

Online archive 25b (ii)

Development of specialties – Forensic psychiatry

Forensic psychiatry has a long history. There have always been problems knowing what to do with people who commit serious offences but are plainly mentally ill (or whatever term, whether 'madness' or 'lunacy' was used). There have always been difficulties in assessing whether someone should be defined as evil or ill, and also whether the decision should be taken by a doctor, a judge or a jury. When someone is a mentally ill criminal, and considered dangerous, a decision has to be taken whether to detain him in a hospital or prison. In the 19th Century arguments about criminal responsibility led to the judge's interpretation of the Law of the day in the case of Daniel McNaughten. Forensic psychiatrists were initially those who worked in special hospitals such as Broadmoor and those who were called in as experts to help the courts decide on responsibility in difficult criminal cases. A criminal lunatic asylum was opened in Ireland in 1845(?) and Broadmoor in England in 1863 (?). Today forensic psychiatrists are more likely to be found working in medium secure units which have taken over some of the responsibilities of asylums now closed. The RMPA had a Forensic Medicine Subcommittee which metamorphosed into the College Faculty of Forensic Medicine. Its functions are to oversee the training of all psychiatrists offering a period of instruction in a rotational training scheme as well as overseeing the education of those who will go on to become consultant forensic psychiatrists. This Appendix gives a much fuller and more detailed account than in Chapter 9.

The subject of forensic psychiatry includes the boundaries between diseases and between normality and mental disease as well as the contribution of mental diseases to socially proscribed acts. At its simplest it deals with patients and problems at the interface of the legal and psychiatric systems. Psychiatrists did not invent mental disorder, which is a common experience, they were invented to try to treat it. Psychiatry still lacks an accepted nomenclature or list of approved terms for describing and recording clinical observations. It also lacks a reliable system of classification. Nevertheless the broad consensus within psychiatry at the present time is that the advantages of the disease approach, the diagnostic exercise, and the present rudimentary classification systems outweigh the disadvantages. The first requirement of a disease theory is the recognition of a cluster of undesirable traits or characteristics that tend to occur together. The second is the hypothesis that the cluster of traits is 'symptomatic' of

some underlying biological disturbance. There will always be different perspectives between medicine and law. The conflict lies between the moral and the pragmatic with outcomes of punishment or excuse and the practicality of working towards prevention of harm.

A forensic psychiatrist is no longer simply a specialist – a ‘mad-doctor’ or ‘alienist’ but a doctor who needs to be familiar with the principles of the criminal law, the functioning of its multifarious agencies, the reasoning of sentencers, the reactions of society.

Such a psychiatrist should know about the frequencies and modes of transmission of the kinds of behaviour, normal as well as abnormal, which sometimes bring people into conflict with the law. The kinds of disorder with which a forensic psychiatrist is professionally concerned may or may not lead to law-breaking. A few of them necessarily do so. Even paedophilia does not always manifest itself in child-molesting. The point at which sadism becomes physical or mental cruelty is not obviously identifiable. Familiarity is not easily achieved when the abnormality is a rare one. Some are so uncommon that few psychiatrists are likely to encounter more than one or two instances in a decade. The more psychiatrists there are the truer this will be. Common aberrations can present problems, especially where motivation is concerned. When a person steals he might be trying to get something for nothing or he might have a mental disorder or social incompetence. He might be so deluded that he believed he had a rightful claim to what he takes. Statistics or other generalisations do not help the psychiatrist here: only thorough interviewing and history-taking.

During the last half-century one difference between psychiatry and the other social sciences has become more marked. Social scientists have moved away from case-studies in the hunt for large samples, with a corresponding increase in the superficiality of the information recorded about each individual. The information takes the form of 'hard', measurable data: age, sex, marital status, occupational group, educational level, employment record, performance in tests. The easier something is to measure the less likely it is to be what one wants to know. It ends in the formulation of weak generalisations masquerading as natural laws of human behaviour, with a plethora of unspecifiable exceptions. The practice of forensic psychiatry obliges practitioners as well as courts to study the individual and forensic psychiatrists have not ceased to practice the clinical study of individuals.

All psychiatrists differ from other doctors in that they may be expected to treat unwilling patients and at times curtail their liberty. They are expected to treat patients, who have symptoms that everyone else may consider to be illness, but who are unaware that they are sick. Such people are said to lack insight into their own condition. They will have other explanations for their symptoms. These patients may lose part of their liberty because they are a danger to themselves or others. Patients may be considered to need treatment against their wishes if, for example, they are suicidal or not eating at all because of some complex delusional system. The law is very much involved in dealing with some mental illnesses. Judges have powers to detain patients and also to enforce treatment on them. The relationship between doctors and patients in these circumstances is unique. Patients may dislike those who are endeavouring to care for, or treat them,

and may consider detention unwarranted. Hospitals may be considered little more than prisons and the staff gaolers. Forensic psychiatry is that branch of the profession who are most involved in the area between medicine, mental illness and criminality.

SOME PROBLEMS WITH DEFINITIONS

Non-statutory admissions to mental hospitals starting in the UK in the 1930s brought the treatment of nervous and mental disorders more closely in line with that of physical illness. There was a wish to assimilate the treatment of physical and mental illness. Many who took this view recognised that there are cases in which mental patients must be detained in hospital against their will and that in these a special procedure is needed.

The terms 'mental illness' and 'mental health' suggest certain definite empirical phenomena suggesting much the same to most people. However in those countries where capital punishment survives the balance of life and death may turn on a precise definition employed in the criminal law. It has proved difficult to provide clear definitions of mental health and it is probably simpler to think of this as an absence of mental illness (or mental retardation). Disease is better thought of as present or not present.

The term 'mental illness' today covers more than the psychoses (or lunacy or madness). Today doctors may be expected to deal with children who steal or have violent tempers or who wet their beds; with men and women who cannot get on with their spouses or manage their love affairs satisfactorily; with criminals convicted of various offences as well as the victims of all manner of irrational fears, anxieties and depressions and

sometimes also of quite rational ones. Psychiatrists deal with people who are complaining or are complained about.

The limits of what is recognised as the medical sphere at any given time is set by what happens to be taught in medical schools or to have been taught there a few years previously. In the nineteenth century a child who persistently steals would not have been referred to a doctor.

