

## ARTICLE

# The interface between general and forensic psychiatry: a historical perspective<sup>†</sup>

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## SUMMARY

Mental disorder and criminality are separate entities but some people with a mental disorder commit criminal offences and some criminals have a mental disorder. Before 1800 there was no separate category of mentally disordered offenders (referred to as criminal lunatics until 1948) in UK legislation. The provision of facilities for mentally disordered offenders in Britain and Ireland overlapped with, but was also separate from, provision for the mentally ill generally. The interface between general and forensic psychiatry is an area of tension and of collaboration. To understand how contemporary general and forensic psychiatry interact, it is useful to have an understanding of how factors have evolved over time.

## LEARNING OBJECTIVES

- Have an understanding of the evolution of general and forensic psychiatry in the UK over the past 200 years.
- Comprehend the similarities and differences between general and forensic psychiatry.
- Be aware of some of the roots of conflict between general and forensic psychiatry.

## DECLARATION OF INTEREST

None.

Seen in this broader context, the interface between general and forensic psychiatry is unexceptional. It is, however, characterised by both collaboration and tension. Who exactly are forensic patients? Is it appropriate that forensic services consume a disproportionately high proportion of the mental health budget (Goldberg 2006)? Why is a separate subspecialty of forensic psychiatry needed? Was it ever thus or is the tension between general and forensic psychiatry a more recent product of the social preoccupation with risk? Pursued further, why are psychiatrists required when physicians could tend to mind and body, which are supposedly indivisible? How have these divergences of perspective arisen (O'Grady 2008; Turner 2008)?

## More remote developments

Taking a historical perspective, how far back in time can we go? Presumably there were 'mentally disordered offenders' in the Stone Age, although of course there is no record of this. Evolutionary theory would no doubt point to clues in our pre-human ancestry of our socialised and antisocial behaviour (Stevens 2000). Almost 2000 years ago, Roman law regarded a mentally ill man who had killed his mother in an insane state as requiring restraint if necessary but not punishment (Spruitt 1998). The criminologist Nigel Walker has traced back reference to insane offenders in England at least 1000 years, to Norman times (Walker 1968). Whether the offender was an 'idiot' or a 'madman' was at that time a matter of local knowledge rather than medical expertise.

Henry de Bracton in the 13th century was the first medieval jurist to comment on the legal aspects of insanity. It was the family who had the task of caring for an offender and, if unable to do so, some other place of safety such as a church or a gaol would be found. Sir Matthew Hale (1552–1634), Lord Chief Justice of England, wrote on the defects of idiocy and lunacy in relation to criminal offences and punishment. Sir William Blackstone (1723–1780), Professor of Law at the

The complexity of psychiatry (and of medicine in general) leads to interfaces between different spheres of practice. There are no natural boundaries at these interfaces. Reaching 18 years of age does not correspond with neurodevelopmental maturation. The age at which we become elderly cannot be accurately drawn at 65 years. Substance misuse may occur with any other mental disorder. The treatment of mental disorders often involves a variety of methods, biological, psychological and social. Psychiatry is firmly embedded in medical practice, reflecting the unitary nature of mind and body. Medicine and psychiatry themselves have an interface with the statistical parameters of normality within human society.

<sup>†</sup>See pp. 359–365, this issue

University of Oxford, offered further analysis of the criminal responsibility of lunatics. All these legal authorities felt that insane offenders lacked guilt for their criminal behaviour if they were deficient of reason and that the lack of reason was total rather than partial (Hunter 1963). In practice, however, decisions by juries on insane defendants were often more nuanced and affected by individual circumstances.

By the end of the 18th century, insane offenders acquitted by a court might have faced varying outcomes. If from a wealthy family, they might have been committed to the care of relatives. In other cases, if violent they might have been sent to the local gaol or houses of correction such as the Bridewell in London. Between 1750 and 1780 some 20 patients were admitted to the Bethlem, the oldest lunatic asylum in England, having committed a murder (Black 1811). In September 1796, Mary Lamb stabbed and killed her mother and injured her father. A coroner's court deemed her insane and her brother, the novelist Charles Lamb, arranged for her admission to a private madhouse (Arnold 2008). By then the French Revolution had rocked Europe and the Napoleonic Wars that followed formed part of the context for the birth of the new concept of the 'criminal lunatic'.

