SOCIAL AND LEGAL REPERCUSSIONS OF THE MENTAL HEALTH ACT, 1959

BY

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On November 1, 1960, the Mental Health Act, 1959, came into full effect. In 1959, the last full year before the Act came into operation, of 482 male admissions to Horton Hospital 19 (4%) had come into collision with the law and had been admitted under the then existing Acts. In 1961, the first full year after the implementation of the new Act, from the same London catchment area as obtained in 1959, 98 male offenders were admitted. They represent 94 individual cases because four were admitted twice in the same year in similar circumstances. The male admissions in 1961 numbered 571, an increase of 89 (12%) on the 1959 figure, so that the 98 offenders represent 17% of the total number of admissions.

In the two years under comparison, therefore, the number of male offenders admitted to one mental hospital had risen by 79, or by 13% of the annual admissions. An increase of such dramatic proportions calls for investigation. It is the purpose then, of this paper, to inquire into the situation and give some possible explanations.

Mode of Admission

The following Parts and Sections of the new Act were invoked in the 98 admissions in 1961.

1. Informal—that is, where the offenders are not unwilling to be admitted to mental hospitals.
2. Part IV (Sections 25 and 29)—that is, compulsory admissions for observation to mental hospital for 28 days in the former and for 72 hours in a case of "urgent necessity" in the latter.
3. Part IV (Section 136)—that is, if a constable finds a person who appears to be mentally disordered and in immediate need of care and control in a place "to which the public have access" he may remove him to a place of safety—for example, a mental hospital—where he may be detained for not more than 72 hours.
4. Part V (Hospital Orders) (Section 60)—that is, where the court is satisfied that the offender is suffering from mental illness, etc., warranting hospital treatment.
5. Part V (Section 65) (with restrictions). This is designed to protect the public from a mentally disordered offender convicted of a serious offence and considered likely to repeat it once he is freed from detention. The main proviso is that discharge, or transfer, or granting of leave is exercisable only with the consent of the Home Secretary. The order may be made only by a Court of Assize or Quarter Sessions.
6. Part V (Section 72)—that is, if a person serving a sentence of imprisonment is found to be suffering from mental illness, etc., so as to warrant detention in hospital for medical treatment, arrangements may be made for a transfer to a mental hospital with the approval of the Home Secretary.

Table I shows the mode of admission. Informal admissions and those under Part IV can be used only in minor or non-indictable offences, so that these

TABLE I.—Mode of Admission of 98 Offenders

Informal	10	Part V (Section 60)	..	47
Part IV (Sections 25 and 29)	7	" V (" 65)	..	5
" IV (Section 136)	17	" V (" 72)	..	12

represent only 34% of the total. The majority (66%), therefore, were on indictable charges for which a sentence of a term of imprisonment was a possible punishment.

Nature of Offences.—The offences for which those admitted had been charged are classified in Table II. Mental illness and anti-social behaviour are by no means mutually exclusive. Indeed, some of the offenders had long criminal records and could rightly be classified as

TABLE II.—Offences With Which Charged (98 Cases)

Nature of Offence	No.
Offences of a public sort (wandering abroad; lodging in open air; drunkenness; insulting behaviour)	31
Offences against the person	13
Attempted suicide	1
Murder	10
Assault	1
Grievous bodily harm	1
Offences against property or intent (larceny; wilful damage; breaking and entering; suspected person; loitering with intent)	48
No information	6

professional criminals. For the most part, however, the offences were of a relatively minor sort and in many instances reflect the mental illness of the offender. Thus it is in the nature of some schizophrenics to drift aimlessly and live "rough" or as tramps. Of the 31 charges of "offences of a public sort," 29 were by schizophrenics, of whom 23 were "wandering abroad" or "lodging in the open air." Similarly, of those charges classified under "offences against property or intent," 15 were against schizophrenics in relation to the somewhat nebulous offences of "being a suspected person" or "loitering with intent."

Clinical Diagnosis.—The clinical diagnosis of the 94 individual cases admitted in 1961 was: schizophrenia in 79 cases, mania in 6, senile depression in 1, psychopathic disorder in 3, dementia in 3, alcoholism in 1, and epilepsy in 1. Clinically the problem is overwhelmingly one of schizophrenia (82%), a fact which is abundantly reflected in almost all the analytical tables which follow.

Age of Offenders.—The ages of the 94 offenders are given in Table III. It will be seen that 80 (85%) are under 50 years of age; this is consistent with the marked preponderance of those suffering from schizophrenia, which is predominantly a disease of young adulthood and early middle age.

TABLE III.—Ages of the 94 Offenders

Age	-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89
No.	1	29	39	11	7	4	2	1

The Chronic Psychotic Offender

Clinical investigation led to the belief that the mental illness for which most of the 94 offenders were admitted was of long standing. The possibility, therefore, that chronic mental illness might be a factor in their social failure was felt to be worth while exploring. To this end an attempt was made to trace their mental hospitals "ins and outs" by means of a form sent to those hospitals where it was known they had been treated. The information sought was a simple statement of the date of each admission and discharge. From this the number of admissions and the total length of stay in hospital during one or more admissions could easily be calculated for each case.