Another problem is to decide what attitude should be adopted towards what has hitherto been called “malingering” should the malingerer be pitied or blamed, punished or given the benefit of therapy. Mental illness in its milder manifestations is no less elusive than mental health. The distinction between physical and mental illnesses along with the distinction between ‘organic’ and ‘functional disorders’ is likely to remain until every mental process has its known physical accompaniment and dualistic language can be discarded.

Another criterion to distinguish between the sick and the responsible among anti-social persons is the presence or absence of recognised symptoms of abnormality which are independent of their misbehaviour. Mental illness should be diagnosed by the presence of a psychiatric syndrome additional to the anti-social behaviour. The criterion alike of mental and physical ill-health should be the presence of specific symptoms or the ‘evident disturbance of part function as well as of general efficiency’. In mental disorders this is shown by the occurrence of disturbed thinking (disturbed thinking, e.g. delusion, disturbed perception, for example hallucination a disturbed emotional state as

in anxiety neurosis or depressive illness). Deviant, maladapted, non-conformist behaviour is pathological if it is accompanied by a manifest disturbance of some such function. Disorder of function should be detectable at a discrete or differentiated level which is hardly conceivable when mental activity as a whole is taken. The deluded, the anxious, the abysmally depressed are mentally ill. The cheerful rational wrongdoer is not. This distinction avoids the circular argument which explains anti-social behaviour by ill health while inferring the ill- health from the behaviour.

Conduct disorder and personality development are central to both adolescent and adult forensic psychiatry. Victims are at the heart of forensic psychiatry. The prevention of harm to others is one aim of forensic psychiatry. Victims not only pose medico-legal problems, but many of them turn their fears and their anger back on to society in anti-social actions. Some adults have a complete personality change as a result of trauma. Victimization during childhood seriously affects the development of the growing personality. Most offender patients are themselves victims in one way or another.

The problem remains with terms such as 'psychopath' when used to describe someone who shows no symptoms other than his complete resistance to the influence of social mores. People who were at one time considered extremely wicked may now be classified as cases of mental disorder. The psychopath makes it difficult for journalists and the public to distinguish the sick from the healthy delinquent by the presence or absence of a psychiatric syndrome or by symptoms of mental disorder which are independent of difficult to explain behaviour. This can be a circular process by which mental abnormality is inferred from anti-social behaviour, while anti-social behaviour is

explained by mental abnormality. Forensic psychiatrists need clear and natural diagnostic classifications.

There can be similar problems when considering mental retardation or learning difficulty. Mental deficiency, an older term, was defined by statute 'arrested or incomplete development of mind' existing before the age of 18. The definition postulated mental deficiency as an independent condition which might cause failure of social adaptation rather than as one to be inferred from or identified with such failure. The defect was envisaged as existing in its own right and as a cause for the need for care and control or in the case of a "moral imbecile" co-existing with vicious or criminal propensities.

The two factors considered to be of most importance in affecting social adaptation were 'general intelligence' and 'general emotionality'. Grades of 'mental deficiency' could be tentatively linked to Intelligence Quotients, below 70 corresponding to clinical feeble mindedness (moron) or mild learning disability. Below 40 would have been considered severe or profound.

The term mental defective, since it led to possible incarceration in mental handicap hospitals, could be defined as 'a person who by reason of arrested development or disease of the brain dating from birth or early years displays at an early age vicious or criminal propensities which are of an incorrigible or unusual nature, and are generally associated with some slight limitation of intellect'. The use of an intellectual test to establish mental deficiency had shortcomings and from a practical point of view the

criterion was social incapacity. This also causes problems as it can be difficult to determine whether social incompetence due to emotional immaturity is to lead to treatment for mental deficiency or neurosis.

If mental health and ill health cannot be defined in objective scientific terms that are free of subjective moral judgments there can be no way to distinguish a sick from a healthy mind. It would be possible to classify all criminal behaviour as symptoms of mental disorder obliterating the distinction between criminality and illness altogether dispensing with the concept of responsibility. The general view however is that for practical purposes a division can be made between those who are sick and those whose behaviour cannot be explained on grounds of ill-health. Crime is not a disease though sometimes the result of it. Sickness as such does not purely depend upon unhappiness inefficiency or social inadequacy as such. Psychiatrists are still asked to investigate and treat disturbances of behaviour in children which can hardly be included within any conception of illness (though they may be the prelude to illness). The criteria of health are not primarily social. Ill health should not be equated with social deviation or maladjustment.

There have always been problems in the relationship between the medical and legal professions. When someone has committed a crime which appears to be the result of a mental illness the outcome can be quite different to that for someone who has committed the same crime who has no symptoms suggesting illness. In these circumstances, where a person is plainly dangerous to other people, they can be detained (sometimes indefinitely) by the law, in one case in a hospital in the other a

gaol. The person detained in a 'special hospital' might consider that this was solely imprisonment under another name, if he had no previous experience of prison.

It is not possible to abandon the concept of responsibility altogether. The need to discriminate between the sick and the healthy is more than the problem of who is to be dealt with by whom.

Britain gets as close to abandoning 'responsibility' as any criminal jurisdiction in the world. The concept remains fundamental to human thought determining our view of accidents (if two people walk downstairs and one stumbles knocking the other down to injury or death it matters profoundly whether the one still standing upright meant to cause the fall or not, possibly the difference between accidental death and murder. This is the question of *mens rea* (guilty mind). In Britain these problems are worried about more after conviction than before. This is a pragmatic view which first asks 'did she do it' and if yes then 'how much shall we blame and punish'. The concept of responsibility occurs in sentencing. It tends to get called mitigation though it is an aspect of responsibility.

In contemporary attitudes toward anti-social behaviour psychiatry and humanitarianism have marched hand in hand. The medical treatment of social deviants has been a powerful reinforcement of humanitarian impulses. Humane proposals are enhanced if expressed in terms of medical science. Even when there was little basis for psychiatric views they were in the tradition exemplified by Shaftesbury.

There continue to be difficulties in deciding between what is illness and what is wickedness and this still leads to disagreements between lawyers and doctors. They may not agree on definitions or on the presence or absence of illness. If someone becomes extremely overactive, behaving in an unpredictable and irrational way, leading to extreme violence and the death of another person they will be arrested and detained. If it is then found they are in the early stages of general paralysis of the insane (GPI), an illness caused by syphilis (with the causal spirochaetes in the brain) which nowadays can be successfully treated with penicillin, they will be appropriately treated, even if it is against their will.

