The historical background: the past 25 years since the Mental Health Act of 1959

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The late 1950s was a time of rapid progress in the treatment of psychiatric disorder, liberal legislation in mental health and expansion of research into the causes of mental illness along a broad front. Drugs that were effective in treating depressive illness had been recently discovered and their applications in clinical practice spread with an unprecedented rapidity. The Percy Commission was coming to the end of its deliberations, and the English Mental Health Act of 1959 which followed has been widely described as this century’s most humane piece of legislation in relation to the mentally ill to be placed on the statute books anywhere. The prospects for better mutual understanding between the law and psychiatry were full of high promise.

The changes that followed the creation of more stimulating and active regimes in psychiatric wards and the successes of new treatments for depression, schizophrenia and other disorders generated a fresh upsurge of scientific investigation into the biological and social origins of mental illness. The steep decline in the number of beds in English mental hospitals which began in 1954 intensified the atmosphere of optimism. There had been 344 beds per 100,000 population at the end of 1954. This was halved to 171 per 100,000 by 1978. The total number of mental hospital beds in England was reduced from 160,000 to 80,000 in the same period. The reduction was due in part to the discharge of patients who had been resident in mental hospitals for many years, but to a greater extent to a decrease in the average length of stay of patients. This was the beginning of the era of the revolving door. But the Department of Health in this country was already looking with confidence to the closure of the large mental hospitals and the creation of small psychiatric units in district general hospitals where the treatment of patients with acute mental illness was mainly to be undertaken in future. The tasks of the mental health
services were to be discharged in the community, where those with chronic illnesses were to be protected from the dangers of institutionalization. A number of these developments had been inspired by the philosophy underlying the Mental Health Act of 1959. Most patients with psychiatric disorder were in future to be admitted without compulsion or formality.

The patients were to enjoy the same privileges and consideration as did those with physical illness, able to enter or leave hospital by their own free choice and to accept or refuse treatment offered to them. In that limited group of patients whose illness rendered them incapable of judging the risks they faced or the treatments they needed, treatment could be arranged on a compulsory basis, but without the intervention of magistrates or courts of law. Authority for the admission of such patients, who made up 10.1% of the total in 1979 (DHSS Consultative Document), was vested entirely in medical hands and it remains in medical hands in the Mental Health Act of 1983 which is described in detail by Professor Bluglass.

Antipsychiatrists and their allies

The clear vision of the future of mental health services and the high optimism and confidence that characterize the Percy Report were even then being eroded by attacks from several directions. All procedures for the care, admission and treatment of patients with mental disorders were soon to be assailed as infringements of basic human rights.

The different lines of attack were inter-related. The antipsychiatry of Szasz, Laing, Esterson and Foucault alleges that mental illnesses are not illnesses but socially deviant behaviours. In Foucault’s version, the function of psychiatry is to exercise control over deviants whose ‘radical voices’ threaten the existing social order. Psychiatry is an instrument of coercion employed by the ruling classes against those who dissent from or revolt against society’s established rules and conventions. As an ideology, it obscures and mystifies the nature of power struggles within society which are resolved by one-sided, arbitrary and repressive means. A similar critique has been advanced along other fronts. In the 1980 Reith Lectures the lawyer Ian Kennedy (1981) declared that the expertise of psychiatrists consists of ‘the exercise of moral, social and political judgments concerning the worth of someone’s thinking’. What passes as mental illness is for the most part no more than politically subversive ideas, protests against racial injustice or deviant sexual behaviour. It is the metaphor of illness that enables the thought-policemen to deprive the individual of liberty without due process of law or adequate right of
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appeal. In the Utopian writings of Ivan Illich the attack is extended to the entire practice of medicine. The quest for health and health services is described as a monolithic world religion, the subversion of which would advance the cause of human well-being.

Fringe medicine and the claims of homeopaths, chiropractors, osteopaths and practitioners of mystical cults who offer to relieve pain and disease and promote positive health are currently much debated in the news media and the glossy magazines. ‘Alternative’ medicine is fashionable and is patronized by the highest in this and other lands, and has recently been given the solemn imprimatur of a first leader in *The Times* and the blessing of a member of the Royal Family.

A succession of scandals in England and elsewhere which have originated from neglect, inhumane treatment or abuse of psychiatric patients in mental hospitals have been used to buttress the case of the antipsychiatric and human rights lobbies. Psychiatrists are described in this literature as favouring compulsion; but the historical record shows that they have often been in the vanguard of liberal reform in mental health legislation for almost two centuries.

