A STUDY OF POLICE REFERRALS TO WOODBRIDGE HOSPITAL

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ABSTRACT

This is a retrospective study of 127 cases brought by the police under Section 32 of the Mental Health Act (1973). The aims of the study were to collect epidemiological data and to review the mental health provisions. Majority of the patients were Chinese, male, 20-39 age-group, single, unemployed, schizophrenic with previous admissions to Woodbridge Hospital. Aggressive behaviour and public nuisance were the commonest reasons for police interventions. Ninety percent of the patients required admissions to hospital. There was no apparent misuse of the Mental Health Act.

Keywords: Police referrals, Mental Health Provisions, Woodbridge Hospital.

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INTRODUCTION

The 1970 Mental Disorders and Treatment Act made provisions to enable police officers to send anyone suspected of having mental illness to hospital. Section 32, Cap. 162 (1970) states that "it shall be the duty of every police officer to apprehend all persons found wandering at large who are reported to be of unsound mind and all persons believed to be dangerous to themselves or other persons by means of unsoundness of mind and to take such persons without delay to a medical officer who may thereafter act in accordance with Section (1) of Section 34 of this Act". Section 34(1) states that "where a registered medical practitioner has under his care a person believed by him to be of unsound mind or to have attempted to commit suicide, he may send such person to a mental hospital for observation".

In 1973, an amendment was made to allow the police officers to either bring the person to any medical officer or to any medical officer at a mental hospital. Section 35(1) Cap. 178 states that a medical officer at a mental hospital who has examined any person who is suffering from a mental disorder and is of the opinion that he should be treated as an inpatient at the mental hospital may sign an order in accordance with Form 1 in the Schedule for the admission of the person into the mental hospital for treatment and that person may be detained for a period of 72 hours commencing from the time the medical officer signed the order. A similar order under Section 136 of the Mental Health Act 1959 and 1983 exist in the United Kingdom. There have been a number of studies done in the United Kingdom on this aspect of mental health care provisions. To date, there has been no such study done in Singapore.

This study was thus undertaken with the aims of delineating the characteristics of patients brought by the police under Section 32 to Woodbridge Hospital and also to review the mental health provisions for this particular group of patients.

METHODOLOGY

This was a retrospective study carried out in the month of April 1987. Other than the single holiday on the 1st, there were no other public holidays in the month. We felt that festive seasons such as Chinese New Year may skew our results as most Chinese families harbour superstitious beliefs about such periods.

There were a total of 127 cases brought by the police to Woodbridge Hospital. We excluded all cases remanded from the court as their admissions were compulsory and fixed in nature. Demographic characteristics were scrutinised and special attention was given to the circumstances leading to their referral. Disposal of these cases were also examined in detail.

RESULTS

There were a total of 477 admissions in April 1987 with a male:female ratio of 1.7:1. Of these, 127 (26.6%) were brought by the police. There were 90 males and 37 females, giving a sex ratio of M:F=2.4:1.

Majority were between the 20-39 age group, Chinese, single and unemployed. 59% of the patients (Table I) were in the 20-39 age group and this was true for the 3 different races. Few came from the extremes of ages. The ethnic group distribution of the patients shows that it corresponds somewhat to the ethnic compositions for

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Singapore with only slight over-representation among the Indians.

About half (46.4%) of the patients received only primary education, 25.1% had secondary education and 11.0% had no records of their educational level. Consistent with these findings, 86.6% were either unemployed or manual workers. Only 2 patients were professionals. More than half (53.6%) were single and about a quarter were married.

In 44.1% (N=56) the public was the complainant. Table II also shows that family members and the police were almost equally responsible for the remainder ie. 29.9% and 20.5% respectively. The remaining 5.5% were referred directly from outpatient clinics or other hospitals.

In the cases where the public had been the complainant, the reason for police intervention was predominantly for nuisance behaviour. Family members would invariably complain of aggressive behaviour and only 4 cases were referred for suicidal behaviour. In cases where the police had acted on their own accord, vagrancy and wandering behaviour were the reasons for their (police) intervention. Approximately one-third of the patients were brought to hospital for aggressive and violent behaviour. About one-quarter were considered public nuisance and a further quarter for vagrancy. Only 8.7% were either suicidal or homicidal.