The difficulties arise when there is doubt about diagnosis; for example when a man is found to have raped and killed children who are strangers to him. Some people argue that it would be unthinkable for any normal person to behave in this way, therefore they must be mad. Other people would put forward the view that this is a case of extreme wickedness (though some strange sexual desire must account for it). These are situations where a judge and jury take a decision rather than a doctor. The doctor may make the diagnosis and then argue for mitigation, but may be overruled 'in the interests of justice'.

The Lancet in 1841, in a leading article, directed attention to what it described as 'one of the most difficult questions in jurisprudence or in morals'. It pointed to the difficulty of determining the precise line of demarcation between the extremes of bad temper, fanaticism, and the commencement of actual insanity. This problem has always beset, and will continue to beset the forensic psychiatrist. He wishes to know if a particular

example of deviant behaviour exceeds the parameters of the normal and crosses over into the realms of the pathological. When does a man cease to be sane; when does he become mentally ill? It is a seemingly simple, but in fact impossible question to answer. Another problem which the same leading article addressed was the case 'where the insanity of the party is indisputable'. It emphasised the difficulty in such a case of 'holding, with a just hand, the balance between the compassion that is due to a miserably afflicted being, and the value of an indefinite number of human lives, which may be sacrificed, immediately to his hallucinations, or, more remotely, to the contagious example of his misguided acts'. Later in the article, it is contended 'that madness being the most dreadful calamity which can afflict a human being, it would be the height of cruelty for man to raise his arm against one already so awfully stricken by the hand of God'.

The Lancet expressed the dilemma which has exercised the minds and hearts of society at all times in relation to mentally abnormal offenders, particularly those charged with murder. Does compassion win the day, or does the 'widespread and all but universal cry for blood' hold sway, allowing an unjust verdict to be reached so that the most rigorous penalty of the law may be exacted? Forensic psychiatry addresses that dilemma. The violent individual is both treated and controlled preserving humanitarianism and preserving public safety. Hence the importance of secure hospitals as opposed to prison.

The history of mentally abnormal or 'criminal lunatics' as they were called has changed in the past 200 years. Before 1800 there were no special facilities for such patients and they were incarcerated in local prisons. John Howard wrote that the conditions were crowded and offensive because the rooms which were designed for prisoners were

occupied by the insane. When these were not kept separately they disturbed and terrified other prisoners. In 1800 a pistol was fired at George III by a mentally ill man who stated he wished to be hung drawn and quartered as God has instructed him to save the world by sacrificing his own life. The Court found him “not guilty by reason of insanity” but left the Authorities with the problem of disposal following this novel verdict. Following this the first Criminal Lunatics Act was passed under which all those acquitted on the grounds of insanity, or insane when arrested, could be ordered to be detained in custody ‘until His Majesty’s pleasure be known’. Most criminal lunatics then went to a prison or a County Asylum. Mentally disordered patients were unwelcome in prisons and similarly offenders were unwanted in mental hospitals. In 1860 a Committee of the House of Commons reported: ‘To mix criminal lunatics with other patients is a serious evil. It is detrimental to other patients as well as themselves’.

Central to any study of the history of law and psychiatry is the insanity defence, which did not in itself occasion much medical attention before the end of the eighteenth century. Nevertheless, the evolution of the defence of insanity can be traced from the thirteenth century onwards and indeed may even go back to Roman law. The insanity defence ‘refers to that branch of the concept of insanity which defines the extent to which men accused of crimes may be relieved of criminal responsibility by virtue of mental disease’. Because of its inherent complexities, it is the practice of trial judges to explain to the jury the precise terms of this defence during summing up. In an historical sense, once an offender’s mental state became a matter for consideration during his trial, provision had to be found for those whose criminal liability was called into question. These, in short, were the mentally ill.

Several cases in the 19th century show the differences of view of the legal and medical profession. They also show the changes in the way that mentally ill criminals were dealt with. These varied from capital (?) punishment to incarceration in a mental hospital. Hadfield, who endeavoured to murder King George the Third, was mentally ill and this was associated with, or had been precipitated by, severe brain damage sustained during service in Flanders as one of the Duke of York's bodyguard. There was abundant evidence given at his trial that Hadfield was subject to outbursts of terrifying madness, during one of which he had threatened the life of his own child because he said he had been commanded by God to do so. He entertained the bizarre delusion that, although he must die to save the world, he must not die by his own hand. He decided to assassinate the King to guarantee his own demise. On the 15 May, 1800, he attempted to put his plan into effect by firing a pistol at George III as he entered the royal box at Drury Lane Theatre. Hadfield failed to hit his royal target by twelve inches: he was immediately disarmed by bystanders and arrested.

The charge brought against Hadfield was that of treason and he was brought to trial six weeks after the event. He was provided with counsel for his defence and Thomas Erskine, often described as 'the brightest ornament of which the English bar can boast', took the case. The defence was masterly. He called a number of lay witnesses to testify to Hadfield's madness, and as a medical witness, called Dr Crichton (Creighton, as his name is spelt in the transcript of the trial) of Bethlem Hospital who had examined Hadfield at Newgate the night before the trial began. So convincing was Erskine's defence that the Lord Chief Justice stopped the trial and directed the jury to find

Hadfield ‘Not Guilty: he being under the influence of Insanity at the time the act was committed’.

The verdict caused difficulties. Hadfield obviously posed a threat to himself, to his family, and possibly to the King, so that it was imperative for him to be detained, in spite of the fact that his detention would be illegal. Legislation was passed in great haste and made retrospective. It provided that if ‘any Person, charged with Treason, Murder, Felony’ was found to have been ‘insane at the Time of the Commission of such Offence’ and hence acquitted, the Court shall ‘... order such Persons to be kept in strict custody, in such Place and in such Manner as to the Court shall seem fit, until His Majesty’s Pleasure shall be known.’ Hadfield was committed Bethlem Hospital, where he died in 1841.

Hadfield’s case provided for a special verdict, ‘Not guilty, he being under the influence of Insanity at the time the act was committed’. It created a new category of offenders, namely criminal lunatics – a wholly undesirable term – and it caused an immediate change in the law so as to oblige the Court, when a person was found insane, to order his safe custody in some suitable place ‘until His Majesty’s Pleasure shall be known’.

