

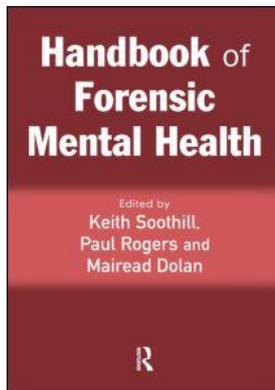
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Handbook of Forensic Mental Health

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The origins and early development of forensic mental health

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Chapter 3

The origins and early development of forensic mental health

David Forshaw

Introduction

The present plethora of organisations and professions involved in the study, care and delivery of services in forensic mental health evolved as a result of various influences over many centuries but particularly over the last two. The origins of the subject can be traced to a range of interdependent fields of scientific knowledge and social endeavour including medicine, nursing, neurosciences, law, psychology, criminology, police, sociology and politics (Forshaw and Rollin 1990). Some of these fields can trace their own origins to antiquity while others are much more recent. Several major contributions were made from some subjects that did not withstand the rigours of scientific progress, for example phrenology (Cooter 1981; Colaizzi 1989), or they led to unacceptable social consequences such as eugenics (Forshaw and Rollin 1990).

Many of the isles and countries that make up the United Kingdom and British Isles have their own domestic jurisdictions. Eire was part of the British Isles during the nineteenth century. Each separate jurisdiction has its own specific history with respect to mental health legislation and services. Developments in England were broadly typical and often set the trend though there were significant exceptions such as the evolution of the diminished responsibility defence in Scottish courts and the establishment of the first special hospital near Dublin in the nineteenth century. This overview of the field will focus on England in order to avoid repetition.

The interests of current-day professionals specialising in forensic mental health differ from their more generalist colleagues in several ways. The most obvious are those arising as a result of the dangerousness of the clients and the consequent need for a close association with the legal system and the use of secure facilities. The core concerns of modern forensic mental health professionals tend to relate to mental health legislation, criminal responsibility and secure psychiatric facilities. This brief overview will highlight some of the principal historical developments in these areas after some background comments which will help place the subject in its overall historical context and relate it to the foundation of general psychiatry.

General historical context

This very brief account of the history of the field focuses on the last two centuries. The nineteenth and twentieth centuries witnessed arguably the most dramatic changes in our social, political, scientific and technological evolution. From the comfort of our modern 'space age' domesticity it is hard to conceptualise everyday life 50 years ago, let alone some two centuries ago.

George III reigned in England during the closing years of the eighteenth century. The United States of America had rebelled against the monarchy and won its independence from Britain. The French people had risen against their king and ruling aristocracy and their bloody revolution had rocked the old order across Europe. Out of its ferment arose a new Republic that led the continent into a period of unrest and war and saw the emergence of a new and militaristic empire. The Napoleonic Wars instigated the social and political processes that were to ultimately culminate in the movement away from small agrarian states to the foundations of larger nation states such as Germany and Italy later in the century. Professional armies protecting nation states and furthering national interests replaced mercenary armies marauding for the gain and advantage of a regional or religious ruler. In parallel with these upheavals the Industrial Revolution was gaining pace with its rapid and progressive urbanisation of the population. In England it drove the rapid change away from an agriculture-based economy to an industrial and commercial-based economy. Small town markets were yielding to prototypical commodity and stock markets increasingly located in the capital. The aristocrat was yielding to the industrialist and banker. The merchant flourished and the tradesman and professional found a growing population able to afford their labours. These advances led to the need to develop centralised controls and administration and the modern civil service started to emerge.

English nineteenth-century philosophy was dominated by utilitarian ethics. Its rule-based nature encouraged the conviction that social reforms could be brought about in an ordered and semi-scientific way. The social reformers would first conduct an empirical study to determine the nature and magnitude of a social problem and identify possible solutions. They would then compare the probable consequences of each possible solution with reference to the guiding rule of 'acting to maximise the greatest happiness for the greatest number'. The chosen option ought to be that which would most likely maximise the overall happiness. The outcome of the chosen option would be checked after implementation and the whole process reviewed again if needed. Jeremy Bentham, often described as the father of utilitarianism, argued for the widespread use of this basic process in the form of the parliamentary process of inquiry, report, debate and subsequent legislation. The legislation would state the rules of conduct expected of the population or delineate the actions to be taken by public or private institutions. They would specify the inducements for compliance and outline the punishments for infringements. Punishment was seen as a necessary evil to deter future infringements and it was not necessarily considered as retribution (Geis 1960).