### The case of James Hadfield, 1800

James Hadfield had been a British soldier who had sustained injuries to the head and body in the wars against France (Walker 1968). His head injuries were such that at trial the jury were able to see the membranes covering the brain. Becoming deluded, melancholic and suicidal, in May 1800 at Drury Lane Theatre in London, he fired a pistol at King George III but the shot missed. Charged with treason, Hadfield was found insane, his defence attorney having established the defendant's insanity on the basis of the presence of delusions and that his criminal act was a product of them. Although the Vagrancy Act 1744 (Box 1) enabled two justices to direct the confinement of a troublesome or dangerous lunatic, the judge in Hadfield's case felt it inadequate as he could have been released on recovery of his senses. As a result, the government rapidly (in July 1800) passed the Act for the Safe Custody of Insane Persons Charged with Offences. Henceforth, certain defendants acquitted on grounds of insanity would be kept in strict custody 'until His Majesty's Pleasure be known'. The 1800 Act was made retrospective to include the case of James Hadfield, a procedure that today would be illegal under the European Convention on Human Rights. The effect of

the 1800 Act was to create the new category of 'criminal lunatic'.

### Facilities for criminal lunatics

At the beginning of the 19th century, concern was expressed regarding the provision of facilities for the detention and treatment of pauper lunatics and the newly created category of criminal lunatics. Sir George Onesiphorus Paul (1746–1820), High Sheriff of Gloucestershire, had played a key role in the reform of prisons in his county. In October 1806, he wrote to the Home Secretary, who established a Select Committee of Parliament to inquire into the state of lunatics in England and Wales. This reported in July 1807 (Hunter 1963). It recommended the building of county and borough asylums, but did not make it compulsory, reflected in the 1808 County Asylums Act for the Better Care and Maintenance of Lunatics, being Paupers or Criminals in England. Paul had pointed out that, since the 1800 Act, some 37 people had been detained at His Majesty's Pleasure but remained confined in county gaols. These included Aaron Bywater, who in 1799 had been acquitted of murder but found insane and confined in Montgomery Gaol, where he killed a fellow prisoner. James Hadfield himself was transferred to Bethlem, but after a few months he knocked over a fellow patient who fell and died. Hadfield escaped after this incident, and on being retaken was returned to Newgate Prison (Russell 1977).

### Criminal wings at the Bethlem

Criminal lunatics were proving to be unsafe both in prison and in the Bethlem and they needed their own special provision. Although a separate State criminal lunatic asylum was proposed, the government preferred to fund two new criminal wings at the Bethlem. These opened in 1816 and provided 45 male and 15 female beds. Hence, the first planned provision in Britain for criminal lunatics was within a mental hospital, albeit in a segregated and separate part of it. The patients were under the care of Bethlem doctors and keepers (later known as attendants and, still later, as nurses) and managed according to regulations stipulated by the Bethlem governors, though admission and discharge were determined by Royal warrant or direction of the Secretary of State.

An enduring difference from the outset was evident between the general patients at the Bethlem and elsewhere and the criminal patients. Pauper lunatics could be discharged once sanity had returned, but discharge of criminal lunatics had to take account of their potential for relapse

**BOX 1 Main mental health legislation involving general or forensic psychiatry**

1744 Vagrancy Act: enabled two justices to confine a dangerous lunatic	1922 Infanticide Act: exempted mothers of newborn from death penalty if suffering from puerperal mental illness
1774 Act for Regulating Private Madhouses: introduced licensing of private madhouses, with inspection and supervision	1927 Mental Deficiency Act: amended 1913 Act to include mental deficiency arising later in life
1800 Act for the Safe Custody of Insane Persons Charged with Offences: created the new category of criminal lunatic, covering those found not guilty by reason of insanity for felonies (serious offences) and those found insane on arraignment (unfit to plead)	1929 Local Government Act: changed 'asylums' to 'mental hospitals'
1808 County Asylums Act for the Better Care and Maintenance of Lunatics, being Paupers or Criminals in England: encouraged building of county asylums	1930 Mental Treatment Act: changed 'lunatics' to 'patients'
1816 Act Amending the 1800 Safe Custody Act: insane sentenced prisoners now included as criminal lunatics and eligible for transfer to asylums	1938 Infanticide Act: amended 1922 Act to include infants up to age of 12 months
1828 County Asylum Act and Madhouse Act: created the Metropolitan Commissioners in Lunacy, who reported to Secretary of State	1946 National Health Service Act: enabled NHS from 1948
1840 Insane Prisoners Act: criminal lunatics now to include those found not guilty of misdemeanours (less serious offences); also, any prisoner found insane during a sentence could be transferred to a lunatic asylum, including those sentenced to death	1948 Criminal Justice Act: changed name of Broadmoor Criminal Lunatic Asylum to Broadmoor Institution; operational from April 1949
1845 Act for the Regulation of the Care and Treatment of Lunatics: created the Commissioners in Lunacy (who covered England and Wales)	1957 Homicide Act: introduced new notion in England of diminished responsibility on basis of mental disorder
1860 Act to Make Better Provision for the Custody and Care of Criminal Lunatics: legal authority for building of Broadmoor Hospital	1959 Mental Health Act: created categories of mental illness, psychopathic disorder, subnormality, severe subnormality; created 'special hospitals', which could accept patients detained on civil orders
1864 Insane Prisoners Amendment Act: 1840 Act amended to ensure that those sentenced to death can be transferred to lunatic asylum only with agreement of doctors appointed by Secretary of State	1964 Criminal Procedure (Insanity) Act: changed wording of 1883 Act from 'guilty but insane' back to 'not guilty by reason of insanity'
1867 Criminal Lunatics Act: provided for transfer of patients from a criminal lunatic asylum to a local asylum	1983 Mental Health Act: introduced psychiatric assessment for prisoners on remand; new regulations on treatability of psychopathic disorder and on detainability for paraphilias
1883 Trial of Lunatics Act: changed the 1800 Act finding of 'not guilty by reason of insanity' to 'guilty but insane'	1991 Criminal Procedure (Insanity and Unfitness to Plead Act): introduced a range of options for disposal of defendants found unfit to plead
1884 Criminal Lunatics Act: consolidation of legislation on criminal lunatics	2004 Domestic Violence, Crime and Victims Act: widened further options for disposal of defendants found 'not guilty by reason of insanity'
1890 Lunacy Act: mental health law focused on legal criteria	2005 Mental Capacity Act: 'offered benefits and protection for people with impaired ability to make decisions'
1913 Mental Deficiency Act: created four classes – idiots, imbeciles, feeble-minded and moral defectives – conditions present since early in life	2007 Mental Health Act: amended 1983 Act and removed the categories of mental disorder added in the 1959 Act
	2009 Coroners and Justice Act: amended law under diminished responsibility