Broadmoor was built, opening in 1863 with transfer from local prisons, Bethlem and other asylums. Rampton opened in 1912, initially for those from the North of England. Soon after it became the State Institution for Mental Defectives. Moss Side (now Ackworth) opened in 1933 when Rampton overflowed. The special hospitals were originally governed by the Home Office, and the attendants joined the only available

Trades Union at the time. For these historical reasons the Nurses remained members of the Prison Officers' Association. Although since 1947 the special hospitals have become the responsibility of the Health Department, this may account for the perception that Broadmoor is a type of Prison Hospital.

LAW AND PSYCHIATRY

During the 19th century, the interface between the law and psychiatry was an area of considerable friction between lawyers, journalists, and the public on the one hand, and asylum doctors on the other. Medico-legal concerns which frequently surfaced in presidential addresses (M.P.A. and R.M.P.A.) were: issues of wrongful confinement, procedures of certification, and the lack of conformity between doctors and lawyers in the legal definition of insanity, particularly in relation to the insanity plea and the boundary between mental illness and criminal responsibility. Kirkman protested against 'hazy legislation' in the area of the lunacy laws, 'which would hazardously interfere in purely medical questions and encroach upon the full prerogative of medical men to judge of mental sanity,' Laycock expressed the general feeling of asylum doctors about their vulnerable position when he declared that:

'Whether you restrain the personal freedom of the insane in the interests of society, or plead for a kindly and charitable consideration of them in the interests of justice and mercy, you are held to be equally in the wrong.'

Edward Oxford attempted to murder Queen Victoria. He was a young man of 18 years when the offence occurred in 1840. He knew what he was doing, and as the law stood at the time, this could have been sufficient to result in the death penalty. Indeed, he described in his notebooks how he was to be the instrument of a plot of an imaginary secret society, and to this end, had purchased the pistols and had practised with them.

When he came to trial in 1840 he excited a degree of compassion because of his youth and the pointlessness of the attack, made more so by doubts as to whether or not the pistols were loaded. Chief Justice Denman allowed evidence in abundance in support of the pleas of insanity. Lay witnesses testified to the abnormal behaviour of Oxford's forebears, and a number of distinguished medical witnesses lent their support. Because of, or in spite of the medical evidence, the defence succeeded and a verdict of 'guilty but insane' was returned by the jury; this verdict was then incorporated in the Act of 1800, passed to deal with the case of Hadfield. Oxford was admitted to Bethlem where he prospered. Any evidence of insanity that he might have manifested evaporated and never returned. Any suspicion that he was of doubtful intelligence was vitiated by the fact that he became an accomplished linguist and learned to play the violin. He also showed a distinct aptitude for chess and draughts. Oxford was one of the early transfers to Broadmoor after it opened in 1863, and in 1868 he was discreetly released with the proviso that he emigrated; it is alleged that he changed his name to Cambridge.

The case of McNaughten (1843), succeeded in transforming the legal concept of insanity in criminal cases. What had been brought home in the cases of Hadfield and McNaughten was the malignancy of paranoid delusions. These mental phenomena, they demonstrated, could be powerful and compelling and could affect the behaviour of those subject to them dramatically, and even disastrously.

The narrowest definition defining the limits within which mental incapacity undermines responsibility is embodied in the McNaughten Rules. A person is responsible for their actions when they are 'labouring under such a defect of reason, from disease of the

mind, as not to know the nature and quality of the act they were doing, or if they did know it did not know that it was wrong’.

This is a test of responsibility. Its strength and weakness are derived from its intellectualist nature. Intellectual understanding of the nature of one’s actions and intellectual grasp of the accepted meaning of right and wrong. It provides a commonsensical definition of the minimum group about whose inclusion in the category of not-responsible there can be no dispute. It has been much criticised as being unduly exclusive. No one could suggest that it includes any who ought to be counted as sane.

The intellectualist quality of the McNaughten formula is a model of clarity and precision though there has been much argument attempting to stretch the formula to cover other than purely intellectual disorder (for example the idea of ‘irresistible impulse’). The meaning attached to the words ‘right and wrong’ can also be held to mean ‘consonant with, or contrary to, the law’ which has the virtue of clarity.

Intellectual insufficiency can be tested by criteria external to the action which it is invoked to excuse. Insanity should be inferred from aspects of behaviour before and afterwards and the capacity to understand things that have nothing to do with his offence. This could avoid the circular argument that the offender ‘must have been made to do such a thing’.

A departure from the M'Naughten formula is the concept of motiveless behaviour. Anyone who knows what he is doing and knows it to be wrong but who has no intelligible motive for his action must be mentally sick, the sickness lies in the absence or irrationality of motive. The 'compulsive crime' label can be used when neither the subject nor anyone else is able to account for the behaviour.

The influence of a 'historic' trial on the fate of disordered offenders has been exaggerated. They had just as much chance of a favourable verdict in the half-century *before* Hadfield's case as after it. In the *middle* of the 18th century there was an increase in the number of successful insanity defences. As for M'Naughten, Nigel Walker considered that much of what had been written about his case was as irrelevant as the way he spelled his name. The question is whether the M'Naughten Rules really represented the common law of the time. Fitzjames Stephen, that Victorian expert on the criminal law, thought not.

Sir Charles Hastings (1859) admitted that the connection between crime and insanity was intricate to unravel, that knowledge on the subject was imperfect, and that there were sometimes ambiguities in the medical testimony in such cases, which led the public to place less reliance on medical evidence than it deserved. Sir James Coxe (1872) succinctly summed up the dilemma, as seen by most asylum doctors:

'It is a matter of extreme difficulty to determine where sanity ends and insanity begins; and it is remarkable that, although it is generally considered to be the duty of the physician to fix that point, it is, nevertheless, the lawyer who decides the question whenever anything more than the mere liberty of the patient is involved. In fact, the lawyer then sits in judgement on the physician, and determines, or directs the jury to determine, whether the acts of the patient, as observed and reported by the physician, afford proof of sanity or insanity.'

Rogers (1874) concurred: ‘the diagnosis and definition of insanity, instead of being treated as a purely medical question, has been a sort of battle field, or at least neutral ground, between the lawyers and doctors’. (Strictly it is the jury that decides *mens rea* in a trial.)