Mental health issues in the political arena

It is not clear why the subject of mental health should in recent times have become politicized in theory and practice through neo-Marxist analysis and the advocacy of the civil rights lobby. The view that the emergence of psychiatry as a medical discipline was closely related to the evolution of capitalist society proves to bear little relationship to fact. Recent research has shown that since the beginnings of recorded history societies have recognised certain disordered states of mind as mental illness and given the profession of medicine responsibility for treating them.

Mental illness, was for example, a well-recognized condition in the Near East in 1000 BC. In the Old Testament David, fearing for his life when captured by the Philistines wearing the sword of Goliath, feigns lunacy, banging on doors and letting spittle run down his beard. His strategy was wholly successful, for the King of the Philistines diagnosed insanity and refrained from causing harm to a madman even though an enemy. During the Middle Ages, contrary to the standard histories of the period, lay and clerical physicians continued by practice and teaching to uphold an ancient humane tradition of medical care of the mentally ill. This flourished alongside the cruel persecutions of the insane that stemmed from beliefs in demonology and witchcraft about which so much has been written. Medical scholarship and healing were kept alive within
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the monasteries throughout the Dark Ages, extending outwards from the cathedral schools after the eleventh and twelfth centuries (Kroll, 1973). The medical take-over of the asylum and the invention of mental illness at the end of the seventeenth century in the interest of bourgeoing capitalism – the teaching of Foucault and Scull – can hardly be reconciled with such findings.

The oscillation between hospital and community care

The last 140 years have seen alternation between care of the mentally ill in hospital and care in the community. In the last century psychiatric patients in the care of the inhumane local authorities were transferred with great ceremony to the new mental hospitals which were to cure them with the aid of moral treatment. Charles Dickens, visiting the United States at the start of this era, was very impressed with a small mental hospital where the superintendent and staff sat down with the patients for meals. The patients ate with knives and forks, enjoyed carriage drives and engaged in productive work in an attempt to rebuild their self-respect. Now, on an equally triumphant note, patients are being transferred in large number from the hospitals which allegedly caused their condition to deteriorate, back into the community. But the community rarely cares, and the facilities provided have proved sadly inadequate. The presence of the whole necessary range of supervised hostels, sheltered housing, adequate medical care, occupation, retraining and rehabilitation within a community service is a very rare exception. In some countries the predicament of families has become desperate. Some of the multitude of patients set adrift in the large cities of the world come into conflict with the law, and when hospitals refuse to admit them they are sent to prison. This is one road leading to the criminalization of the mentally ill.

In the writings of antipsychiatrists these trends are depicted as the evils of ‘incarceration’ and the even greater iniquities of ‘decarceration’, that is, the release of patients in large number into unprepared communities. But as Professor Kathleen Jones (1982), has cogently said, ‘If it is wrong to get patients out of mental hospital, and wrong to keep them in, what are we to do with them?’ The fact is that such obdurate and painful dilemmas are not to be resolved or spirited away with the aid of any known social, medical, political or administrative remedies.

The right to receive and the right to refuse treatment

We are caught in uncertainty between the poles of another antithesis when we turn to rights relative to treatment. The right of patients confined in mental hospitals to receive treatment has been
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The right to treatment can run into head-on collision with the right to refuse treatment, also established in law: if the patient has a legal entitlement to adequate care, has he also the right to receive treatment under compulsion when suffering from depression with grave suicidal risk? The implementation of this right is demanded in some cases by spouses, children and relatives, and by patients between attacks of periodic illness. Manic-depressive patients, whose insight often returns in the course of a remission, may give instructions to their psychiatrists that when they refuse treatment during illness, appropriate action should be taken to protect their lives. There are clear and well-established indices of suicidal danger in patients and when they have not been heeded the responsible psychiatrist is liable to be sued for negligence by relatives seeking redress and compensation.

The problem with principles and doctrines such as the right to refuse treatment is that they advance simplistic solutions to problems of a complex and obdurate nature. To take up just one thread in a whole web of causes and consequences, there are the human rights of dependent wives, children and parents to be considered as well as those of the patient.

But in spite of all these reservations recent developments in attitudes to psychiatric treatment are a forward step. In an increasing number of countries it is being clearly spelt out that treatment should normally proceed only on the basis of the full consent of those competent to give it. In some legislation it is also explicit that, except in emergency, the refusal of those manifestly incompetent to give consent must not be overridden unless an independent assessment confirms that treatment is essential to preserve life or conserve health.

