SOME CHARACTERISTICS OF MALE INPATIENTS OF THE FORENSIC WARD IN WOODBRIDGE HOSPITAL

Y W Wong

SYNOPSIS

In this study, 73 male inpatients who had been under remand for at least 6 months were identified. The majority committed their alleged offences at a young age, between 21-30 years (45.2%). The commonest diagnosis was schizophrenia (80.8%) and the commonest offence was that of voluntary causing hurt (39.7%). The most frequent interval between first admission and time of offence was 10 years and most offenders (86.3%) were known to us. There were significant differences between those who commit murder and those who voluntary cause hurt(VCH).

INTRODUCTION

Woodbridge Hospital is a 2600 bedded psychiatric hospital. There are two forensic wards for males with a capacity for 120 inpatients who are in varying phases of observation and treatment.

This study was carried out as part of an effort to look into certain aspects concerning patients who were psychiatrically ill at the time of their alleged criminal offences.

Woodbridge Hospital
Singapore 1954

Y W Wong, MBBS, MRCPsych
Registrar

The patients involved were:

1) those who were found by the courts to be guilty but legally of unsound mind at the time of the offences and
2) those who were not fit to plead. This excludes the group of patients who were not of unsound mind at the time of the alleged offences. Those who were unable to plead were found to be of unsound mind and further remanded till they were fit to plead to the alleged charges.

METHOD

Using a Case Summary form, (which is for the use of the Visitors' Board) certain data were collected. Other relevant data were obtained directly from the case notes.

RESULTS

On 1st November 1984, there was a total of 73 male inpatients who had been staying in the forensic ward for more than six months, under the remand order of the Minister for Law. All had originally been referred by the Courts for psychiatric reports.

(A) Characteristics for all psychiatrically disordered offenders

1) Age at the time of remand

The peak was between 21-30 years (45.2%) followed by those between 31-40 years (32.9%). These two age groups form 78.1% of all offenders. Only 4.1% presented after the age of 50 years.

2) Diagnosis

The commonest diagnosis was that of schizophrenia (80.8%) followed by mental dullness (8.2%), mental dullness with schizophrenia (5.5%), epileptic psychosis (2.7%), alcoholic psychosis (1.4%) and acute confusional state (1.4%).

3) Interval between first admission and time of offence

The most common interval was more than 10 years (28.8%). A significant group of 12 (16.4%) were never admitted. Of these 12, one was known to us as an out-patient and another repatriated to us from a Rumanian psychiatric hospital. Those actually not known to us was 10 (13.7%). A further breakdown is shown in Table I below.

TABLE 1 INTERVAL BETWEEN FIRST ADMISSION AND TIME OF OFFENCE

Interval	Number (%)
Never admitted	12 (16.4)
Within a year	3 (4.1)
2 — 5 years	17 (23.3)
6 — 10 years	20 (27.4)
More than 10 years	21 (28.8)

4) Number of previous admissions

The majority (37.0%) had between 4-9 admissions.

5) Type of offences

The majority (39.7%) were remanded for voluntarily causing hurt (VCH) followed by those for murder (19.1%). A breakdown of the type of offences are shown in Table 2.

TABLE 2 TYPE OF OFFENCES

	No. (%)
Voluntarily causing hurt (VCH)	29 (39.7)
Murder	14 (19.1)
Molest	9 (12.3)
Theft	8 (11.0)
Possession of offensive weapons	3 (4.1)
Vandalism	3 (4.1)
Criminal intimidation	2 (2.7)
Armed robbery	1 (1.4)
Housebreaking	1 (1.4)
Trespass	1 (1.4)
Exhibitionism	1(1.4)
Disorderly behaviour	1 (1.4)

6) Propensity to violence

About (80.6%) of such offences were violent or potentially violent leading to physical bodily harm. On the other hand, 19.4% of those remanded were for offences of a non-violent nature. However, this included molesters (12.3%).

7) Fitness to stand trial

The majority (75.4%) had been tried for their alleged offences leaving 25.6% who were not well enough to stand trial despite treatment for at least six months. The latter group were all found to be of unsound mind but not tried because they were mentally not fit to stand trial.

8) Previous remand

About 10% had a past record of a remand which included offences like murder, VCH, vandalism and housebreaking.

9) Family support

The majority (61.5%) were visited. However, those rejected form a high percentage of 38.5%.

(B) Characteristics of those who commit more serious violent offences: murder and voluntarily causing hurt (VCH)

1) Age at the time of remand

The peak age was not different when compared to all offenders.

2) Interval between first admission and time of offence

The majority (57.1%) of those who commit murder were never admitted. As one was known as an outpatient, the figure for brand new murder cases was 50%. Of those admitted 21.6% were more than 10 years ago. The corresponding figures for those not admitted for all offenders and VCH were 16.4% and 3.4%.

3) Identity of victim/victims

The majority of victims were known to the patients, especially in murders (85.7%). For VCH 58.6% of victims were known to our patients.

4) Weapons used

A weapon was commonly used in most cases. In Murder cases, 21.4% of victims were bodily thrown to their deaths. A breakdown of the weapons used is shown in Table 3.

5) Number of previous admissions

The majority of those who commit murder (57.1%) were never admitted before whereas 55.2% of those who commit VCH had four or more admissions. A breakdown is shown in Table 4.