It is notoriously difficult to compile a comprehensive psychiatric history in any series of cases, and it is readily acknowledged that for a variety of reasons the data collected on this occasion are incomplete. For example,

only data from hospitals in the United Kingdom were obtainable, although there were a number of immigrants, coloured and white, who it was fair to assume on clinical grounds were chronic psychotics and indeed were psychotic on arrival in the United Kingdom. Again, only data from civilian hospitals were sought, because of the difficulty in obtaining information from military sources. Furthermore, for various reasons aliases are often used, or information is wittingly or unwittingly withheld, all of which makes for an incomplete picture of the situation.

Nevertheless, despite the admitted shortcomings in the method of collecting data, from our own records and those of other hospitals who kindly co-operated it was possible to substantiate a history of previous mental illness in no fewer than 63 (66%) of the offenders.

Short of the cumbersome method of writing a précis of the histories of the 63 cases individually it was felt that a fair presentation of the evidence collected could be given by two tables, one complementing the other. The first (Table IV) gives the number of previous mental-hospital admissions, while the second (Table V) gives the total length of time previously spent in mental hospitals. It will be seen that 41 (65%) of the 63 cases had had multiple admissions to mental hospitals, while 47 (75%) had spent an aggregate of more than six months in them.

TABLE IV.—*Previous Mental Hospital Admissions in 63 Offenders*

No. of admissions	1	2	3	4	5	6	7	16
„ „ cases	22	12	12	10	1	4	1	1

TABLE V.—*Total Period Previously Spent in Mental Hospitals by 63 Offenders*

Period	<1 mth.	1-6 mth.	6-12 mth.	1-3 yr.	3-10 yr.	>10 yr.
No.	7	9	24	16	6	1

Of the 63 cases, 56 (88%) were classified as schizophrenics. Schizophrenia is a mental illness characterized by alternating relapses and remissions: at some arbitrary point in its course it must be regarded as having become chronic—and no apology is made for the use of this honest but nowadays most unfashionable adjective. It is not surprising, therefore, that there is such a weight of evidence in favour of chronic mental illness in such a large percentage of the offenders.

Social Failure of the Chronic Psychotic

In the 63 cases in which there was documentary evidence of previous mental illness information was obtained through the good offices of the governors of the prisons concerned concerning the date on which they were arrested or were committed to prison. In those admitted under Part IV, Section 136, "place of safety," the date of admission to Horton Hospital would be the same as the date of arrest.

Table VI shows the interval between the date of the last known discharge from a mental hospital and arrest by the police or committal to prison either on remand for a medical report or to serve a sentence. A measure

TABLE VI.—*Interval Between Discharge from Mental Hospital and Arrest or Committal to Prison in 63 Offenders*

Interval	No.	Interval	No.
Same day	4	3 to 6 months	11
2 days to 1 week	3	6 months to 1 year	12
1 week to 1 month	5	1 year to 2 years	10
1 to 3 months	8	Over 10 years	10

of the social failure of the offenders or their inability to survive on even terms with others in society, is reflected in Table VI. Thus 4 (6%) were unable to survive even for a day; 12 (20%) had collided with the law in under a month; within a year 43 (66%) had done so; and within two years 53 (84%) had offended.

Again it must be emphasized that 56 (88%) of these 63 offenders were schizophrenics. The interval in so many of these cases between discharge from mental hospital and being found to be mentally ill either while on remand for a medical report or while serving a prison sentence is very brief. It is fair to assume, therefore, that at the time of discharge from hospital they were still overtly psychotic or their remissions were singularly short-lived.

Commentary

The fivefold increase in the number of male offenders admitted to one mental hospital in the two years 1959 and 1961, the full years before and after the implementation of the Mental Health Act, 1959, poses a serious problem, legally and socially.

It is true that the majority of the offences committed are of a minor order. Even so, the fact is that whenever one hapless chronic schizophrenic steals a bottle of milk because he is thirsty, snatches a few tomatoes because he is hungry, or sleeps on a park bench because he has no other lodging, the whole weighty machinery of the law has to be set in motion. But, minor or major, the embarrassment in the aggregate occasioned by the offences to the public, the police, the judiciary, and the prison services must be enormous.

Where has this horde of mentally ill offenders erupted from? The possibility that 1961 was somehow a freak year may be dismissed by the simple fact that the number of male offenders admitted to the same hospital was running at a significantly higher rate in 1962—that is, 69 by the end of July as compared with 56 in the same period in 1961. The number of recent immigrants, coloured and white, who, it is presumed, were psychotic on arrival in the United Kingdom would not materially alter the picture. The scope of the new Act, relative to the previous Acts, is widened only in respect of the admission to mental hospitals of psychopaths: only three of the 1961 admissions were suffering from this disorder.

The somewhat ironic and seemingly paradoxical conclusion arrived at, therefore, is that the major source of the offenders is the mental hospitals themselves. This conclusion is supported by the data presented: of the 94 individual cases studied, 53 (56%) had been discharged from mental hospitals within two years of the commission of their offence. If complete information were forthcoming the figure might be substantially higher.