Skae (1863) advocated that members of the Medico-Psychological Association should use all their energies and influence to bring about a revision of the law regarding insanity, so as to get the distinctions and definitions of lawyers in conformity with theirs, that is, ‘in conformity with nature and facts’. Rogers (1874) agreed: ‘It is time that we made an effort to claim for the profession of medicine the right to determine what does and what does not constitute insanity, whilst we leave to the lawyers the legal questions affecting the insane’. Sankey (1868) also proposed that doctors should be exempt from cross-examination in the witness box because: ‘It is well known . . . that the whole process of cross-examination is mere trickery, a carefully laid pitfall; it cannot elicit truth, and is as often intended to confound it’. Similar sentiments were expressed almost 20 years later by Needham (1887), who suggested that part of the explanation for the continuing low esteem of asylum doctors was that in court they were frequently ‘brow-beaten by opposing counsel and depreciated by the bench and juries’.

The final example of the disagreements between the Judiciary and psychiatrists comes from the *Journal of Mental Science* in 1888:

‘Now comes the extraordinary feature of the case from the judicial point of view. MrJustice Field, in addition to treating the medical witnesses with studious rudeness, refused to receive their opinion as to the sanity of the prisoner. When DrNeedham had given his evidence and expressed an opinion that he was insane, his lordship said he was determined not to allow a medical gentleman, however eminent, to

be substituted for the jury. Again, when the gaol surgeon was asked whether he formed any opinion as to what the prisoner was suffering from, and he replied that when first brought in he thought he was imbecile, the Judge objected 'that is answering the question that I did not wish you to answer'. When counsel asked whether he might inquire whether the prisoner was suffering from disease, his lordship replied, 'Bodily, Yes; mentally, No'. When MrBucknill suggested that the opinion of a medical man regarding the prisoner's state of mind now might assist the jury in arriving at a conclusion as to his state when the act was committed, MrJustice Field said, 'I shall rule clearly not. The jury see what his conduct and appearance are and have been. I don't see that the opinion of a medical gentleman carries it a bit further. *He could no more dive into a man's state of mind than I can*'. (*Journal of Mental Science*, **34**, April 1888)

There was also frustration at the complete lack of autonomy afforded to asylum doctors as medical witnesses in the court-room, which appeared to confirm their inferior status compared with doctors in other branches of medicine (Smith, 1981).

The threat of wrongful confinement was an abiding Victorian fear and was the subject of novels such as *Hard Cash*, written by Charles Reade, a friend and collaborator of Charles Dickens, and published in 1863. Most cases of alleged wrongful confinement involved the affluent, and critics therefore tended to concentrate their attacks on private asylums and doctors, whereas public asylums were frequently ignored (McCandless, 1981). A number of presidents (Hastings, 1859; Bucknill, 1860; Munro, 1864; Wood, 1865; Rogers, 1874; Fielding Blandford, 1877; Crichton-Browne, 1878; and Lush, 1879) attempted to allay this public fear by denying that wrongful confinement was common. Wood (1865) also complained that public suspicion about the motives of asylum doctors often resulted in their reluctance to diagnose and treat patients showing early signs of mental illness, to the detriment of the patients and also their families.

Although the number of such cases was relatively small, perhaps the greatest medico-legal concern of asylum doctors in the second half of the 19th century was the question

of crime in relation to insanity. As Smith (1981) has described, the newly emerging psychiatric profession was at a considerable disadvantage in a court-room, compared with lawyers, when dealing with the issue of criminal responsibility. Asylum doctors had no agreed conceptual framework for the diagnosis and classification of mental illness and were unable to demonstrate any underlying physical basis to the conditions which they described in court. They were thus open to the accusation of being biased in favour of diagnosing mental illness when it did not exist, and also of being deceived by simulation. Also, public court-room disagreements between asylum doctors on whether or not mental illness was present in the accused inevitably undermined the credibility of these 'expert' witnesses. The language and milieu of the court-room was that of the lawyer and not the doctor, and asylum doctors consequently had considerable difficulty in communicating their ideas in this formidable setting. Finally, few doctors had sufficient training and experience to cope with counsel's incisive cross-examination of their evidence. Any rejection of individual medico-psychological evidence also had the unfortunate effect of appearing to undermine asylum doctors' professional expertise in other areas of mental illness.

In 1883 Dr W. Orange, who was the second Medical Superintendent of Broadmoor Hospital (having been Deputy Superintendent since it opened in 1863) became President of the Medico-Psychological Association and discussed some of these problems in his Presidential Lecture to the Association. He considered that under the term 'criminal lunatic' two very different classes of persons were comprised. One class consisted of those who had been found insane while awaiting trial or when arraigned or when tried; the other, of those certified insane whilst undergoing penal servitude in

convict prisons. The former class consisted mainly of persons whose offences had been the direct result of their insane state and who might have previously led honest lives. In the latter class were chiefly habitual criminals, whose offences were part of their everyday life. Dr Orange's experience had convinced him that the arrangements suitable for the former class was not suitable for 'insane convicts'. The unrestricted association led to the corruption of the younger by the older inmates. He concluded that special arrangements should be made for this group and that they should be separated from those who were detained 'during Her Majesty's pleasure'.

Dr Orange gave an example of the sort of problem that could arise from differences of opinion of this sort. He drew attention to a 'rather startling statement which the Commissioners in Lunacy had made in their last Report about a patient who made a fatal attack upon [their colleague] MrLutwidge in Fisherton House Asylum [now the Old Manor, Salisbury]. This patient had been in confinement since 1846. When he was put on trial Dr Finch [of Fisherton House] deposed that he was labouring under chronic mania with delusions; the Lord Chief Baron said it was useless to go on with the case, and the jury returned a verdict of 'not guilty, on the ground of insanity'. Nevertheless, the Commissioners expressed their opinion that the man 'was quite responsible for his actions'. Dr Orange presumed that they were of the opinion that the man ought to have been hanged. He could not help thinking that to treat a lunatic who had been nearly thirty years in confinement as a responsible agent would be startling and revolutionary. If such a lunatic attacked an attendant and the attendant punished him 'we should have to hold the attendant excused or indeed justified'. 'Medical Superintendents would have an anxious difficulty if they were to treat patients according to the supposed degree of

their responsibility, unless they could obtain from the Commissioners at their visits a positive opinion as to the degree of responsibility of each one of the 60,000 lunatics whom they visit in the year’.