Legislation proved both an efficient and democratic way of bringing in new law but also provided a basis for a more cost-effective process of enforcement

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than the often confused, and sometimes contradictory, common law. The early nineteenth century witnessed the shift to increasing reliance on legislation as the main statement of English law (Manchester 1980). Armed with this tool for instigating progressive change, the early social reformers and legislators set about reforms in a range of areas including the abolition of slavery, improvement in the conditions in prisons, limiting the use of capital punishment and improvement of the care of the insane. As the nineteenth century progressed consolidation and codifying acts became essential additional tools for the reformer in order to clarify and simplify the earlier mix of case law and statutes (Baker 1979). The modern legal and parliamentary systems were established and used to demarcate and shape mental health care.

The nineteenth century saw the progressive unfolding of various technological developments. It quickly became the age of steam power. A network of railways displaced the canals for fast transport of goods and people on land. Steam power gradually replaced sail power at sea. The telegraph opened up rapid communication across distances. Events on the other side of a continent, and later ocean, could be reported within hours instead of days or weeks. The advent of photography revolutionised our ability to visualise distant people and places and so ourselves. The scientific discoveries in the basic sciences of physics, chemistry and biology, particularly Darwin's work on evolution, further revolutionised the way man saw himself, his world and his place in the world. Gas and electricity in the streets and home made their first appearance and started to revolutionise domestic life.

Queen Victoria's reign started in 1837 and later coincided with the height of her Empire's international power and wealth with England firmly in the centre of a world on which the sun never set. Her reign witnessed the appearance of state intervention in the care of the mentally ill on an unprecedented scale. This was mediated by legislation during the first decades of her reign that required counties to provide public asylums. The significance of the ensuing asylum era for the history of psychiatry is difficult to over estimate. Andrew Scull (1981: 6) emphasised this when he wrote:

The Victorian age saw the transformation of the madhouse into the asylum into the mental hospital; of the mad doctor into the alienist into the psychiatrist; and of the madman (and madwoman) into the mental patient.

The outstanding advances in science and technology during the twentieth century saw the practical and widespread application and development of the cinema, telephone, radio, motorcar, aeroplane, television, jet engine, computer, nuclear power, satellite and the World Wide Web. Each major development precipitated a new mini social revolution or new age. However, the twentieth century was characterised by conflict. Dictatorships vied with democracies. Fascism, communism, capitalism, imperialism and socialism, or combinations thereof, fought each other in two devastating world wars and a host of regional conflicts. In some respects, the conflicts hastened technical developments and enhanced expectations of a better world to come. However, cynicism generally replaced any such optimism. The conflicts were often distractions from the process of development of forensic mental health. 'Shell shock' and 'battle

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fatigue' diverted much attention. In some instances physical resources were transferred away, for example the newly acquired Moss Side Hospital was loaned to the War Office in 1914. However, the widespread acceptance and consolidation of the newly introduced dynamic psychological therapies in the wake of the First World War and group and community therapies following the Second World War greatly facilitated the application of these techniques into forensic settings between the world wars and during the post-war era respectively.

Early foundations of psychiatry

The roots of modern general psychiatry can be traced to the closing years of the eighteenth century and the first half of the nineteenth. Social historians have suggested many possible reasons for this. The Industrial Revolution was driving urbanisation with its concomitant reliance on organised care and support for the infirm from people other than the increasingly distant family. Some historians have noted the apparent prevalence of a sense of optimism among the intelligentsia and leaders of this time and the widespread popular belief that the application of will power and 'scientific method' would solve most, if not all, problems. However, the optimism was fragile and easily undermined by the threat of social unrest as exemplified by the French Revolution. These historians have argued that the fragility of the optimism led to an intolerance of irrationality because it was perceived as contagious and a threat to social order. As a consequence, the response to the insane was to segregate them by incarceration in institutions (Foucault 1967). Society protected itself by the process of stigmatising the mentally disordered as 'deviant', then isolating them and rationalising the process as being for 'their own good' (Szasz 1970).