if in the community. The nature of the mental disorder was as relevant as its severity or degree. The longer stays of the criminal group was, and is, underpinned by this difference in emphasis.

The Bethlem criminal wings were probably the first forensic psychiatric facilities in the world. But the government's policy was that the Bethlem would take only the most dangerous criminal lunatics, the remainder being admitted to county and borough asylums. But who qualified as a criminal lunatic evolved over time. The 1800 Act had included those found not guilty by reason of insanity to a charge of a felony and those found insane on arraignment (what later was known as unfit to plead): a group dubbed His Majesty's Pleasure patients. From 1816, the Act also included those found to be insane during a prison sentence and transferred to asylums. In contrast

to His Majesty's Pleasure patients, they were subject to a transfer warrant by the Secretary of State and were referred to as Secretary of State patients. Unlike His Majesty's Pleasure patients, Secretary of State patients could be transferred back to prison if they recovered their sanity. In 1840, a finding of not guilty by reason of insanity could be reached following not only felonies but also less serious misdemeanours.

Both groups were therefore criminal lunatics, but it was the Secretary of State patients who proved more troublesome, probably as their personalities were more antisocial. Many His Majesty's Pleasure patients who had committed a homicide had little, if any, prior criminal record, whereas many Secretary of State patients who had not been convicted of homicide nonetheless had extensive histories of criminality and antisocial

behaviour. They were often unwelcome even in the Bethlem criminal wings. Dr William Hood, Medical Superintendent of Bethlem from 1852, regretted that there were not special units in prisons for insane sentenced prisoners, some of whom he felt had feigned insanity in prison to be transferred out to Bethlem (Hood 1854). But the clinical reality may not in practice have been so simple. In some cases, insanity may have been incubating at the time of the index offence but not yet evident and only manifest itself during the prison sentence. In others, defendants though insane pleaded guilty, preferring a prison sentence to an indefinite admission to an asylum.

### *State criminal lunatic asylums, Broadmoor and Rampton*

The opening of the Bethlem criminal wings did not provide a facility for the admission of all criminal lunatics. Preferable no doubt to a death sentence or perhaps to a sentence of transportation, most His Majesty's Pleasure patients in Bethlem stayed until they died, although a few were discharged. The male criminal wards were therefore usually full, though vacancies were available on the female side. In 1836 the male wing was enlarged by 30 beds and in 1849 the Home Office funded a criminal wing for less dangerous criminal lunatics at Fisherton House, a private licensed house in Wiltshire (O'Donoghue 1914). The role of the private sector has already been noted in the case of Mary Lamb, and its contribution to the treatment of mentally disordered offenders is therefore not a new phenomenon. In 1850 the first separate State criminal lunatic asylum opened in Dundrum, Dublin, Ireland, which paved the way for the opening in England of Broadmoor in 1863 for female and 1864 for male patients (Gordon 2012). In Scotland, a different approach was followed. Asylums there also objected to receiving criminal lunatics (Thompson 1867). From 1846 lunatic wings were established in Perth Prison for insane sentenced prisoners and, in 1857, a criminal lunatic department was opened for those found not guilty by reason of insanity or insane on arraignment (Baird 1984).