Dr Orange discussed the term criminal lunatics.

‘The name appears, at first sight, to imply a contradiction of terms, inasmuch as a person who is a lunatic may be said to be incapable of committing what, in the strictest sense of the word, can be called a crime. But, in spite of this seeming inconsistency, the term has been in use for the last eighty years, and it appears likely to continue to be used, because it is, after all, really descriptive of the class of persons to whom it is applied; inasmuch as every criminal lunatic, of whatever class, has not only been charged before a court of law with the commission of some crime, but is actually in custody, so long as he remains in the class of criminal lunatics, on account of such crime – the nature of the crime, and the circumstances of its commission, determining whether the person ever enters the class of criminal lunatics or not. If the crime is not grave, the person accused is generally handed over to the parish authorities or to friends, to be dealt with in accordance with the provisions of the general lunacy laws; but if, on the other hand, the crime is grave, or if the circumstances of its commission are such as to give reason for believing that society would be insufficiently protected by trusting to the operation of the general lunacy laws, then the individual passes on into the class of “criminal lunatics” and becomes subject to special statutes.

Insanity and crime may be combined in an infinite variety of proportions; and if the term ‘criminal lunatic’ were expanded so as to be made to include, on the one hand, all insane persons who had ever committed any act contrary to law, and, on the other hand, every criminal whose mental organization falls short of an ideal standard of perfection, it might be, in that way, made to embrace a very large proportion of the inmates of the lunatic asylums and also of the prisons of the country.

But it is a term which, though useful, cannot claim for itself mathematical precision, and the intention is that no person who has committed a crime shall become a criminal lunatic unless, having regard to the nature of the crime, the protection of the community requires this to be done; and also, that no criminal whose mental organization is imperfect shall be included, unless the defect or derangement of mind be of such an extent or degree as to prevent the application of the penal code from being efficacious; or, in other words, such as to render the person an unfit subject for penal discipline.

In a more ideal state of society than that which now exists, the class of criminal lunatics would disappear, because no one would be sentenced to punishment without his mental state being ascertained before sentence, instead of, as now so generally happens, afterwards; and, furthermore, because persons known to be insane would then be placed under proper control before, and not, as now, after they have committed some alarming act of homicide or violence.

But we are far from this ideal state, and, therefore, it happens that the number of insane persons who are left to enjoy, as it is termed, their freedom, until they have done some terrible deed, is large; and society is thus constantly being called upon to consider in what way it shall cover its own sins of omission.

In the year 1800, the trial of Hadfield for firing at George III, in Drury Lane Theatre, produced a definite amendment both with regard to law and practice. Hadfield had been gravely wounded in the battle of Lincelles – and had given unmistakable proof of serious mental derangement long before the commission of the act for which he was tried. The evidence of his insanity, and of the connection existing between his mental derangement and his attempt upon the life of the King, was conclusive, but then the question arose as to what was to be done with him. The presiding judge, Lord Kenyon, made use of the following words, which have served as a guide for the proper treatment of persons similarly situated. He said: ‘For his own sake, and for the sake of society at large, he must not be discharged, for this is a case which concerns every man of every station, from the King upon the throne to the beggar at the gate; people of both sexes and of all ages may, in an unfortunate frantic hour, fall a sacrifice to this man, who is not under the guidance of sound reason, and, therefore, it is absolutely necessary for the safety of society that he should be properly disposed of, all mercy and humanity being shown to the unfortunate creature; but, for the sake of the community, he must somehow or other be taken care of with all the attention and relief that can be afforded him.

The immediate result of the trial and acquittal, on the ground of insanity, of Hadfield, was the passing of the “Insane Offenders Bill,” which became law on the 28th July 1800. This was an Act which made provision for the detention of insane offenders, acquitted on the ground of insanity, or found insane on arraignment, for whatever length of time might be required by considerations of public safety. This statute, however, only applied to persons charged with offences classed as treason, murder and felony; and it was not until forty years later that, owing to the beneficial results of the former statute, similar provisions were applied to persons charged with misdemeanours.

As early as 1807, MrWynne, who did much in his day to improve the treatment of the insane, obtained a Select Committee to inquire into the state of criminal and pauper lunatics; and this was the first appearance of the term “criminal lunatic” in official documents. This report stated that, from the time of the passing of the Act in 1800, the number of persons detained under its provisions was 37, and the report went on to recommend that a building should be erected for the separate confinement of these persons, and of others who might in future come under the provisions of that Act for offences committed during a state of insanity.’

Dr Orange whose Presidential address covered Forensic Psychiatry and the building of Broadmoor as a Criminal Lunatic Asylum had taken patients from the Bethlem Hospital who had been there ‘during His Majesty’s pleasure’.

There was a long tradition of trying out controversial things in Ireland and Scotland before using them in England. An earlier Criminal Lunatic Asylum was the “Central Mental Hospital” in Dublin which first accepted patients in 1850. This may be why it was considered more urgent to open a high security hospital in Ireland before constructing Broadmoor. Debates at annual general meetings of the Association stressed how successful it was, underlining the need for a similar establishment in England. In the 1980’s Dr Charles Smith, its Medical Director, noted that in Dublin its patients were separated into two broad groups. The first was ‘predominantly ill’ and secondarily dangerous and needed strenuous treatment responses with less emphasis on accompanying security. With the illness under control dangerousness should recede and ordinary progression towards community care would be earlier achievable.

The second group was ‘predominantly dangerous and criminal’. While psychotic illness might be present, and often paranoid in content, nevertheless the main threat derived from well established abnormal behaviour patterns which were basically anti-social. This group needed surrounding security as a priority when treatment was attended. There is little difference between the views of Dr Smith and Dr Orange a century earlier.

Little has changed in the 21st century. A White Paper and draft reform of the Mental Health Act suggested a new legal framework for the compulsory treatment of people with mental disorder in hospitals and in the community. The White Paper had an overriding emphasis as public safety with a suggested new category of patients, ‘dangerous people with severe personality disorder’.