The highly publicised mental disorder of King George III towards the end of the eighteenth century raised public awareness of mental illness and helped focus attention on the plight of the insane at this time (MacAlpine and Hunter 1969).

Other historians have pointed to the various groups of practitioners who were unifying into an identifiable medical profession and demarcating specific areas of influence. Some of these practitioners saw the possibilities of 'trade' in managing the mentally disordered and so turned their attention to the subject. Medical practitioners in the field organised themselves into an effective economic and political group in order to further their own interests and those of their clients (Parry Jones 1972; Hervey 1985). This claimed 'medical imperialism of the insane' led to the foundation of psychiatry as a medical speciality at the time. Once established and recognised by the state and delegated the power to protect and care for the insane, psychiatry was inevitably placed in the position of having to balance between 'protection' and 'oppression' with the result that the field was positioned in the public arena (Szasz 1974). Public scrutiny was inevitable. Fears that vulnerable, but sane, individuals were admitted unjustly to asylums by unscrupulous relatives and doctors were often expressed (Jones 1972). From this perspective, it is no coincidence that the first major act solely concerned with the care of the insane was aimed mainly at dealing with preventing improper incarceration.

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Medical historians tend to emphasise the role of developing medical concepts and discoveries in shaping the history of medicine. A principal factor contributing to the success of the development of psychiatry at this time was the importation from the European continent of the clinico-pathological approach to the study of illness (Ackerknecht 1959). This consisted of observing symptoms and signs during life and correlating them with pathological findings at post mortem. Initially, the pathological changes studied were gross anatomical abnormalities but, as the nineteenth century progressed, histological changes were evaluated and, later still, biochemical lesions investigated. The correlations often suggested techniques for eliciting physical signs during life such as Auenbrugger's use of percussion, and Laennec's use of the stethoscope, to detect fluid in the lung. The successes of the approach in general medicine were impressive (Ackerknecht 1982). The identification of the underlying pathology for general paresis of the insane by French physicians in the nineteenth century encouraged alienists, and others, to believe that the utilisation of this technique would ultimately yield results in the realm of mental disorder. Implicit was a belief in monism; mental illness was brain illness. This optimistic belief in medicine's ultimate victory provided a rationale for the medical profession's jurisdiction over mental disorder.

An important aspect of the clinico-pathological approach at the time was the large hospital. Such institutions provided sufficient numbers of patients to allow meaningful correlations. Also, they provided opportunities for treatment facilities to be shared. Large mental asylums, in this view, did not just 'lock away the insane' but provided greater opportunities to study the phenomena and concentrated facilities for treatment.

Physicians complemented the insights gained from their clinicopathological studies with an understanding of physiological processes revealed by scientific experiments. Early in the process, the results of careful observations led to the realisation that long cherished treatments were ineffectual and often barbaric. Samuel Tuke (1813) described how the Retreat's physician Thomas Fowler came to this conclusion soon after the opening of the private asylum in York in the late eighteenth century. He recognised that the mentally ill retained some self-control over their behaviour and he aimed to facilitate this by ensuring the asylum provided an atmosphere of retreat and family support. Other physicians and attendants came to similar conclusions and the reliance on restraint, bleeding and purges for treatment waned. 'Moral management' was established. By the middle third of the nineteenth century it had progressed to a 'total non-restraint movement' under the influence of proponents such as Edward Parker Charlesworth and Robert Gardiner Hill from the Lincoln Asylum, and John Connolly in the Hanwell Asylum (Hunter and MacAlpine 1963). The violent criminally insane patients challenged this progressive movement. Concerns were frequently expressed that the criminally insane presented real dangers to other patients within the asylums (Willis 1843; Hood 1854). Also, asylums were not generally as secure as prisons and many feared that removing restraint would furnish greater opportunities for escapes. Removal of the criminally insane from the general asylums was the obvious solution and calls for separate secure facilities increased as the total non-restraint movement gained in influence. The segregation and concentration of the criminally insane in specialist

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institutions provided both the academic opportunity and clinical foundation for the development of forensic mental health.