52 cases (40.9%) were brought to hospital during office hours ie. between 8 am to 4.30 pm. 40 cases were brought in between 4.30 pm and 12 midnight. Approximately one-quarter (26%) were brought in between 0001 hours and 0759 hours. Table III indicates the time delay taken from the time of arrest to the time patient was brought to hospital. About half the cases were brought in within 6 hours and a further quarter were brought in between 6-24 hours. Only one case came in 24 hours after the time of arrest.

Table IV illustrates the outcome of the cases. Out of the 127 cases, 115 (90.5%) were admitted. Of the 12 cases that were rejected, 7 were mentally defective, 4 schizophrenic, 1 vagrant and 1 with no evidence of any mental illness. One of the mentally defective was referred to the Ministry of Community Development. The rest were returned to the care of the police and given follow-up on an outpatient basis.

Generally, looking at the case notes diagnosis (Table V) schizophrenia (62.2%) forms the main bulk of the 127 cases, compared with 14 cases (11%) of mental defective, 7 affective (5.5%) and 5 stress reactions and

Table I

Age Group	No	%
<20	8	6.3
20-29	36	28.4
30-39	39	30.7
40-49	21	16.5
50-59	11	8.7
≥60	5	3.9
Unknown	7	5.5
Total	127	100

Table II

	Reasons For Intervention					
Complainants	Aggressive Violent	Suicidal & Homicidal	Nuisance	Vagrancy	Others	Total
Family	31	4	1	0	2	38
Public	6	6	27	9	8	56
Police	0	0	5	16	5	26
Others	3	1	1	2	0	7
Total	40	11	34	27	15	127

Table III

Time Delay (hrs)	No	%
1-6	71	55.9
6-24	36	28.3
>24	1	0.8
Unknown	19	15.0
Total	127	100

Table IV

Outcome	No	%
Admitted	115	90.5
Rejected – No F/U	2	1.6
Rejected – ORD	9	7.1
Referred – MCD	1	0.8
Total	127	100

Table V

Case Notes Diagnosis	No	%
Schizophrenia	79	62.2
Affective Disorder	7	5.5
Neurosis	0	0.0
Paranoid Disorder	1	0.8
Stress Reaction	5	3.9
Organic Syndrome	1	0.8
Personality Disorder	3	2.4
Mental Defective	14	11.0
Others	17	13.4
Total	127	100

3 personality disorder. Among the 17 cases diagnosed as 'others' – 4 had no mental illness, 4 were diagnosed as alcoholic intoxication, 3 as acute psychosis, one delirium tremens, one hysterical trance state, one drug induced paranoid state, one post ictal confusional state and 2 epileptic psychosis.

About one-third (29.9%) of the cases were first admission and a further one-third (32.3%) had between 1-5 admissions. 22.8% had 6-10 previous admissions and 15% had over 10 previous admissions.

Looking at the duration of stay in hospital, 13 cases (10.2%) stayed less than 72 hours, the period allowed under Section 35(1) Cap. 178, for observation. Another 13 were discharged within a week. About half (47.2%) stayed between 1-4 weeks and about one-quarter (20.5%) stayed between 1-6 months. Only 2 cases stayed more than 6 months – both were schizophrenics. One was rejected by the family, the other was a chronic schizophrenic.

DISCUSSION

As mentioned earlier, majority of the studies done in the United Kingdom were based on Section 136 of the Mental Health Act. It is pertinent to point out that Section 136 authorised a police officer who finds a person appearing to suffer from mental disorder (in a place to which the public has access) to remove him to a place of safety where he may be detained for up to 72 hours for further assessment. In contrast, Section 32 is not an admission order. Both however serve a similar function ie. empowering the police to bring these patients to a place of safety.

The predominance of males as compared to the rest of the admissions is not a surprise as this is comparable to all the studies done through the years (1-3).

More than three-quarter (81.6%) of the cases comes from Social Class IV. This is also comparable to Sims & Symonds (2) and Kelleher & Copeland's findings (4). Perhaps it reflects the nature of the illness which afflicts the patients – majority are schizophrenics with a drift down the social scale. The other reason is that patients who are disturbed from Social Class I and II are more likely to be admitted to private hospitals and nursing homes at an early stage of their illness.