The best predictions of violence are: mental state; stated intentions; provoking circumstances. In retrospect violent people have often been violent before, but there needs to be an awareness of new violence in a population. As well as this, violent people can stop being violent. While some extreme violence, such as murder, committed by schizophrenic patients comes out of the blue it can be the culmination of several or many violent episodes, which have been ignored by the law for two reasons. It is increasingly difficult to get the Police to take any note of a mentally ill patient, short of actual murder. Their main goal now is to reach targets and they may believe that they are not entitled to charge a patient who has committed a violent crime 'because he is mad'. A man unfit for trial cannot be prosecuted.

Although it is rare, some psychiatrists and psychiatric nurses deem it part of their duty to protect their patients from the legal consequences of their own actions 'because they are mad rather than bad'. Compassionate carers may not call the police. This may give some patients the dangerous impression of immunity ('you can't touch me, I'm a schizophrenic').

The law has adequate provisions for people with schizophrenia who have committed violent acts and are likely to do so again. If the courts are satisfied that they did the acts of which they are accused, and that they are likely to repeat those acts, it can detain them in hospital 'until such time as the Home Secretary deems that they are safe to be released'.

SCHIZOPHRENIA

Schizophrenia poses an acute dilemma for psychiatrists. They have to decide on the right balance between freedom for their patients and the safety of the public. Sometimes the two are at odds, and the psychiatrist has to act as if he were Solomon. When he gets it wrong, he is decried as a fool; when he gets it right, no one notices. Patients with schizophrenia can suffer hallucinations, often voices insulting or threatening them, and delusions, often of a persecutory nature. As a result of these, they sometimes lash out, and even kill people for reasons which are completely mysterious to people who know nothing of their hallucinations or delusions. Patients with schizophrenia who respond well to treatment and are released from hospital may cease to take their medication and also may misuse alcohol, cannabis and other drugs which may lead to dangerous relapses in their condition, and sometimes stimulates a profound paranoia.

While they believe that alcohol, sedatives, and cannabis calm them down, in fact they can sometimes become dangerously aggressive. This provision may be less frequently invoked nowadays. Doctors don't like to mention it to the court, because to do so makes them sound punitive rather than therapeutic and it is easier to overestimate a person's dangerousness than to underestimate it. By recommending the implementation of this they may condemn a patient to several years' detention in a psychiatric ward, perhaps unnecessarily.

There is also a gross shortage of psychiatric beds in the National Health Service. Successive government ministers, aided by administrators who follow government instructions have reduced the number of psychiatric beds to such an extent that each

admission can create a crisis for the system as a whole. Occasionally no bed is available in a radius of a hundred miles of a major British city. In these circumstances, doctors tailor their recommendations to what is available, not to what is necessary both for the welfare of the patient and the safety of society.

The last thing they want is to have a patient who will occupy one of their scarce beds for three or four years to come. Such a patient will only add to their daily difficulties in finding beds for their patients who need them.

The dilemma of how best to deal with mentally disordered people who commit crimes and criminals with mental disorders remains unresolved today. A recent report on secure psychiatric services made 50 general recommendations. Three-quarters of them related to procedural security issues and one quarter to physical security including enhanced perimeter security, magnetic locking systems, increased staffing levels in the security departments and having dedicated search teams (making the hospital more of a prison). Security however needs: sufficient physical security appropriate to the patient; high staff ratios; and a therapeutic policy which encompasses individual programmes. The most effective forms of security and safety lies in the treatment of the patient. The 21st century appears to be starting with greater fears of the mentally ill and programmes to incarcerate more of them in more secure units.

In the 200 years covered in this book the most striking changes in public attitudes and public policy towards social deviants were those due to a growing influence of medical and in particular of psychiatric concepts. In the 18th Century no clear distinction was

clear between the mentally afflicted and the criminal. Lunatics were treated more or less as criminals. In the mid-19th century there was a realisation that insanity, feeble mindedness and criminality were conditions between which it was well to make a clear distinction and that the practical approach to which should be governed by separate and distinct principles.

Segregation of these three groups made the problems peculiar to each group stand out in such a way as to demand attention. It is difficult to appreciate the magnitude of the change that has occurred.

The doctor's professional responsibility is for the health, not for the morals, of his patient. The consulting room has no place for the principles of retribution and revenge which have played so large a part in the evolution of penal codes. The impact of psychiatric concepts upon the treatment of offenders and of other social deviants has been in overwhelming degree a humanizing influence. Psychiatry and humanitarianism have marched hand in hand. The medical treatment of social deviants has been a most powerful, perhaps even the most powerful, reinforcement of humanitarian impulses. The prestige of humane proposals is enhanced if they are expressed in the idiom of medical science. (Even if the intellectual foundations of current psychiatry were proved to be wholly unsound, and even if psychiatric 'science' was exposed as nothing more than fantasy we should be grateful for the results of so beneficent a delusion.)

Whatever may be thought of the scientific pretensions of psychiatry, there can be no question as to its humanizing effects upon the treatment of socially refractory persons

and particularly of offenders against the criminal law. This humanizing influence is a good in itself. Humane reformatory measures are morally admirable though there may be uncertainty about their effectiveness. Further developments of humane methods of treatment should be further developed. Clear evidence that reformatory measures, whether punishment or treatment, do in fact reform and would be very welcome. Experience of harsh treatment may harden a person's character in an anti-social mould.

THE FACULTY OF FORENSIC MEDICINE

Forensic psychiatry has a long history. In 1841 (the year the Association was founded) a leading article in *The Lancet* drew attention to "one of the most difficult questions in jurisprudence or in morals...the difficulty of determining the precise lines of demarcation between the extremes of bad temper, fanaticism and the commencement of actual insanity."

In 1843 the case of Daniel McNaughten, who attempted to kill the then Prime Minister, but killed his private secretary instead, led to acquittal with a defence of insanity. In reaction the 'McNaughten rules' developed which stated that for a successful defence of insanity it must be clearly proved that 'at the time of committing the act the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know what he was doing was wrong'. One consequence was that it became virtually impossible for the law of England to develop or to accept the concept of diminished responsibility (which was accepted in Scotland from 1867) until the Homicide Act of 1957, which then included the possibility of 'irresistible impulse'.