The main contribution of the clinico-pathological approach to psychiatry was the shift of emphasis towards the careful delineation and description of signs and symptoms of mental illnesses. This led to an understanding that the most dominant individual symptom or sign was not as important as recognising the combinations and timings of symptoms and signs in 'syndromes'. This culminated in the late nineteenth century and early twentieth century in Kraepelin's classic descriptions of manic-depressive psychosis and dementia praecox (later relabelled schizophrenia) (Ackerknecht 1982). As psychiatrists focused on more detailed studies of mental states they realised that the range of abnormal mental phenomena extended beyond abnormal moods and delusions and included distorted volitions, hallucinations and automatic behaviours in altered states of consciousness such as those associated with epilepsy.

Physicians came to understand that patients were affected by their illnesses in many ways. For example, Kraepelin (1919) noted how the ability of patients with dementia praecox to make rational judgments was adversely affected by the disease process. As understanding of abnormal mental phenomena grew practitioners concluded that their patient's responsibilities for their actions were undermined by these phenomena. The doctors argued for a broader concept of criminal responsibility and often met public, official and legal disbelief and opposition. The use of capital punishment prior to the abolition of the death penalty for murder in 1965 ensured that the outcomes of such debates in court often meant life or death for the defendant. The highly publicised debates in court in some rare sensational case raised the public profile of the subject and emphasised the need for practitioners to become familiar with various legal practices and concepts. Forensic mental health had some added dimensions.

The most obvious medical contributions to psychiatry during the second half of the twentieth century were pharmaceutical. The introduction of the major tranquillisers, anti-depressants and mood stabilisers revolutionised psychiatric practice and provided the necessary stability for care of the mentally ill to move out of the old, large mental hospitals and into the community.

The growth of mental health legislation

At the end of the sixteenth century the only public asylum for the insane in England was Bethlem in London. By the end of the following century a handful of others had been added. Norwich, Manchester, York and Liverpool had opened their own public lunatic asylums or infirmaries. The Poor Laws had provided the basis for the reception of vagrants and the poor into asylums. However, asylum places were limited and the poor were often incarcerated in gaols or workhouses.

For centuries, relatives, concerned that a mentally ill member of the family was squandering their livelihoods, had been able to approach a court for a declaration of insanity that legally transferred control over the patient's estate to an appointed representative. From the sixteenth century the Court of Wards and Liveries had dealt with this but the procedure was complex and costly. In the

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nineteenth century the process was simplified and the costs reduced by hearing the cases before special commissioners who, from 1845, were called the Masters in Lunacy. Admission to asylums could follow such a procedure and patients dealt with under this jurisdiction were known as Chancery Lunatics and the hearing in court called an inquisition. However, the mentally disordered relative could also be managed at home with a private attendant.

The growth in public asylums in the seventeenth century was paralleled by an expansion of madhouses owned by private individuals and operated for commercial profit. This increase in the facilities for detaining people was naturally associated with growing public concern about the powers of the managers of these facilities and the potential for unjust admission of sane people by unscrupulous relatives and asylum managers. These anxieties were particularly focused on the private facilities. The first major attempt at formalisation of the legal basis for the reception of the insane emerged late in the eighteenth century. The Act for Regulating Madhouses 1774 (14 Geo III c.9) aimed mainly to counter the concerns about inappropriate detentions. The Act required proprietors of private asylums to submit to licensing, notification of receptions and inspection. The principal purpose of inspection was to ensure that those wrongfully detained were released. Licences could be revoked if inspection was refused but the inspectors, or Commissioners as they were officially known, had few effective means of action or remedies under the Act if they found neglect.

