Contemporary Themes

Liberty and psychiatry

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British Medical Journal, 1975, 4, 94-96

Summary

The security facilities available in one regional health authority area have been surveyed. The simultaneous run-down of the large mental hospitals and the open-door policy have resulted in a lack of facilities for mentally abnormal offenders, and the increasing scarcity of common lodging houses has exacerbated the problem. Newer psychiatric units associated with general hospitals have been mainly concerned with patients suffering from neurosis or acute psychoses. The failure to develop other services to deal with offenders has seriously overburdened both the penal system and the special hospitals.

Introduction

Webster in 1834 asserted that to protect liberty from the assaults of passion it was necessary to demand checks, seek for guards, and insist on securities.¹ Since 1954, however, when the number of psychiatric beds reached 150 000 (3.44 per 1000 population) the trend has been towards the liberalisation of mental hospitals: closed hospitals have become open ones.²⁻⁵ In 1961 the then Minister of Health, Mr Enoch Powell, stated that the mental hospital was to go,⁶ and the future of care for an important group of patients then depended on implementing one vital provision: "adequate security arrangements for patients whose condition makes this necessary."⁷ By 1971 there were only 110 000 psychiatric beds (2.25 per 1000 population).⁸

This reduction in beds together with the incautious discharge of chronic patients from mental hospitals has highlighted the problem of mentally abnormal offenders.⁹⁻¹¹ On the one hand, many people wanted to abolish the mental hospital's role as an asylum for the offloading of problem cases,^{12 13} and, on the other, many considered that the new psychiatric units in district general hospitals could not cope with certain patients: those with aggressive, antisocial, damaged, or immature personalities and those with drug dependence, epilepsy, or other organic disorders.¹⁴⁻¹⁷

In the light of these developments the practices of all psychiatric hospitals and units in one administrative region were studied in relation to the treatment of mentally abnormal offenders to determine the characteristics of hospitals that provided facilities for such patients and to study the change in provisions over the past few years.

Method

In October 1974 the hospital administrators of all hospitals and units within one regional health authority which contained inpatient psychiatric beds were asked to provide information on existing security arrangements and the change in such provisions over the past five years. Administrators were also asked to list current inpatients under part V of the Mental Health Act 1959. Fifteen of the largest hospitals were visited and a member of the senior medical staff interviewed to discuss the management of mentally abnormal offenders.

Results

The region had a population of 3 546 600 and was served by 34 psychiatric hospitals and units. Of the 10 189 mental illness beds (2.87 per 1000 population) 2709 (27%) were in hospitals without a closed ward. At that time 87 inpatients were subject to the sections on mentally abnormal offenders in the Mental Health Act (0.025 per 1000 population), 86% of whom were in hospitals with a closed ward. Altogether 1% of beds in hospitals with closed wards and 0.44% of beds in mental illness hospitals without closed wards were occupied by patients under part V of the Act.

The region had 3596 beds for mental subnormality (1.014 per 1000 population), of which 2127 (59%) were in hospitals without a closed ward. Thirty-two inpatients were held under the relevant sections of part V (0.009 per 1000 population). Eighteen (56%) were in hospitals with a closed ward, and 1.3% of beds in hospitals with a closed ward and 0.67% of beds in open hospitals were occupied by these patients.

In the past five years the number of beds in permanently closed units fell by 39%, from 478 to 292. Two hospitals, both with over 700 beds, became completely open, three hospitals greatly reduced the number of beds in locked units, and in six hospitals closed provisions remained unchanged.

Of the hospitals with over 400 beds eight (73%) had closed wards, whereas only one of the 23 hospitals with less than 400 beds had a locked unit. Two of the 23 smaller hospitals took part V patients, while all 11 larger hospitals took such patients. There were highly significant correlations between the number of beds in a hospital and the number of patients held under sections of part V: section 60 (persons admitted to hospital by order of court) $r=0.745$; section 65 (persons held under an order restricting discharge) $r=0.920$; and sections 71-73 (persons kept in custody and those transferred from prison) $r=0.749$. There were similar correlations between the number of closed beds and number of part V patients: section 60, $r=0.686$; section 65, $r=0.798$; section 72, $r=0.798$ (all correlations were significant at the 0.1% level).

Thus the number of part V patients and whether the hospital had closed wards were both related to the size of the hospital. The former depended more on the presence of a locked ward than on the size of the hospital. While most (65%) of mental illness and subnormality beds were in hospitals with a closed ward, a greater proportion (78%) of inpatients held under sections of part V were resident in hospitals which contained a closed ward. If only the nine hospitals with more than 700 beds were considered, 0.59% of the 3202 beds were for section patients in the three open hospitals, whereas 1.13% of the 8031 beds in the six hospitals with a closed ward were for such patients. Thus hospitals with closed units took more part V patients than open hospitals of a similar size.

