TABLE I

Type of offence	*Pre 1983 Act*	*Post 1983 Act*
Offences against property		
Theft, stealing and larceny	9	5
Burglary, robbery, breaking and entering	3	1
Criminal damage and attempted criminal damage	9	3
Arson	6	0
Offences against person		
Minor or trivial offences		
(Threatening/insulting behaviour; possession of offensive weapon)	6	0
More serious offences		
(Assault occasioning actual bodily harm, unlawful wounding; attempted murder	3	3
Sexual Offences		
Indecent assault	4	2
Importuning for immoral purposes	1	0
Incest, rape and attempted rape	2	0
Total number of admissions	27	11
Total number of offences	43	14

Comment

Compulsory admissions to the unit in the five years after the 1983 Act were, in most respects, similar to those for the five years immediately preceding. This is true of key characteristics such as age, IQ, and class of offence. Men greatly outnumbered women. It was striking that, constant over the two time periods, almost all the admissions to this unit for mentally handicapped people were in respect of people with IQ either in the borderline intelligence or mild mental handicap range. Similarly, Mayor *et al* (1990) recently reported that admissions to their sub-regional semi-secure unit have included individuals with a mild degree of mental handicap. This is despite the recommendation of the Royal College of Psychiatrists (1980) that only people with at least a moderate degree of mental handicap should be treated in such specialist mental handicap facilities.

The most dramatic change over the ten years of the study was the fall in number – by over one half – of compulsory admissions to the unit. The trend towards admission only of more serious offenders and the absence of female admissions are also of interest. However it cannot be assumed that this is all due to the legislative changes of the 1983 Act. Two other major factors should be borne in mind. Firstly, by a concurrent change in the Law, Section 77 of the Police and Criminal Evidence Act (1984), when a mentally handicapped person is interviewed by the police another adult should be present. In recent years, there has been a general reduction in the number of mentally handicapped people being charged, mediated in part by a fall in the number of unreliable confessions which used to be obtained when mentally handicapped people did not have this important right (Turk, 1989). Secondly, the ten year period of the study has seen a trend away from hospital admission of mentally handicapped people. It is understandable that any change in forensic practice within mental handicap psychiatry might mirror this trend.

In conclusion, there has been some change in admission practices to this unit since the 1983 Act, but these are best understood in the light of other legal and societal changes. But most worrying is the continued inappropriate use of mental handicap psychiatry facilities by people of mild and borderline intelligence, despite the indications of earlier research (Parker, 1974) and the clear position of the College on this issue. It can only be assumed that this is due in turn to lack of other suitable provision.

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Psychiatric audit

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Medical audit has been defined "as the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient" (Department of Health, 1989).

The term "clinical audit" (Royal College of Psychiatrists, 1989) is preferable in psychiatry as it indicates that audit activities need to involve the work of all staff delivering health care to psychiatric patients.

Audit in psychiatry differs in some respects from audit in other clinical specialties. For example, it cannot be confined to in-patient activities as a considerable amount of psychiatric care is given in the community. Also, good clinical outcomes may be more difficult to define, and indeed psychiatric outcomes may be strongly influenced by family and socioeconomic factors outside the influence of the health service.

Why undertake audit?

Audit is essentially a tool (Royal College of Physicians, 1989) for:

(a) assessing and improving the quality of patient care

(b) enhancing medical education by promoting discussion between colleagues about practice

(c) identifying ways of improving the efficiency of clinical care.

Medical audit has as its cornerstone, peer review of professional standards of care, and it can only be effectively conducted in an atmosphere of mutual trust.

Audit can be regarded as a continuous cycle which involves: observing current practice; defining and setting standards; comparing current practice with these standards; implementing necessary changes to enable these standards to be achieved; and finally observing the new practice. The cycle must be completed if the audit process is to be properly undertaken, so that any beneficial results from the audit process lead to change in everyday clinical practice.

For successful audit an organisational framework is required which includes: the appointment of a chairman and secretary; agreed terms of reference; and the holding of regular audit meetings on dates agreed well in advance with those responsible for presenting their audit findings. As well as the actual audit meeting, time is obviously needed for any necessary data extraction from clinical records, the preparation of audit reports, and for the implementation of any recommendations for change that arise as a result of audit. The time required for the audit process must be regarded as a legitimate use of clinicians' time.