Growing public concern about conditions within private and public asylums led to a series of Parliamentary Select Committees that reported in 1807, 1815–17 and 1828. Their reports shocked the public. Asylum inmates were often subjected to inhumane treatment. Many were restrained in irons for prolonged periods, poorly clothed and kept in cold damp cells with filthy straw mattresses (Sharpe 1815). The committee reporting in 1828 had examined asylums in London and Middlesex. It identified the deficient arrangements for inspection and the inadequate powers of the inspecting Commissioners as the main reasons for the persistence of the problem. It recommended increasing the number of Commissioners and advised extending their role to include inquiry into the behaviour of attendants and the investigation of patient's complaints. These new Commissioners for the Metropolis ought to be given, argued the committee, the power to recommend the revoking of a proprietor's licence if conditions were inadequate. The committee also recommended the appointment of lay members in addition to those who were medically qualified. The Madhouse Act 1828 (9 Geo IV c.41) enacted these suggestions. The new Metropolitan Commissioners in Lunacy consisted of a maximum of 15 lay and five medical members.

The Act for the Care and Treatment of Insane Persons (2 & 3 Will IV c.107) 1832 shifted the balance between lay and professional members more towards professionals and two barristers joined the commission.

In 1842 the number of commissioners was increased again and their jurisdiction extended to inspection of asylums throughout the country for a three-year trial period (5 & 6 Vict c.87). Conditions within asylums between 1828 and 1844 did improve though to what extent the new commissioners were responsible is difficult to determine. However, despite tensions between the medical and lay members (Hervey 1985), it was generally accepted by many contemporary commentators that they had played an important role (Jones 1972).

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The Metropolitan Commissioners' Report of 1844 noted few serious abuses in the asylums inspected but the authors were concerned about the lack of consistent standards and the fact that many counties were not meeting the needs of their population by failing to provide a county asylum. The Commissioners noted that the law did not require counties to build asylums. The Commissioners were also concerned about the lack of inspection of the insane detained in places other than asylums such as in workhouses and gaols. The Lunatics Act (8 & 9 Vict c.100) 1845 countered these deficiencies and empowered the Commissioners to inspect asylums throughout the country beyond the three-year trial period instigated in 1842 and extended the inspection rights to include workhouses and gaols. The new commissioners were called the Lunacy Commissioners. Interestingly, the Bethlem Hospital remained exempt from inspection until after the passage of the amendment acts of 1853. The counties were now required to establish an asylum (though some united in joint programmes) and the following years witnessed the building of many new public asylums during the asylum era. The medical profession's responses to the Lunacy Commissioner's greater powers were ambivalent but the practitioners slowly accepted the system (Hervey 1985).

During the 45 years following the 1845 Act Parliament passed several amendments and related acts with the result that mental health law became fragmented and cumbersome. A comprehensive consolidation act was enacted in 1890. Under this Lunacy Act (53 & 54 Vict c.5) the role of the Lunacy Commissioners in inspection and reporting continued. Private asylums were permitted to receive both voluntary and involuntary admissions but the public asylums were limited to admissions under an order of the Act or following inquisition. As with modern mental health legislation, the Act specified the orders for admission. Paupers were admitted under a summary reception order after a police or poor law relieving officer had petitioned a Justice of the Peace with a supporting medical certificate. Non-paupers were admitted under a reception order. This order required two medical certificates and the patient's relative petitioned the Justice of the Peace. In an emergency, private patients could be admitted for up to seven days under an urgency order after petition of the asylum authorities by a relative. A medical certificate was required. Summary reception and reception orders needed renewal after one, two, three and five years and then at five yearly intervals. As with modern Mental Health Act legislation, there were a number of rules relating to the medical certificates. They had to be completed within seven days before the petition and, when two medical certificates were required, the signatories were required to be unrelated to each other by blood or business interests.

The reception and summary reception orders of the 1890 Lunacy Act were for relatively long periods. By the 1920s it was realised that many involuntary patients were likely to benefit from treatment over shorter periods. A temporary admission order, lasting six months, was introduced by the Mental Treatment Act (20 & 21 Geo V c.23) 1930. The Act also allowed voluntary admission to public mental hospitals.