TABLE 3 WEAPONS USED BY SERIOUS OFFENDERS

	Murder	VCH
Sharp object	4 (28.6)	21 (72.4)
Blunt object	4 (42.8)	5 (17.2)
Bare hands	1 (7.2)	1 (3.5)
Bodily thrown	3 (21.4)	2 (6.9)

TABLE 4 NUMBER OF PREVIOUS ADMISSIONS AND TYPE OF SERIOUS OFFENCE

Number of admissions	Murder	V C H
None	8 (57.1)	1 (3.4)
1 — 3	6 (42.9)	12 (41.4)
4 — 9	0	10 (34.5)
10 and more	0	6 (20.7)

6) Duration of remand

The duration here is at the time of the study and therefore an ongoing process. They are not actual completed remand periods but it does give an idea as to how long some patients have been confined so far. For those who commit murder, 71.4% had been remanded for more than 10 years. In practice, most are confined indefinitely.

C) Schizophrenic patients who commit offences

There were 63 of such patients.

1) Age at time of offence

The peak age was between 21-30 (44.4%) followed by 31-40 (34.9%). Few (1.6%) present after 50 years.

2) Number of previous admissions

Those who had more than 4 admissions made up 55.5%. Another 14.3% were never admitted. As one was known as an outpatient, the actual figure for brand new cases was 12.7%.

3) Interval between first admission and time of offence

About 14.3% were never admitted. However, 2 were known to the hospital. The actual figure not known to us was 7 (11.1%). The majority (31.7%) had a first admission 10 years ago while 23.9% had a first admission 5 years ago.

4) Type of offences

Table 6 shows a breakdown of the type of offences committed by schizophrenics.

5) History of known previous violence

The majority (71.4%) had history of previous violence.

TABLE 6 TYPE OF OFFENCES THAT SCHIZOPHRENICS ARE REMANDED FOR

Type of Offence	Number (%)
Voluntarily causing hurt	27 (42.8)
Murder	13 (20.6)
Theft	6 (9.5)
Molest	5 (7.9)
Vandalism	3 (4.8)
Possession of offence weapon	3 (4.8)
Criminal intimidation	2 (3.2)
Armed robbery	1 (1.6)
Housebreaking	1 (1.6)
Trespass	1 (1.6)
Exhibitionious	1 (1.6)

6) Fitness to stand trial

The majority (76.1%) had been tried.

7) Duration of remand

The majority had so far been remanded for less than 5 years. On the other hand, 20.5% had been remanded for more than 10 years. A detailed breakdown is shown in Table 7.

TABLE 7 SCHIZOPHRENIC OFFENDERS AND DURATION OF REMAND

Duration in years	Number (%)
Less than 5	34 (54.0)
More than 5	16 (25.5)
More than 10	3 (4.7)
More than 15	10 (15.8)

8) Family support

The majority (71.4%) receive visits from their families.

COMMENTS AND DISCUSSION

Of the 73 male forensic inpatients in Woodbridge Hospital, most were remanded at a young age, viz between 21-40 years. They seldom present after 50 years of age.

Four out of five carry a diagnosis of schizophrenia and this did not differ greatly from the figure in the usual acute non-forensic male ward. This figure is also in agreement with an American study by Socowsky (2) in 1978. One is surprised by the absence of the

hypomanic offender. However, we are aware that the hypomanic tend to commit less serious offences like vandalism, disorderly behaviour or obscenity and therefore may not be charged for them.

Mentally ill offenders not known to us was a significant 13.7%. If we look at murders not known to the psychiatric services, the figure was even higher at 50%. This was in contrast to 3.4% of the VCH offenders who were not known to us. The figure for murder might be consistent with the popular view that serious violence is a feature of the prodromal phase of some schizophrenics. This less overtly psychotic phase may be missed by relatives or friends and therefore not brough to psychiatric attention until after an offence has been committed.

If the offence of molest is included as a potentially violent and fear-inducing behaviour, 9 out of 10 of those remanded were considered violent and therefore arguably rightly detained in hospital. About 1 in 5 commit murder and 1 in 3 commit VCH.

On the question of fitness to plead, 1 in 4 were unable to, despite 6 months of continuous treatment. Experience reveal that a proportion of our patients will never be legally fit to plead. For such cases, a trial of the facts should be considered especially if the alleged offence is of a non-violent nature. If there is no evidence against the patient, the patient should be appropriately treated in a normal non-forensic ward.

About 1 in 10 had a previous record of remand and this merely means that patients do reoffend. This is quite different from the liability to reoffend which will only be apparent if we follow up previously remanded, discharged, patients who fall foul of the law again. Those who commit theft were those most frequently with a past remand record. This is in agreement with non-psychiatric offenders who commit theft. The act of theft itself was the behaviour at issue rather than the illness which caused the behaviour.

Whatever their offences, the relatives (61.5%) were supportive in as much as they regularly visited the patient. However, the clinical impression was that relatives were more reluctant to sign a bond to supervise these patients outside hospital, even though the latter have been mentally stable for a sufficiently adequate period of time in the forensic ward.

Certain interesting features were apparent when one looked at the more seriously violent offences, viz murder and VCH. Almost all murder victims (85.7%) were known to the patient whereas the corresponding figure for VCH was only 58.6%. It would appear that relatives or friends were more liable to be murdered and strangers more likely to be injured. This is only true as far as being a relative meant the presence of a relationship. Virkkunen (3) has shown that generally only those relatives who have had a long standing hostile relationship with the patient were prone to be attacked.

A weapon was commonly used; 71.4% in murders and 89.6% in VCH. Murderers preferred blunt weapons (42.8%) while VCH offenders preferred sharp weapons (72.4%). Only 28.6% of murders were through a sharp weapon. Murder offenders were remanded indefinitely unless in very exceptional circumstances.

The schizophrenic offender is young at remand (79.3% were between 20-40 years) and rarely present after 50 years (1.6%). Almost 87.3% were known to the hospital and the commonest offence was VCH followed by murder. In fact, 12 out of the 14 murders were by schizophrenics. About 3 out of 4 had a past history of known violent behaviour. Again 3 out of 4 were fit to plead to the charges.

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