A criminal lunatic asylum was opened in Dublin in 1845 for Ireland and at Broadmoor for England in 1863. Forensic psychiatrists were initially those who worked in these special hospitals and those who were called in as experts, such as Henry Maudsley and Benignus Forbes Winslow, to help the courts decide on responsibility in difficult and serious criminal cases. A forensic psychiatrist was no longer simply a specialist (a 'mad doctor' or an 'alienist') but a doctor who needed to be familiar with the principles of the Criminal Law, the functioning of its multifarious agencies, the reasoning of sentences, and the reactions of society. Senior psychiatrists also advised the Home Secretary after conviction especially about capital crimes, until such punishment was abolished.

The M.P.A. and the R.M.P.A. later were regularly concerned with medico-legal issues which frequently surfaced in Presidential addresses. These included: issues of wrongful confinement, procedures of certification, and the lack of conformity between doctors and lawyers in the legal definition of insanity, particularly in relation to the insanity plea and the boundary between mental illness and criminal responsibility. With the introduction of the Mental Health Acts 1959 and 1960 which allowed detention of a mentally disordered person in hospital and detention with restrictions on discharge, the R.M.P.A. began to form a specialist group to discuss these issues together and to formulate the policy of the Association to Ministers and others. There was no formal Forensic Psychiatry Section in England although the Scottish Division had a Forensic Psychiatry Section. In 1961 in England and Wales an informal group of senior medical superintendents and deputy superintendents began to meet to discuss forensic psychiatry matters, with membership by invitation. In addition the Research and Clinical

Committee of the R.M.P.A. had a sub-committee on Forensic Psychiatry. When the R.M.P.A. became the Royal College of Psychiatrists at its first General Meeting it was proposed and agreed that a Forensic Section should be established. The news supplement of the College Journal in April 1973 published the names of the first officers and executive committee of the (then) four Specialist Sections all elected by ballot: the first Chairman of the Forensic Psychiatry Specialist Section was Dr P.G. McGrath of Broadmoor Hospital and the Secretary was Dr R. Bluglass; the executive committee members included Dr M. Faulk, Professor T.C.N. Gibbens, Dr J. Gunn, Dr J. Harper, Dr I. Pierce James, Dr D.J. Power, Dr P.D. Scott, Dr D.O. Topp, Dr K.R.H. Wardrop, Dr W.A. Weston and Dr P.B. Whatmore. This membership included representatives from the prisons, the Home Office, Scotland, and universities.

The business of the section during its first months was mainly concerned with preparing evidence to the Butler Committee on Mentally Abnormal Offenders and to the Aarvold Committee (about the release of serious offenders from hospital) which were set up by the Government to deal with the overcrowding crisis in the special hospitals and the aftermath of the conviction of Graham Young (who following discharge from Broadmoor into the community committed further murders). It was also preoccupied with representatives of other groups in preparing the College's policy for a new Mental Health Act.

In the early days forensic psychiatrists were defined by the new appointments established by the Department of Health and Social Security and the Home Office (joint appointments), and those few distinguished colleagues who had become established

forensic psychiatrists by reason of their special interests. As more forensic psychiatrists were trained, senior registrar posts were established, more joint appointments were made and forensic psychiatry became a necessary part of a psychiatrist's training, so the Section began to enlarge. Among topics to which initially a relatively small body of individuals in the Section gave their attention were preparing evidence for inquiries on the law on rape, sex offences, the prison service, incest and mental health law. Later the topics included the role of the special hospitals, funding of secure units, the criminal justice system and the prison medical service and the review of services for mentally disordered offenders in 1992. There have been contributions to inquiries concerning Rampton, Broadmoor and Ashworth Hospitals and to other inquiries. Representatives of the Section gave evidence to select committees and to inquiries.

The first residential meeting was held at Castle Priory, at Wallingford when Professor Sir Denis Hill, Lord Justice Frederick Lawton and Professor Nigel Walker were among the speakers at the first Annual Dinner. As the Section grew in size more space was required and for seven years meetings were held at the Alveston Manor Hotel at Stratford upon Avon. The Annual Meeting then moved to York and later to more suitable and bigger venues in different parts of the United Kingdom and Ireland as the membership grew. Initially it was a meeting of a small group but the membership is now at least 400. When regional (medium) secure units began to be planned and the problems of establishing them became a preoccupation, an informal group of regional secure unit consultants was established to exchange experiences and make representations. This group continued to meet for some years and till the unit was established. They met at the same time as the annual meeting. The interests of the

Faculty broadened as the first 30 years widened from an initial concern with legal and administrative topics to a more extensive range of interests in forensic psychotherapy, psychological therapies, management and research. The number of academic departments in the UK increased from the first at the Institute of Psychiatry to some half a dozen and this has had an important influence on the work of the Section and the quality of its academic and educational contributions within the College.

In 1997, along with the other main Sections of the College, the Forensic Section became a Faculty with increased opportunities to develop its activities and oversee training standards. A Mental Health Law Committee took on scrutiny of the increasing legislative issues which affect the mentally ill and an Ethics Committee was established concerned with other matters which once would have been taken on by the forensic section.

References

Online archive 17 James Hadfield (not guilty by reason of insanity)

Online archive 18 Law and insanity

Online archive 19 The M'Naughten Rules

Beveridge, A. (1998) Psychology of Compulsory Detention. *Psychiatric Bulletin*, **22**, 115–117.

Exworthy, T. & Gunn, J. (2003) Taking another tilt at High Security Hospitals. *British Journal of Psychiatry*, **182**, 469–471.

Gunn, J. & Taylor P. (1993) *Forensic Psychiatry*. Butterworth Heinemann

Renouise, E. The Association of Medical Officers and Asylums and Hospitals for the Insane. The Medico-Psychological Association and their Presidents. In *150 Years of British Psychiatry, Vol.1 1841-1991* (ed. G.E. Berrios & H. Freeman), pp. 29 – 78. Gaskell.

Rollin, H. (1996) Forensic Psychiatry in England: a Retrospective. In *150 Years of British Psychiatry (The Aftermath)* (ed. H. Freeman & G.E. Berrios). Athlone.

Walk, A.A. (1977) What we thought about it all. In *Daniel McNaughten, His Trial and the Aftermath* (ed. D.J. West & A. Walk), pp. 113–128. Gaskell.

Walker, N. (1990) Foreword. In *Principles and Practice of Forensic Psychiatry* (ed. R. Bluglass & P. Bowden). Churchill Livingstone.