The Ministry of Health had been formed in 1919 and responsibility for control of lunacy transferred from the Home Secretary to the Minister of Health. Hence, by the 1930s the fundamental components of modern mental health legislation

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were in place though the nineteenth-century requirement to petition a Justice of the Peace for the majority of admission orders might seem unnecessarily bureaucratic today. This was addressed by the Mental Health Act 1959 (7 & 8 Eliz II c.72). Compulsory civil admissions became medical rather than judicial matters (Jones 2006). However, admissions via the criminal courts and transfers from prisons remained the concern of the judiciary and the Home Office.

The law relating to the criminally insane

The first dedicated Act relating specifically to the management of mentally disordered offenders was passed in 1800 following the trial of Hadfield for high treason. He had discharged a pistol in the direction of the Royal Box in the Drury Lane Theatre in London as King George III entered. Hadfield had sustained a serious head wound at the Battle of Lincelles in Flanders in May 1794. Since then he had suffered from violent episodes of madness terrifying his family and friends. He believed that God had decreed that he ought to die to save the world but that he must not die by his own hand. Hadfield's solution was to commit high treason and so arrange his own execution. In fact, Hadfield's diseased state of mind was recognised at the trial and the judge directed the jury to find him 'not guilty: he being under the influence of insanity at the time the act was committed'.

The case highlighted the law's lack of clear instruction on disposal in such circumstances. Technically the defendant had been found not guilty. He had been acquitted and so he should have been released though it was obviously unsafe to do so. True, there were precedents in the past of such individuals being released to the care of their relatives and subsequently being admitted to an asylum or managed at home. There were even examples of individuals, such as Margaret Nicholson who attempted to stab George III in 1786, who were admitted to Bethlem on the legal grounds of archaic crown privileges relating to offences committed within a specified distance, or verge, of a royal residence. In the age of modern legislation, it was argued, a clear statement of the law was needed. The Act for the Safe Custody of Insane Persons Charged with Offences (39 & 40 Geo III c.94) 1800 followed and made provision for the safe detention of individuals found insane and acquitted of treason, murder or felony at His Majesty's Pleasure. Hadfield's case prompted Dr John Johnstone to publish the first specialist medical text on the *Medical Jurisprudence of Insanity* in 1800.

Unfortunately, the Act of 1800 had not stated where or how insane defendants were to be detained other than to note that it should be in a 'place and manner as to His Majesty shall see fit'. The Act made no mention of treatment. The Report from the Select Committee Appointed to Enquire into the State of Lunatics in 1807 recorded that 37 people had been detained by 1807 in gaols under the Act. The committee deplored their detention in gaols and called for provisions to allow admission to asylums. The Act for the Better Care and Maintenance of Pauper and Criminal Lunatics (48 Geo III c.96) followed in 1808. This permitted such insane individuals detained in penal institutions to be admitted to asylums, providing funding from private sources or the parish was agreed, but it did not require such admission. Little changed. The Repeal Act (1 & 2 Vict c.14) 1838 finally specified that, where possible, the place of safety referred to in the 1800 Act was to be considered an asylum. The Act for Making

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Further Provisions for the Confinement and Maintenance of Insane Prisoners (3 & 4 Vict c.54) 1840 extended the jurisdiction of the 1800 Act to include similar acquittals in cases of misdemeanour.

The Amendment Act 1816 (56 Geo III c.117) allowed the transfer to asylum of sentenced prisoners who were found to be insane while serving a penal sentence. The Criminal Lunatics Act (30 Vict c.75) 1867 permitted transfer of convicted idiots and imbeciles who were unable to tolerate prison.