**Mental illness and morality**

Criticisms have often been voiced in the past 25 years regarding the extent to which the concept of illness has increasingly encroached upon and usurped the territory that was once the exclusive province of morality. Not only conditions cruelly subsumed in the past under the heading of ‘madness’ but all forms of psychiatric disorder were assimilated into ‘illness’. And it was implied that only those free from psychiatric taint were regarded by psychiatrists as fully answerable and responsible for their antisocial deeds. Under the Durham laws in the United States some 30 years ago, psychiatric illness was given a very wide definition and
advocacy within the adversarial system contributed to widen it even further. It was pleaded in some cases that conditions that go under the name of personality disorder could in themselves give rise to the same global disturbance with distorted perception of the world, derangement of motivation and impaired control over conduct as do psychoses such as schizophrenia. The repute and standing of psychiatry and psychiatric testimony in court inevitably suffered. In Europe a much stricter definition of psychiatric illness survived, as Professor Lunn discusses in his paper. In Denmark’s Medico-Legal Council only those offenders diagnosed as psychotic are likely to be judged not punishable and sent to a mental hospital. Different judgments are pronounced in cases of personality disorder and psychopathy.

The inverse care law in psychiatric services

The ‘inverse care law’ refers to the situation in which the needs of substantial groups of patients with severe forms of psychiatric disorder prove to be inversely proportionate to the location of the facilities required for their treatment or long-term care. It comes into operation by a number of different routes. In the United Kingdom psychiatric hospitals are given the right to refuse admission to patients who are regarded as being unsuited to the facilities available. In consequence a relatively large number of highly disturbed, aggressive and difficult patients have been denied admission to ordinary psychiatric hospitals. Some have had to be accepted in Broadmoor or other maximum security hospitals, which are often inappropriate and which have become appallingly overcrowded. Others end in prison. The Butler Committee recommended that the majority of such cases be accommodated within special secure units to be created within each region. Very few have been established, and a proportion of the patients who should be in such units are adrift in the large cities, asleep under bridges, in doorways or in the corners of railway stations.

In other countries the situation develops by a different route. In the United States dangerousness appears to have become the criterion employed by the courts in deciding whether compulsory admission of mentally disturbed patients is justified. This criterion survives despite the repeated insistence of many legal authorities that the prediction of dangerousness is a highly unreliable exercise. Be this as it may only a small proportion of psychotic patients are dangerous and therefore qualify for admission to hospital. The majority are consequently denied the treatment they often need as a matter of urgency. Those admitted contain a relatively high proportion of patients with serious personality disorder.
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passing through a phase of explosive conduct complicated by alcohol abuse, drug dependence or both. There are no effective treatments available for such patients and hospital can provide only a ‘cooling-off’ period while their condition reaches a more quiescent stage. The net result is that those cases where management in an ordinary psychiatric hospital is of little avail or can have only a transient effect cause such hospitals to strain at the seams, while many of those in need of a specific treatment that would be likely to help them to remission do not receive care.

Concluding remarks

The number of psychiatric beds has fallen steeply during the past 25 years. Almost half a century ago Lionel Penrose (1939) demonstrated an inverse correlation in the countries of Europe between prison places and psychiatric beds: the smaller the number of psychiatric beds (the only psychiatric facilities available at that time) the larger the number of prison places. A high ratio of the number of patients in mental hospitals as against the number of those confined in prisons has in the past been regarded as one index of progress towards more humane, enlightened and non-primitive attitudes within societies. As far as the mentally ill are concerned the clock has, by this criterion, been put back. For care in the community which was intended to fill the gap created by closure or contraction of the mental hospitals has been found wanting almost everywhere.

A little over 130 years ago, on 25 November 1853, Sir John Bucknill, writing in the first issue of the Asylum Journal (later to become the Journal of Mental Science), paid tribute to Pinel who had ‘vindicated the rights of science against the usurpations of superstition and brutality and rescued the victims of mental disease from the exorcist and the gaoler’. He went on to state that the physician had become the responsible guardian of those with mental disorder and that he must remain so, adding with unshakable confidence and Victorian thunder ‘unless by some calamitous reverse the progress of the world and civilisation should be arrested and turn back in the direction of practical barbarism’.

Now, 130 years later, exorcism is still with us, the mentally ill are to be found in large numbers in prisons of every kind, the ‘medical model’ of mental illness and all models bearing any kinship to it are under attack from many quarters. ‘Alternative’ forms of medicine thrive and a whole range of new religions have attracted converts and earthly riches through their promises of tranquillity and identity to large numbers of young people who have felt bereft of them. One objective of the conference was
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to promote better understanding and to rebuild bridges between disciplines that should be working in cooperation at the interface between the medical, social and legal aspects of mental disorders.