With 500 beds at the time, Broadmoor was much larger than the Bethlem provision. However, by the end of the 19th century it was already full and another criminal lunatic asylum was required. In 1906 Parkhurst Prison opened a criminal lunatic wing for insane sentenced prisoners, but this closed in 1912 when Rampton opened as a branch of Broadmoor.

With a new focus on the provision of facilities for the mentally deficient, Rampton

in 1920 became a State institution for mental defectives (Jones 1960).

An interest in mental disorder in prisons was already well established, but from the 1930s a degree of emphasis was placed on treatment in prison, albeit in a context of realism regarding the risk of recidivism. A prominent prison psychiatrist and administrator William Norwood East described how some prisoners were psychopaths who were 'non-sane, non-insane', implying that sanity and insanity were on a continuum rather than there being a distinct boundary between mental disorder and normality (East 1945).

### *From lunatic to patient*

The term 'lunatic' was replaced with 'patient' by the 1930 Mental Treatment Act. The term 'criminal lunatic' was, however, more enduring, the Criminal Justice Act of 1948 replacing it with the confusing term 'Broadmoor patient'. It was confusing as it referred to any insane offender, whether detained in Broadmoor or in a local mental hospital. The 1948 Act also renamed Broadmoor Criminal Lunatic Asylum as Broadmoor Institution. Criminal lunatics no longer officially existed, although the term is still occasionally heard today, albeit misplaced. Broadmoor also ceased to be designated an asylum, but it did not assume as yet the status of mental hospital as had been the case with local asylums since the Local Government Act of 1929. Following the Mental Health Act 1959, Broadmoor became a Special Hospital, along with Rampton and Moss Side, with separate legislation for the State Hospital, Scotland.

### **Criminal lunatics in local asylums**

Legislation in 1828 had created the Metropolitan Commissioners in Lunacy, and their report of 1844 recorded the distribution of criminal lunatics in England and Wales at the beginning of that year (Table 1).

**TABLE 1** Distribution of criminal lunatics in England and Wales in 1844

	Male	Female	Total
County asylums	76	20	96
Bethlem criminal wings	70	20	90
Metropolitan licensed houses	18	6	24
Provincial licensed houses	38	9	47
St Luke's public asylum	0	0	0
Other public asylums	0	0	0
Military and naval asylums	0	0	0
Total	202	55	257

Source: Metropolitan Commissioners in Lunacy (1844).

Notable from the 1844 report is that there were more criminal lunatics in county asylums, albeit distributed around the country, than in the Bethlem criminal wings. Concern was also expressed regarding criminal lunatics in private licensed houses. The report also noted 33 criminal lunatics in gaols, despite the 1807 Parliamentary Select Committee having declared this a danger. The Commissioners noted that the county asylums made frequent complaints about the admission of criminal lunatics, especially those who had committed serious crimes. The county asylums asserted that criminal lunatics were a source of annoyance to pauper lunatics and their relatives, were more prone to feigning insanity and more liable to escape and posed a danger to others; furthermore, the local asylums had no special wards for them and, at a time when mechanical restraint was being abolished, they were harder to manage. Overall, the extra security needed for them led to the asylum becoming more like a prison.

#### *Separating of pauper and criminal lunatics*

By the 1850s there seemed to be a consensus that mixing pauper and criminal lunatics was entirely undesirable. The underlying reason for that view was that local asylums should function as havens of recovery and should not be associated with the vice of criminality, which required stricter custody along the lines of a prison. In 1845 the Commissioners in Lunacy had replaced their Metropolitan predecessors and in 1852 their Chairman, Lord Shaftesbury, rejuvenated the call for a separate State criminal lunatic asylum for England and Wales. Bethlem's new medical superintendent, Dr William Hood, initially opposed the plan, preferring the improvement of Bethlem and retention of the practice of county asylums taking criminal lunatics who had committed minor offences. Dr John Bucknill, an occasional medical superintendent of Devon County Asylum, though offering no praise for the Bethlem criminal wings, nonetheless also felt that the local asylums should continue to accept the less dangerous criminal lunatics. Dr Bucknill stated that he had not noticed any particular problems with the relatively small numbers of criminal lunatics admitted. He noted that there were some pauper lunatics who were dangerous and some criminal lunatics who were relatively harmless. He felt that a State criminal lunatic asylum should take patients who were dangerous, irrespective of their legal status (Bucknill 1851). However, the view in Devon may have been more determined by Dr Bucknill himself, as

when he left the asylum in 1862 antipathy to the admission of criminal lunatics there increased (Melling 1999).