The Act of 1840 introduced an interesting legal device that seemed to side-step the courts by permitting the direct transfer from prison to asylum of defendants awaiting trial under the instructions of a Secretary of State. In 1885, the Home Secretary ordered the admission of Baron Huddleston Marshall to Broadmoor Asylum before his trial for murder of a young girl. The public protest that justice had been set aside by the Home Secretary's action led to recommendations that in future this provision of the 1840 Act should not be used except with extreme caution. Later acts acknowledged this potential problem by giving separate consideration to individuals on remand awaiting trial. The main essentials of the law relating to the criminally insane were established by the time of the consolidation act of 1890.

The evolution of ideas about criminal responsibility

Since antiquity philosophers and theologians have argued that someone ought to be held morally responsible for their actions only if those actions were within his or her control and he or she wanted, or was reckless about, the reasonably anticipated consequences of those actions. People were morally good or bad depending upon their intentions. The law took a practical approach. It made a distinction between the action, the *actus rea*, and the guilty state of mind or *mens rea* (Edwards 1955). The distinction formed the basis for the legal recognition that mental disorder might absolve someone from criminal responsibility. Two early legal tests for criminal responsibility were the 'rightwrong test' and the 'wild beast test' (Radzinowicz 1968). These tests were based upon what the perpetrator knew at the time of committing the offence. In the former, an individual was considered not responsible if the mental disorder was such that the individual 'did not know that what they were doing was wrong'. This was interpreted in the sense of wrong as against the law rather than morally wrong. In the second test, the mental disorder needed to be such that the person did not know what they were doing 'no more than an infant, or than a wild beast'. The mental disorder needed to be extreme.

With growing knowledge about the symptoms of mental illness came a better comprehension of how mental illness might influence a person's intent when committing a crime. By the beginning of the nineteenth century the importance of delusions in mental illness were well appreciated and it was realised that a deluded person was not necessarily a furious manic or a totally withdrawn and stuporous melancholic. The individual's ability to reason and carry on their life in areas other than that covered by the delusion might remain relatively intact. This new understanding challenged the validity of the old tests. At Hadfield's trial for high treason in 1800, his defence counsel, Thomas Erskine, dismissed

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the wild beast test out of hand in his comment 'no such madman ever existed'. He argued that if a man was deluded at the time of the offence and the act was committed under the influence of the delusion then the man should not be held legally responsible (Ridgeway 1812). Hadfield was found 'not guilty, he being under the influence of insanity'. This was an acquittal though he was ultimately detained in Bethlem.

During the early decades of the nineteenth century there were several high-profile trials in which these more enlightened views held sway. Jonathan Martin was acquitted in 1829 of arson and felony when he set fire to the York Minister under the influence of delusional beliefs about the church. He was sent to an asylum. Interestingly, the jury had initially returned a verdict of 'guilty but consider that he was insane at the time' but the judge recorded the verdict as 'not guilty'. However, Edward Oxford was found 'guilty but insane' at his trial after firing two pistols at Queen Victoria on Constitution Hill in 1840. He appeared to believe that he was an agent of a secret society. The different wording of the verdict in his case was regarded as making more sense to the public because a 'not guilty' verdict implied to the public mind that the individual had not committed the offence at all when patently the defendant had committed the act albeit while labouring under a mental disorder. Though there had been uncertainty about whether the pistols were loaded the discharging of the pistols was still a treasonable act. Notwithstanding the wording of the verdict, with its implication that it was not an acquittal, he was also sent for detention in an asylum.

During the same period there were several cases where less enlightened views held sway. John Bellingham shot Spencer Perceval, then serving as both Chancellor and Prime Minister, inside the entrance to the House of Commons in 1812. The victim died. The public outrage was great. Bellingham was tried and convicted within a week. His defence counsel had unsuccessfully sought a postponement in order to prepare an insanity defence and seek a medical witness. There was a family history of insanity and there were witnesses who would attest that Bellingham was periodically deranged and confused. Bellingham was a merchant from Liverpool who had incurred several debts and served a period of imprisonment in Russia. He blamed the government for his plight and had sought recompense. He said he had assassinated Spencer Perceval because the government had refused to recompense him. Bellingham was hanged seven days later. The trial and execution of Bellingham were to become renowned as one of the greatest injustices carried out by the English legal system.