Contrary to expectations, only 11 cases (8.7%) were brought in for suicidal and homicidal intent. Similar findings were also noted by Kelleher and Copeland on their study "Compulsory Psychiatric Admission in a London Borough – Circumstances Surrounding Admission". One of their most "striking findings was the incidence of public disturbances among the compulsory patients . . . violence to person and properties both in public and private was more common than suicidal attempts and threats". As mentioned earlier, about one-third of the cases were brought in for aggressive behaviour and one-quarter were brought in for 'nuisance' behaviour. The latter included patients who stripped and shouted in public and those who attempted to stop the flow of traffic.

More than half (57.5%) the cases were brought in 'out of office hours' (4.30 pm to 8.00 am). This in fact is lower than that of the findings in Fahy, Birmingham and Dunn's study (3) on Police Admissions to Psychiatric Hospitals. In their study, 77% of the urban Section 136 admissions arrived in hospital out of office hours. Perhaps one of the reasons is that the police in Singapore have been issued circulars to try to bring them during office hours.

The predominance of schizophrenics (60.6%) among the case notes diagnosis is comparable to the findings in the other studies – Eilenberg (54.1%) Kelleher & Copeland (42.7%). The latter even suggested that Psychiatric Services have failed to keep in contact with a clearly identifiable and vulnerable group. Somehow these younger males with liabilities to aggressive acts, unmarried and with slight preponderance of Schizophrenia . . . when under stress, their mental state deteriorate and their condition is allowed to progress until they become a nuisance to society. In fact Kelleher discussed the problems of aftercare in these cases where the possibility of relapses should be anticipated and community contact and support be vigilantly maintained. Our results indicated that three-quarter of the cases had previous admissions and over one-third (37.8%) had more than 6 previous admissions. Hence it is clear that this group of patients are already well known to our psychiatric services.

The recent study by Fahy (3) in 1987 found that schizophrenics only accounted for one-third of admissions with a larger proportion of alcohol and drug abuse cases. In our study only 5 cases were diagnosed as alcohol intoxication and only one case with drug induced psychosis. The under-representation of these cases is probably not a reflection of the prevalence of these problems, but perhaps such cases are catered for by other provisions and agencies ie. the general hospitals and drug rehabilitation centres.

Concern about the possible inappropriate and over-use of Section 136 had been expressed by several authors. Paterson and Dabbs (1963) recommended that justification for application of the Section 136 should be equated with its subsequent conversion to a lengthier Section following detailed assessment. Fahy (1987) however felt that this criterion is over strict and he was of the opinion that a better estimate of the efficacy of Section 136 would be by looking at the time of discharge and offers of follow-up made on discharge. We felt that similar principles could be used to assess whether the police had abused Section 32.

As noted in our results, over 90% of the cases were

admitted by the duty medical officer. Of these, 13 were discharged within 72 hours. In fact about 50% of the patients stayed between 1 to 4 weeks and a further 25% stayed between 4 to 24 weeks. These results would appear to support the fact that there is no abuse of Section 32 by the police.

CONCLUSION AND SUMMARY

Our findings indicate that there is no abuse of Section 32 by the police. However, it delineates a vulnerable group of young, single, unemployed males with a preponderance of schizophrenics, who are liable to aggressive acts, nuisance behaviour and numerous repeated admissions to Woodbridge Hospital. It would be important to identify the needs of this special group and the subsequent appropriate allocation of limited resources. Perhaps it is timely that over the past 1-2 years, we have started the Continuous Case Register (CCR) for potentially aggressive patients. The recently launched Pilot Community Psychiatric Nursing Programme is geared to closely monitor problematic cases who are prone to default follow-up and not comply with medication. Such cases are liable to relapse and result in subsequent acts of aggression. We have also recently launched numerous educational programmes for relatives as well as patients. These programmes are geared towards the recognition of early relapse, the importance of medication and various avenues to get help and advice even before the patients become violent. Perhaps a repeat of this study should be carried out in 5 years time to see if the establishment of these services have any positive contribution to this vulnerable group of patients.

Reducing the incidence of aggressive behaviour may help to reduce the stigma of our psychiatric patients and decrease rejection by family and society.

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