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Discussion

These findings show that a large hospital with a locked ward takes proportionally more part V patients than a large hospital without a locked ward and that the number accepted is also directly proportional to the gross number of beds in the hospital. The overall number of beds is being reduced, however, as are both the number of beds in locked wards and the number of hospitals which contain a locked ward. These processes work against hospitals that take mentally abnormal offenders.

In this region there were several levels of security: constantly locked wards, wards locked "as required," and lockable single rooms. Hospitals tended to use the second of these alternatives for current inpatients but were reluctant to admit patients for whom they would have had to lock an otherwise open ward. Single rooms were rarely used. Nursing shortages—38% in psychiatry for the region as a whole (information provided by the regional health authority)—had several grave implications. Firstly, more wards seemed to be temporarily locked because of staff shortages than to provide a secure therapeutic environment. Secondly, locked units for disturbed patients were labour intensive and therefore unpopular, and so both locked wards and demanding patients were shunned. Thirdly, restriction orders were often seen as demanding a degree of supervision that simply could not be provided because of undermanning of both hospital and community services. Though the special hospitals and the judiciary might be reassured in committing a patient to a hospital with some security, section patients were before managed in a secure setting for only about a fortnight mostly transfer to an open ward.

BACKGROUND

The Mental Health Act 1959 made a group of patients (psychopaths) the responsibility of psychiatrists at a time when the services that could cope with them were being dismantled. More patients were admitted to special hospitals, and the increasing use of restriction orders¹⁸ meant that discharge from these secure establishments became a less absolute process, requiring more supervision from the receiving authority. The special hospitals are now grossly overcrowded, mainly because the number of discharges has not kept up with the number of admissions. From 1964 to 1973 yearly admissions to all three special hospitals increased 40% from 249 to 348—from 1965 onwards there were more admissions than discharges (see table). Thus the special hospital population has increased 12% from 2106 in 1964 to 2354 in 1973 (figures provided by DHSS).

The average daily prison population rose by 24% from 1963 to 1972 (30 896 to 38 328), but the number remanded for psychiatric reports increased by 54% from 8418 to 12 958 yearly.¹⁹ The courts were tacitly inviting prison medical officers to recommend psychiatric disposal for more offenders. Such disposal depended, however, on the ability of the prison doctor to find a National Health Service colleague who would accept the patient. Despite this increase in the numbers remanded the numbers found "unfit to plead" or disposed of under sections 71-73 of the Mental Health Act have remained reasonably constant. After an increase in the early 1960s, the numbers receiving disposal under section 60 or 65 fell from a mean of 1274 in 1966-9 to 1211 in 1970-3. These trends are reflected in the gross decrease in the proportion of those remanded for a psychiatric report who eventually get a psychiatric disposal—16.75% in 1966 and 13.2% in 1973.¹⁹

Common lodging houses—Together with the reduction in mental hospital beds the amount of accommodation for the single homeless has fallen. The number of common lodging-house beds registered with local authorities fell in the decade before 1972 from 1532 to 293 in Manchester, 632 to 431 in Birmingham, 2087 to 812 in Glasgow, and 6415 to 4708 in London.²⁰ Not surprisingly, the numbers sleeping "rough" rose, from a national figure of about 1000 in 1966²¹ to about 12 000 in London alone²² and to 50 000-100 000 nationally²³ in 1972. This vagrant population contains many people with a history of repeated admissions to mental hospitals.²⁴⁻²⁶

RECOMMENDATIONS OF SPECIAL HOSPITALS WORKING PARTY

In 1961 the report of a working party on special hospitals predicted these developments. It acknowledged that what was done in the NHS and penal system greatly affected the special hospitals and emphasised that the absence of security arrangements at NHS hospitals made courts hesitate in sending patients to hospitals; it was feared that people who really needed treatment would be caught up in the penal system. The working party recommended the establishment of secure diagnostic and treatment units. Admission to and discharge from these units would be to and from the community, mental hospitals, special hospitals, penal institutions, and remand centres.

In the next decade, however, not only were no security treatment facilities developed but those that existed were run down; the special hospitals became grossly overcrowded²⁸ and their doctors found it increasingly difficult to discharge patients. Similarly, prison medical officers could not find the suitable vacancies in psychiatric hospitals they needed to recommend hospital orders, and by 1973 section 64 was being implemented in a way that was tantamount to using a prison hospital as a secure admission ward before transfer to an open ward.¹⁹ Mental hospital consultants were asked to continue to provide services for these patients, but the open-door policy worked against such provision and the new district general hospital psychiatric units were not suitable for such patients.