Indeed, serious violence, including homicides, did occur in local asylums, carried out by pauper lunatics. From the opening of Broadmoor in 1863 until the Mental Health Act 1959 took effect in November 1960, 82 male and 11 female patients who had killed in local asylums were subsequently admitted to Broadmoor (Gordon 2012). Many Victorian psychiatrists thought that there was a mental illness known as homicidal insanity (Maudsley 1897), although in fact homicidal urges can occur in patients with various mental disorders. Despite serious risk posed not only by some criminal lunatics, but also by some pauper lunatics, during the passage of the 1860 Act that authorised the building of Broadmoor, it was declared 'an evil' to mix pauper with criminal lunatics.

By the end of the 1860s, two-thirds of all criminal lunatics in England and Wales were in Broadmoor, a proportion much higher than in Bethlem's criminal wings and local asylums (Table 2). Some ambiguity occurred as to whether all criminal lunatics needed to be in a criminal lunatic asylum. A survey by the Commissioners in Lunacy of criminal lunatics in local asylums concluded that criminal lunatics who were less dangerous or for whom family visiting might prove difficult need not be transferred to Broadmoor (Commissioners in Lunacy 1863).

In 1867, further legislation caused much concern for county and borough asylums. The Criminal Lunatics Act 1867 declared that all Secretary of State patients in Broadmoor at the end of their prison sentence would have to be transferred to local asylums if still insane. A criminal lunatic asylum was not for those who were no longer criminals and were now essentially ex-criminal lunatics. Indeed, some psychiatrists referred to Secretary of State patients not as criminal lunatics but as lunatic criminals (Brayn 1901). The end of their prison sentence did not mean the end of their criminal propensities and the local asylums found them troublesome. But so did everywhere else. The prisons wanted their insane prisoners in an asylum, whilst even Broadmoor attributed most of its early escape attempts and some of its more difficult patient behaviour to that group. In fact, Broadmoor did retain a few such patients at the end of their prison sentences, if they were dangerous or unfit to travel, by arranging for a civil or justice order to be made, though the threshold for that was much higher than that preferred by the local asylums.

**TABLE 2** Criminal lunatics in England and Wales 1843–1960

Year <sup>a</sup>	Local asylums, hospitals, private licensed houses			Criminal lunatic asylums <sup>b,c</sup>			Totals		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
1843	110	27	137 (61%)	66	21	87	176	48	224
1851	228	54	282 (73%)	86	19	105	314	73	387
1861	488	164	652 (83%)	114	22	136	602	186	788
1871	180	58	238 (34%)	380	82	462	560	140	700
1882	162	52	214 (30%)	379	123	502	541	175	716
1891	72	15	87 (12%)	474	150	624	546	165	711
1901	101	21	122 (16%)	482	170	652	583	191	774
1911	169	32	201 (18%)	663	231	894	832	263	1095
1921	198	69	267 (30%)	470	157	627	668	226	894
1931	80	14	94 (10%)	616	201	817	696	215	911
1951	120	30	150 (15%)	689	190	879	809	220	1029
1960	186	24	210 (19%)	712	173	885	898	197	1095

a. All counts took place on 1 January, with the exception of 1843, which took place in April. Figures are not available for 1941.

b. The first 3 rows of data for criminal lunatic asylums (1843, 1851 and 1861) are for Bethlem criminal wings, which closed in 1864 when Broadmoor opened.

c. Criminal lunatics became Broadmoor patients in April 1949.

Compiled from reports of the Metropolitan Commissioners in Lunacy, Commissioners in Lunacy and Board of Control.

### *The financial burden of Broadmoor*

Studies in the Victorian era and beyond have shown that local asylums preferred not to accept criminal lunatics (Hearder 1898; Lord 1913; Saunders 1988). Broadmoor had been open only 12 years when, in 1876, local asylums complained of the cost of running it, due essentially to the higher staff-to-patient ratios necessary to maintain safety and prevent escape (Cross 1876). Key parameters such as the mortality rate and rate of escape of criminal lunatics were considerably lower in Broadmoor than in local asylums (Orange 1883). In 1882, a Commission on Criminal Lunacy confirmed the necessity of retaining a State criminal lunatic asylum (Criminal Lunacy (Departmental) Commission 1882). It also considered the need for local asylums to make provision for their more dangerous pauper lunatics, although no special arrangements were subsequently made. The 1882 Commission report did, however, note as necessary the higher cost of running Broadmoor and to some extent opened a debate on the need for local special provision for more dangerous patients, which would be revisited some 80 years later.

