Psychiatry, human rights and the law
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Editors’ preface

The past twenty-five years have seen rapid change in the manner in which the needs of those suffering from mental illness have been met, in the laws relating to their admission to psychiatric hospitals, and in the treatments administered.

The mid 1950s had been a period of high optimism generated by the introduction of effective new drugs for the treatment of the most serious forms of mental disorder, both in their acute phases and as part of prophylactic management aimed at reducing the chances of relapse. An atmosphere of positive endeavour and high aspiration permeated a large number of mental hospitals and led to the introduction of active programmes of social rehabilitation and resettlement for patients who had, in the past, been all too liable to become residents of such hospitals for years or for life. There was a burgeoning of scientific investigation into the causes and treatment of mental disorder. A group of British mental hospitals had played a pioneering role in these developments and the programmes of management, organization and rehabilitation they employed were emulated in many parts of the world. This movement found expression in the Mental Health Act of 1959 which implemented the main recommendations of the Percy Commission. For ten to fifteen years the Act was regarded as the most humane and imaginative piece of legislation enacted this century in relation to the mentally ill anywhere in the world.

But in the 1970s the Act came under increasing attack as leaving too much scope for medical paternalism. The right given to doctors to administer involuntary treatment to patients whose judgment regarding their best interests may have been impaired or undermined by illness came under particular attack as an infringement of fundamental human rights. The pendulum has swung back, in many countries, to increased legal surveillance and control of the procedures for the compulsory
admission of patients to psychiatric hospitals. The right of detained patients to refuse treatment has been incorporated in the legislation enacted in the past decade in several countries, most notably in the United States. It was in this atmosphere of rapid change and intense controversy that ideas incorporated in the Mental Health Act of 1983 germinated and developed.

The Cambridge Conference of which this book is the proceedings, brought together psychiatrists, lawyers, judges, criminologists, social scientists and health administrators; it was held at Trinity College between 1 and 4 September 1983, less than a month before the new Act came into operation on 30 September 1983. It was hoped that the pooling of ideas and the sharing of experiences by scholars and practitioners from six different countries might prove of value and that their contributions in formal papers and discussion be worthy of a wider audience. These hopes have been justified. Some limitations of scope were inevitable, but, in the event, the participants learnt from each other’s experiences and ideas and managed to cover a great deal of ground. A few of the themes will be briefly mentioned here by way of introduction.

In the United States ‘dangerousness’ has become a leading criterion for the admission of mentally ill persons to hospital, displacing from this role the person’s need for protection, care and treatment aimed at the restoration of mental well-being. However, used as the only legal and moral justification for involuntary admission it has proved controversial, contentious and an unwieldy instrument in practice. The risk of suicide or danger to others can only be expressed in statistical or actuarial terms aided by clinical judgment; it cannot be ‘proved’ in a legal sense.

Where courts of law have been given responsibility for arriving at decisions regarding compulsory admission, they have tended to rely on the risk of imminent danger to others as their guideline. However, as they have also proved prone to judge the prediction of risk as wanting in precision for legal purposes, the selection of cases for commitment has become an arbitrary process and the law has seemed, in such settings, to have entered an era of confusion. There is a mounting volume of protest against the growing number of violent attacks by the mentally ill and personality-disordered discharged from hospital into some of the large cities of the world.

The right of the mentally ill to punishment for any offences committed, rather than confinement in a psychiatric hospital on an indeterminate basis, has in recent years been increasingly asserted as an inalienable human right. It is generally accepted that patients should not be sequestered for long periods following trivial offences such as simple
exhibitionism or obscene telephone calls merely because a psychiatric diagnosis has at one time been attached to them. Yet, when an individual has committed repeated arson or an act of poisoning or a number of sexual murders, some estimate of the risk for society and an objective, fair and compassionate judgment of what action might be taken to minimize it, is inescapable. Neither short nor long sentences nor the substitution of ‘punishment’ for ‘treatment’ will dispose of the problem. In its essence, it is far older than the disciplines of psychiatry or the law.

The rift between psychiatry and the law has been reflected in dramatic manner in the United Kingdom in the trials and in the judgments pronounced in the cases of Sutcliffe (the ‘Yorkshire Ripper’) and Nielsen, and in the trial of President Reagan’s would-be assassin, Hinckley, in the United States. These are merely well-publicized examples drawn from a multitude of others in which a growing divergence between the philosophies and the practices of the two intellectual disciplines and social institutions has become manifest in recent years. Although the insanity defence has been accepted in its essentials since the beginnings of recorded history, demands for its abolition or redefinition have been increasingly voiced and implemented in the last few decades. Lord Devlin has complained that ‘everywhere the concept of illness expands continually at the expense of the concept of moral responsibility’. There are, indeed, real problems inherent in the insanity defence and the difficult concept of diminished responsibility. But examination of the historical record makes it plain that these problems are also ancient and not the creation of psychiatrists, lawyers or any particular form of social organization.

Twenty-five years ago, the evils of institutionalization provided the main target for the critics of psychiatry. This has changed to the hardships imposed by ‘de-institutionalization’ or ‘de-carceration’. In the United Kingdom, the number of psychiatric beds has been halved in the past quarter of a century. But many patients with chronic illness have been discharged into communities who care little, or not at all. Some return home to inflict hardships on relatives, whilst others can be seen wandering homeless and aimless in city streets. When refused admission to hospital after committing minor offences, they are sentenced to terms of imprisonment contributing substantially to the serious overcrowding of the prisons and the depersonalization of those condemned to inhabit them.

The Cambridge Conference considered possible approaches towards resolving the main dilemmas that face psychiatry, society and the law in healing the rifts that have arisen between the professions concerned with the care of the mentally ill. It sought, also, to learn from past errors and
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consider means for the promotion of more humane, successful and socially efficient mental health and prison services. The Conference was made possible by the generosity of the late Baron ver Heyden de Lancey, who endowed a Fund for the encouragement of medico-legal studies at Trinity College, Cambridge. He took great interest in the Conference, but was unable to attend owing to failing health. It is sad that his death in the past year should have denied him the satisfaction of seeing the consummation of its work in the publication of this volume.

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