By 1974 the need for secure hospital facilities in regional units had become urgent²⁹ and the Committee on Mentally Abnormal Offenders³⁰ hoped that such units could form a nucleus for forensic services and a foundation for academic forensic psychiatry. In 1974 Scott³¹ argued that mentally abnormal dangerous offenders should be treated in psychiatric units within the prison service because the therapeutic capacity of the prisons is effectively retarded while the administrative possibility of transferring the difficult prisoner is open to them.

Paradoxically at a time when open-door psychiatry reflects a concern with individual liberty more people are incarcerated within hospitals because of staff shortages than because of direct management policy. The illusory freedom is therefore selective, with the result that some patients are detained outside the mental hospitals. They cannot avail themselves of either day hospitals, community based support, or rehabilitation programmes and they are not wanted in the new open units; neither can they be managed by the older establishments because of changed attitudes and lack of manpower and facilities.

These "antique monstrosities, these mausolea of the living,"¹² provided a superior service than their successors for some patients. Regional security units were first proposed by the special hospitals report in 1961 to provide an additional service for a particular group of patients whose needs cannot be

Number of admissions in excess of discharges (and vice versa) in 1960-73 (figures provided by DHSS)

Year:	1960	61	62	63	64	65	66	67	68	69	70	71	72	73
Admissions in excess of discharges*	-68	-31	-34	-7	-38	54	-14	45	36	-19	20	26	49	57

*Minus signs indicate that discharges exceeded admissions.

adequately met in completely open conditions. They are now an urgent necessity since, by default, these patients are sent inappropriately to prisons and the special hospitals, thus adding to the pressures on these institutions. Bennett³² has consistently warned against the wholesale acceptance of the open-door policy in mental hospitals, arguing that freedom of choice usually means the freedom to dispose of undesirable patients so that staff with most skill and training can concentrate on treating those who are least disabled.

The urgent need for secure regional units is shown by the fall of nearly 40% in the number of closed beds in one region over the past five years. But a regional policy is also needed because the proposed secure units can improve matters only if they enable psychiatric units and mental hospitals to take on again these "objecting and objectionable"³³ patients by facilitating their management outside a secure setting.

I am grateful to Professor T C N Gibbens who supervised this work; the study was supported by a grant from the DHSS. Dr John Gunn and Dr Douglas Bennett have both provided valuable criticism and advice.

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Outside Medicine

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British Medical Journal, 1975, 4, 96-97

Great discoveries in science have usually been made by one man: standing, no doubt, on the shoulders of his predecessors, but for all that making the intellectual leap by himself. Great popular movements, on the other hand, usually result from the coalescence of several original notions, produced by several people. Each of these may involve an intellectual leap, but any one might have been ineffective without the co-operation of the others. In the first half of the eighteenth century western thought underwent a considerable revolution, the adoption of the naturalist theory, attempting to base society on "natural (primitive) man, natural religion, natural law, natural rights, natural economic laws."¹ This was a development from the mathematical, physical systems of the preceding century, which had culminated in Newton; it took the form of a search for an organic system, to replace the mechanical system of Newton, a man whom they might attempt to transcend, but whose greatness they both acknowledged and imitated.

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Noble Savage

One of the foundations on which the new attitude was based was the concept of "the noble savage," the natural man, unspoiled by misguiding civilization. But in the path to this ideal stood what they knew of "natural man," the pygmies, satyrs, dog-faced men, wild men, men of the woods, orang-outangs, and similar creatures reported by the ancients and found by more or less credible travellers. They were even vouched for by St. Jerome, who described a long conversation between St. Anthony and one of them.² They seemed to be men, and they were in a state of nature, but so far from being noble, they were very ignoble indeed. Some could be explained away as defective specimens of men, already spoiled by civilization, who had deserted it. In less organized societies it was not uncommon for the mentally abnormal to escape to the maquis, rather than risk imprisonment in asylums; there are tramps of that kind today; there were boys who had been abandoned or thrown out: the Wild Boy of Aveyron, Peter the Wild Boy of Hanover,³ the later Kaspar Hauser. Some of these were genuine, even if some were frauds. They did not affect the theory of the "noble savage." The rest were accepted as being degenerate men, who had fallen from the perfection of man in the Golden Age, and the inference would have been that the state of nature had not prevented their becoming ignoble. And so they stood in the way of any idealiza-