### *Criminal lunatics unwelcome in local asylums*

The disinclination of the local asylums to accept criminal lunatics continued into the 20th century. Most were Secretary of State patients transferred during a prison sentence, though a small

proportion were what had previously been dubbed His Majesty's Pleasure patients who had carried out less serious offences. Most such patients in Broadmoor who had sufficiently improved were conditionally discharged to the community, and only a minority were transferred to local asylums. In 1913, medical superintendents of county and borough asylums reiterated their view that it was undesirable for them to have to accept criminal lunatics. Accordingly, the Medico-Psychological Association (a precursor of the Royal College of Psychiatrists), supported by the Commissioners in Lunacy, so advised the Home Secretary (Journal of Mental Science 1913). In the same year, the Home Office issued a document in which it acknowledged that local asylums were institutions for treatment that should avoid any return to excessive custodial practice. It noted that there was a good deal of prejudice among the public against criminal lunatics, and that local authorities and local asylums were reluctant to accept them. There were no precise rules determining whether a criminal lunatic went to Broadmoor or to a local asylum. However, the main deciding factors were the nature of the offence, the nature of the patient's lunacy, the level of potential dangerousness and, for insane sentenced prisoners, the length of the sentence (Home Office 1913).

### *New possibilities of treatment*

As the 20th century progressed, especially from the 1930s, an increased level of confidence

developed in the treatment of those termed psychopaths. Whether that therapeutic optimism was well grounded remains a disputed issue. The number of such patients with personality disorder admitted to Broadmoor began to rise even before the legal recognition of psychopathic disorder that came with the Mental Health Act of 1959. Out of the ruins of the Second World War emerged a National Health Service in 1948 in which mental health services were part of a wider, comprehensive system of healthcare provision (Jones 1960).

The remit of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1957) (the Percy Commission) did not include mentally disordered offenders. However, the Royal Medico-Psychological Association submitted that less serious offender patients should continue to be admitted to local mental hospitals, but subject to agreement by the hospital's medical superintendent. Broadmoor had hitherto conditionally discharged its patients when stable directly to the community. Now increasingly it would transfer most of its patients to local mental hospitals. The Mental Health Act 1959 was effectively the birth of the modern era in mental healthcare, its underlying principles having largely remained unchanged by the 1983 Act and its amendments in 2007.

### **The modern era**

The Mental Health Act 1959 brought about the creation of the 'special hospitals' for patients of 'dangerous, violent or criminal propensities'. Patients on civil orders could now be transferred from local psychiatric hospitals if clinically appropriate. This is what Dr John Bucknill had suggested a century earlier. The virtually automatic transfer to local psychiatric hospitals from Broadmoor, and now from Rampton and Moss Side, of sentenced prisoners at the end of their sentence also came to an end; they would now have to wait until they were clinically stable, an entirely more suitable parameter for transfer, though one that increased their length of stay in maximum security.

The unlocking of the doors of local psychiatric hospitals and the integration of male and female patients in mixed-sex wards from the early 1960s afforded a degree of normalisation but were not without their disadvantages (Taylor 1999). The removal of perimeter security made absconding easier and the management of disturbed patients more difficult (Rollin 1966). The integration of male and female patients led to concerns about privacy, dignity, pregnancy, venereal disease and physical and sexual assault. The general psychiatric hospitals became less willing and less

able to accept mentally disordered offenders or to safely manage some of the severely mentally ill. The special hospitals, especially Broadmoor, became overcrowded, with substantial delays in the transfer of patients to general psychiatry (Dell 1980).

### **Regional medium secure units**

The notion of some form of regional security, at least for civil patients, had first been proposed in 1882 by the Commission on Criminal Lunacy. The idea resurfaced in 1961 for offender patients (Ministry of Health 1961). A decade later, galvanisation of the proposal followed homicides committed by Graham Young a year after he had been conditionally discharged from Broadmoor. The Report of the Committee on Mentally Abnormal Offenders (the Butler Report; Home Office 1975) noted divided opinion in general psychiatric hospitals regarding the feasibility of treating offender patients, open-door conditions conflicting with the need for security, and consultant psychiatrists not welcoming the loss of autonomy involved in the treatment of patients subject to a restriction order, whose transfer or discharge required the approval of the Home Office. The first interim medium secure unit in England opened in 1976, and by a generation later there was comprehensive national provision. The interface between general and forensic psychiatry now focuses on the relationship between general psychiatric hospitals and medium secure units (and, more recently, low secure units), with an overall protective envelope provided by what are now called the high secure hospitals. A new forensic 'intraface' has evolved between high security and medium security, which is characterised by both collaboration and tension. But whether in high, medium or low security, most patients have previously been treated in general psychiatric services and are likely to return to them at some stage (Taylor 1997).

### **Concluding remarks**

There have always been people with mental disorder who committed criminal acts, but before the start of the 19th century they had no special designation. The term 'criminal lunatic' evolved into that of the 'Broadmoor patient' and then the 'mentally disordered offender'. But patients in local asylums could also be dangerous, whether they were pauper or criminal lunatics, and indeed some criminal lunatics could be virtually harmless. After the Mental Health Act of 1959 patients could be admitted to special hospitals on a civil order. The modern definition of a forensic patient is therefore essentially dependent on risk rather

than on legal status. To a partial extent it is also the case that a broader range of mental disorder has been encompassed by forensic psychiatry, including personality disorders and paraphilias (Gordon 2004).