Clinically, the problem presented by these offenders is overwhelmingly that of schizophrenia. Certain authors have claimed that as the result of modern treatments the prognosis in mental illness in general and in schizophrenia in particular—Norton (1961) for example—has been greatly improved. So eloquently have these claims been made that they have moulded Government policy, as witness the recent 10-year hospital plan in which approximately half the existing mental hospitals are destined to be destroyed and some of the services they afforded given over to "community care."

In a previous paper (Rollin, 1961) I indicated that the alleged improvement in prognosis in schizophrenia, at

any rate, might well be an illusion based on statistical fallacies. I went on to point out that an increased discharge rate was an unreliable prognostic index. What was in fact happening was that a proportion of patients discharged with perhaps indecent haste from mental hospitals, not necessarily cured or even improved, were being redistributed in the community in a variety of ways, most of them socially retrogressive, before ultimately being returned to the mental hospital.

From what has been disclosed in this paper it would seem that one of the important centres of redistribution is the prison. A hospital bed is, in effect, being exchanged for a prison cell. Historically this situation is by no means new. Penrose (1949), for example, states "there is an inverse relationship between the number of beds provided for the mentally ill and defective and the number of people in prison." But to allow this trend to continue, or increase, as it appears to be doing, would be socially disastrous and morally indefensible.

As for "community care"—the currently popular psychiatric catchphrase—the question arises: Does the community care? The social failure of so many of the mentally ill offenders studied is in itself an index of the failure of the community to look after them. Seemingly, it is the case that the community, in London at least, is not overzealous in its efforts to look after the chronic psychotic in its midst.

The danger inherent in a tepid welcome-on-the-mat for the mentally ill is that if they continue to be funnelled into the community from the mental hospitals without adequate provision, then even those doors now open to them may be slammed in their faces. The point is excellently made by Jones and Sidebotham (1962). They say, "If public tolerance is to be maintained in this country it is important that we should not try it too severely, and that we should proceed with care in releasing those whose actions might constitute a danger or an offence to the ordinary citizen"—with which statement, on the evidence supplied, I heartily concur.

Summary

In 1961, the first full year after the implementation of the Mental Health Act, 1959, there were 98 male offenders admitted to Horton Hospital, Epsom, whose catchment area is in Metropolitan London. In 1959, the last full year before the Act, the corresponding number was only 19. The paper sets out the results of an inquiry into this fivefold increase in the number of offenders in 1961.

In 1961 79 (81%) of those admitted were suffering from schizophrenia, the characteristics of which are reflected in all facets of the inquiry.

In 63 (66%) offenders, 56 of whom were schizophrenics, there was documentary evidence of previous mental illness. Forty-one had had multiple admissions to hospitals and 47 had each spent an aggregate of more than six months in them. It was a fair assumption, therefore, that a high proportion of the offenders were in fact chronic psychotics—that is, in all probability chronic schizophrenics. This must account in some measure for their social failure, evidence of which lay in the commission of antisocial acts.

Fifty-three of those admitted had committed their offences within two years of the last recorded discharge from a mental hospital. The conclusion must be drawn that the major source of the steep increase in the number of offenders is the mental hospitals themselves.

The grave legal and social consequences of incautious discharge of chronic patients from mental hospitals are discussed. Doubts concerning the efficacy of "community care" in the treatment of the chronic psychotic, in the London area at any rate, are expressed.

I gratefully acknowledge the courtesy shown and help given by the governors, medical officers, and officers of H.M. Prisons. Thanks are also due to the many mental hospitals which kindly co-operated in the investigation, and to Dr. J. H. Watkin, physician-superintendent of Horton Hospital, for permission to publish this paper.

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TREATMENT OF STAPHYLOCOCCAL INFECTIONS WITH "FUCIDIN"

BY

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The object of this communication is to report clinical experience with "fucidin" in the oral treatment of a series of chronic and acute staphylococcal infections.

The isolation of fusidic acid, of which fucidin is the sodium salt, from the fermentation broth of *Fusidium coccineum*, a fungus which is parasitic on the plant *Veronica* (K. Tubaki), was reported by Godtfredsen *et al.* (1962a).

Chemically the drug is related to cephalosporin P₁ (Baird *et al.*, 1961) and helvolic acid (Allinger and Coke, 1961), and is believed (Godtfredsen and Vangedal) to have the following steroid structure:

Despite its perhydrocyclopentenophenanthrene nucleus, fusidic acid would not be expected to exhibit hormonal properties. The methyl group at C₁₃ is lacking in fusidic acid and the side chain at C₁₇ differs from that of steroid hormones. The oxygen function at C₁₁, which is necessary for glucocorticoid effect, is also missing.

Microbiological studies have been reported by Godtfredsen *et al.* (1962b), Barber and Waterworth (1962), and Hilson (1962) and clinical studies by Scowen and Garrod (1962) and Taylor and Bloor (1962). Fucidin is mainly active against Gram-positive micro-organisms and neisseria. Its activity against Gram-negative bacilli and fungi is extremely low. No cross-resistance exists between fucidin and other antibiotics in common use. Cross-resistance, however, is found with cephalosporin P₁.