A further purpose was to extract some of the lessons learned during a period of 25 years that has seen more rapid and radical changes than any other quarter-century since the start of the debate between medicine, society and the law about the problems posed by mental disorder. New laws are already being administered in a number of countries and it is to be hoped that they will be able to draw upon the conclusions reached by the many groups of medical and legal scholars, criminologists, philosophers and social scientists who have come together as they did in Cambridge in 1983 to pool their knowledge and observations and to distil the experience of what proves to have been a revolutionary era in the history of the mental health movement. They have worked in the hope that the insights gained may be applied with benefit when the winds of change commence to blow afresh in relation to the organisation of services for the mentally ill, the legal provisions made by societies for their care and for protection of their human rights, and the proper roles of medicine and the law within those areas of psychiatry in which problems of common concern for both disciplines are frequently posed.

REFERENCES

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The social and medical consequences of recent legal reforms of mental health law in the USA: the criminalization of mental disorder

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During the decade of the eighties, two images of mental illness have come to dominate the public imagination and the mass media in the United States. One image is of the violent, paranoid killer. This is the image featured on the evening news. John Hinckley’s attack on President Reagan is perhaps the most famous example. It has been shown all over the world and has been replayed scores of times in the United States. Hinckley was under the care of a psychiatrist at the time. This and other similar cases have focussed media attention on the alleged negligence of psychiatrists in allowing these insane killers to go free. John Lennon’s killer left a mental hospital in Hawaii, travelled to New York, and gunned down his victim. An acutely psychotic man released from a Massachusetts state hospital travelled to Florida and decapitated an innocent young boy. A man sent home on a visit from a New York state hospital, killed the wife he had been threatening to kill. This image of violent insanity unleashed by incompetent psychiatrists blends into that other familiar image of violent crime: mugging, rape, murder – crime in the streets.

Whatever the explanation for these kinds of violence, whether it is madness or badness, it is clear that the American public now wants more protection. Many Americans feel betrayed by the criminal justice system and in addition there is a growing public feeling that incompetent psychiatrists and radical civil libertarians have together deprived the public of a measure of much-needed protection and unleashed maniacs on society. Is the American public correct? Are they now more at risk? If so, is it because of incompetent psychiatrists and because of civil libertarians who care more about the rights of maniacs than the lives of victims? I shall come back to these questions, but here I want to anticipate. Incompetent psychiatrists are a problem, and some of the lurid examples above are instances of incompetence, but all psychiatrists are incompetent when
they are assigned tasks beyond their abilities. And, of course, new procedural safeguards for the mentally ill increase the risks that the dangerous mentally ill will go free. The significance of procedural safeguards is to increase the burden of the state in making its case for confinement.

The other eighties image of mental illness in the United States is typified by the ‘bag lady’. The public sees her wandering the streets of all our major cities – distracted, dishevelled, homeless, and acting peculiarly. Decades ago one could safely assume that the majority of derelicts were alcoholics. Now one can assume that 50 to 75% of the homeless are chronic psychiatric patients – the deinstitutionalized.\(^1\) Although some citizens are frightened by the sight of this new class of derelicts, there is also a feeling of shame and outrage when one sees an elderly lady sleeping in the doorway of an office building or rummaging through trash cans. Where is the Government’s vaunted safety net of welfare services? Who is getting her social security checks? Where are her food stamps? Why isn’t someone taking care of her? Where is her social worker, her psychiatrist, her lawyer?

The first image of madness, the violently insane, points up the failure of public protection, and the second image of madness, the ‘bag lady’, suggests the failure of public responsibility. Public protection – the police power – and public responsibility – *parens patriae* – are of course the underlying legal justifications for civil commitment, and these two images of the eighties seem therefore to demonstrate the failure of both of those objectives. In fact, these images of madness in the eighties are a reflection of American legal reforms in the seventies. They are a second generation of problems created by attempts to solve a first generation of problems.

But these public images of madness do not tell the whole story of the failures of legal reform in the United States. There is a tragic set of private images known to those who have a child, a spouse, or a parent who is mentally ill. Consider the following case example which is a fair composite of several cases I have dealt with in the past decade.

Mr X is a 23-year-old law student. He has worked hard to get into law school and his family have worked hard to support his education. During the second semester of his first year, his classmates notice that Mr X has begun to act strangely. He arrives early in class, takes the seat closest to the professor and fixes him with an angry and intimidating glare. Over the course of the next few days the student’s behavior becomes more objectionable. He interrupts his classes with incoherent tirades. He refuses to leave classes when asked to by his professor. He looks increasingly dishevelled and students avoid sitting next to him because he