The higher amount of funding allocated to forensic services is not a new phenomenon. It was a source of criticism of Broadmoor by local asylums in the 1870s and even earlier, in 1837, the Charity Commissioners felt that the Bethlem criminal wings deprived general patients there of extra accommodation (Charity Commissioners 1837). Within psychiatry, and indeed medical practice more widely, there are inevitably some patients who consume a higher level of resources as a result of the nature or severity of their mental disorder.

A balanced emphasis on risk in society is appropriate and indeed intrinsic to safe human interaction. Psychiatry relates not only to care of individual patients but also to the health of the public as a whole (Clouston 1907; Rees 1957). Part of preventive psychiatry historically related to the need to prevent a lunatic becoming a criminal lunatic (Orange 1883). Although homicide by psychiatric patients is uncommon, some may be preventable subject to improved consistency of diagnosis, treatment and supervision.

Reluctance to accept mentally disordered offenders in local psychiatric hospitals is also not confined to the modern period. It occurred from about the 1840s, long before asylums opened their doors. In part it may perhaps be rooted in an aversion to criminality. On the other hand, patients who pose a risk to others require effective levels of security for as long as clinically necessary. The optimum approach is one involving collaboration between general and forensic psychiatry. In our second article in this issue (Khosla 2014), we discuss this collaboration in the present day.

## References

- Arnold C (2008) *Bedlam: London and its Mad*. Simon & Schuster.
- Baird J (1984) *Transfer of Scottish Prisoners: An Historical and Descriptive Study of Convicted Prisoners Transferred to Psychiatric Hospitals* (MD Thesis). University of Edinburgh.
- Black W (1811) *A Dissertation on Insanity, Illustrated with Tables and Extracted from Between Two and Three Thousand Cases in Bedlam* (2nd edn). Ridgway.
- Brayn R (1901) A brief outline of the arrangements for the care and supervision of the criminal insane in England during the present century. *Journal of Mental Science*, **47**: 250–60.
- Bucknill C (1851) *Inquiry into the Proper Classification and Treatment of Criminal Lunatics*. Churchill.
- Charity Commissioners (1837) *Report of Charity Commissioners Concerning Hospitals* (House of Commons Parliamentary Papers, 32: Part VI). House of Commons.
- Clouston TS (1907) Psychiatry as part of public medicine. *Journal of Mental Science*, **53**: 704–23.
- Commissioners in Lunacy (1863) *Seventeenth Report of the Commissioners on Lunacy*. House of Commons.
- Criminal Lunacy (Departmental) Commission (1882) *Report of the Commission Appointed by the Secretary of State for the Home Department to Inquire into the Subject of Criminal Lunacy* (British Parliamentary Paper C3418). Houses of Parliament.
- Cross RA (1876) *Warrant Appointing a Committee to Inquire into Certain Matters Relating to the Broadmoor Criminal Lunatic Asylum*. Whitehall.
- Dell S (1980) Transfer of special hospital patients to the NHS. *British Journal of Psychiatry*, **136**: 222–34.
- East WN (1945) Psychopathic personality and crime. *Journal of Mental Science*, **91**: 426–46.
- Goldberg D (2006) The state of British psychiatry. *Progress in Neurology and Psychiatry*, **10**: 12–6.
- Gordon H, Grubin D (2004) Psychiatric aspects of the assessment and treatment of sex offenders. *Advances in Psychiatric Treatment*, **10**: 73–80.
- Gordon H (2012) *Broadmoor*. Psychology News Press.
- Header FP (1898) An analysis of 131 male criminal lunatics admitted to the West Riding Asylum, Wakefield, during the years 1884–1896 inclusive. Being a Graduation Thesis presented to the University of Edinburgh. *Journal of Mental Science*, **44**: 64–74.
- Home Office (1913) *Memorandum on Home Office Practice in Dealing with Criminal Lunatics*. HMSO.
- Home Office, Department of Health and Social Security (1975) *Report of the Committee on Mentally Abnormal Offenders* (Cmnd 6244). HMSO.
- Hood WC (1854) *Suggestions for the Future Provision of Criminal Lunatics*. John Churchill.
- Hunter R, MacAlpine I (1963) *Three Hundred Years of Psychiatry, 1535–1860*. Oxford University Press.
- Jones K (1960) *Mental Health and Social Policy 1845–1959*. Routledge and Kegan Paul.
- Journal of Mental Science (1913) Report re Criminal Lunatics. *Journal of Mental Science*, **59**: 531–2.
- Khosla V, Davison P, Gordon H, et al (2014) The interface between general and forensic psychiatry: the present day. *Advances in Psychiatric Treatment*, **20**: 359–65.
- Lord JR, Bartlett (1913) Criminal types in a county asylum. *Journal of Mental Science*, **59**: 343–52.
- Maudsley H (1897) *Responsibility in Mental Disease*. D. Appleton & Co.
- Melling J, Forsythe B, Adair R (1999) Families, communities and the legal regulation of lunacy in Victorian England: assessment of crime, violence and welfare in admissions to the Devon Asylum, 1845–1914. In *Outside the Walls of the Asylum: The History of Care in the Community 1750–2000* (eds P Bartlett, D Wright): 153–80. Athlone Press.
- Metropolitan Commissioners in Lunacy (1844) *Report to the Lord Chancellor*. Bradbury and Evans.
- Ministry of Health (1961) *Special Hospitals: Report of Working Party*. HMSO.
- O'Donoghue EG (1914) *The Story of Bethlehem Hospital From its Foundation in 1247*. T Fisher Unwin.
- O'Grady J (2008) Time to Talk. Commentary on ... Forensic psychiatry and general psychiatry. *Psychiatric Bulletin*, **32**: 6–7.
- Orange W (1883) Presidential Address. Delivered at the Annual Meeting of the Medico-Psychological Association, held at the Royal College of Physicians, London. July 27th 1883. *Journal of Mental Science*, **29**: 329–54.
- Rees JR (1957) The Thirty-First Maudsley Lecture: Psychiatry and public health. *Journal of Mental Science*, **103**: 314–25.
- Rollin HR (1966) Mental hospitals without bars: a contemporary paradox. *Proceedings of Royal Society of Medicine*, **59**: 701–4.
- Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1957) *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954–1957: Report*. HMSO.

### MCQ answers

1 b 2 a 3 a 4 d 5 a

Russell D (1977) *Scenes from Bedlam: A History of Caring for the Mentally Disordered at Bethlem Royal Hospital and the Maudsley*. Baillière Tindall.

Saunders JF (1988) Criminal insanity in 19th century asylums. *Journal of the Royal Society of Medicine*, **81**: 73–5.

Spruit JE (1998) The penal conceptions of the Emperor Marcus Aurelius in respect of lunatics: reflections of D. 1, 18, 14. *International Journal of Law and Psychiatry*, **21**: 315–34.

Stevens A, Price J (2000) *Evolutionary Psychiatry: A New Beginning* (2nd edn). Routledge.

Taylor PJ (1997) Damage, disease and danger. *Criminal Behaviour and Mental Health*, **7**: 19–48.

Taylor PJ, Swan T (eds) (1999) *Couples in Care and Custody*. Butterworth Heinemann.

Thompson JB (1867) The Criminal Lunatics of Scotland. *Journal of Mental Science*, **13**: 1–7.

Turner T, Salter M (2008) Forensic psychiatry and general psychiatry: re-examining the relationship. *Psychiatric Bulletin*, **32**: 2–6.

Walker N (1968) *Crime and Insanity in England: The Historical Perspective*. Edinburgh University Press.

## MCQs

Select the single best option for each question stem

### 1 Regarding the use of the term 'criminal lunatic':

- a it was first used during the 17th century
- b it came about following the case of James Hadfield in 1800
- c it initially excluded those found not guilty by reason of insanity and those insane on arraignment (unfit to plead)
- d those found not guilty by reason of insanity were regarded as fully responsible for their criminal behaviour
- e in 1816 'criminal lunatics' excluded those found insane during a prison sentence.

### 2 Provision for criminal lunatics in Britain and Ireland in the 19th century included:

- a Bethlem criminal wings
- b naval military hospitals
- c Rampton
- d regional secure units
- e churches, mosques and synagogues.

### 3 Regarding general and forensic psychiatry:

- a forensic psychiatry places more emphasis than general psychiatry on the nature of the mental disorder and the risk posed
- b the Home Office has always determined the discharge of patients who pose a serious risk to others, whether or not they were criminal lunatics
- c criminal lunatics were always welcome in county and borough asylums
- d most psychiatrists in the 19th century felt that there was no real difference between lunatics and criminal lunatics
- e the subspecialty of forensic psychiatry was established in the 19th century.

### 4 Legislation affecting criminal lunatics or mentally disordered offenders has included:

- a the Royal Commission on Capital Punishment 1953
- b the Mental Treatment Act 1930

- c the abolition of slavery in the 1830s
- d the Mental Health Act 1959
- e the 1957 Percy Commission.

### 5 Regarding the provision of medium security:

- a some consideration was first given to this in 1882
- b a proposal was made in 1961 and effected the following year
- c the case of Graham Young was entirely unrelated to the establishing of the medium secure units
- d the first interim medium secure unit in England was opened in 1988
- e mentally disordered offenders are better placed in prison than in medium or high secure hospitals.