The conception of partial insanity or monomania, when an individual might be deluded in one area of their mental life but otherwise sane, was popular in the early nineteenth century. The concept of monomania was popularised among English-speaking alienists by Sir Alexander Morison (1840), among others, who drew heavily from the work of French physicians such as Esquirol. Morison was physician to Bethlem when the criminal wings were open. He took the opportunity to study the relationship between mental illness and offending and collected some simple statistics. He noted how illnesses could be associated with crime in different ways. For example, he noted how theft might be committed in dementia and idiocy because of an 'indistinct' notion of property and morality. Of the Bethlem patients, he described how the following diagnoses were associated with homicides: furious maniacs, mischievous idiots, monomaniacs labouring

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under delusion, monomaniacs overpowered by ‘irresistible impulses’ and melancholics. Physicians wishing to explain irresistible impulses often likened them to the longings or pica of pregnancy. Feuchtersleben (1847) maintained that these longings were sometimes present to such a degree in pregnancy that it amounted to mania. He cited Reil’s example of a woman whose longing was to eat her husband. She had killed him and then salted his flesh. However, many physicians were uneasy at the thought that irresistible impulses or instinctive monomania *per se* should constitute some sort of defence of insanity. Even Morison (1848: 457) expressed his doubts in his lectures:

There can be no security for life, if the consequences of an act may be evaded by metaphysical conjectures on the strength of morbid impulses, and the impossibility of controlling evil passions. There is not a crime for which, with some show of reason, the excuse might not be made – ‘I did it because I could not help it’.

In 1843 a jury found 29-year-old Daniel McNaughton ‘not guilty on the ground of insanity’ at his trial for murder of the Prime Minister’s private secretary, Edward Drummond. The victim died five days after being shot in the back in Parliament Street in London. McNaughton, the son of a Glasgow wood turner, had mistaken Drummond for the Prime Minister, Sir Robert Peel. Evidence was presented in court that McNaughton had been deluded for years. He believed that there was a conspiracy against him led by the Tories. An unprecedented number of physicians gave evidence in the court. They were unanimous in testifying to his insanity. Dr Edward Monro and Sir Alexander Morison from Bethlem appeared for the defence, among others, and Dr Forbes Winslow and Dr Philips gave evidence for the crown (West and Walk 1977).

The public cry of injustice in response to the court’s verdict was loud and vehement. Queen Victoria expressed her discontent. The authorities were unable to disregard the public response and the issue was hotly debated in the House of Lords. Lord Lyndhurst (the Lord Chancellor) recommended the use of an archaic constitutional device that permitted the House to ask a panel of judges to clarify the law by responding to a series of questions on the topic. The judges gave their answers to the questions on 19 June 1843 and their replies have been referred to ever since as the ‘McNaughton Rules’. One of the judges dissented from the general view and the judges indicated that their replies only applied to ‘those persons who labour under such partial delusions only, and are not in other respects insane.’ The following quotes contain the essences of the ‘rules’ (Wallis 1892: 931, 931, 932, 930, 932 and 932 respectively):

- ‘Every man is to be presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved’.
- ‘To establish a defence on the ground of insanity, it must be clearly proved that at the time of the committing of the act the accused party was labouring under such 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 he was doing what was wrong’.

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- A defendant labouring under a delusion 'must be considered in the same situation as to responsibility as if the facts with respect to which the delusion exists were real'.
- An insane defendant is 'punishable, according to the nature of the crime committed, if he knew, at the time of committing such crime, that he was acting contrary to law, by which expression we understand your Lordships to mean the law of the land'.
- 'It is for the jury to decide' whether the defendant is insane or not.
- Dr Forbes Winslow had given his opinion in court on the defendant's insanity without having interviewed him. The judges were asked to comment on the legality of this and they replied that physicians in these circumstances 'cannot in strictness be asked' for an opinion.

The 'rules' indicate that McNaughton ought to have been found guilty in the view of the judges. McNaughton knew that it was against the law of the land to kill and his delusion of persecution was such that he was not killing in self-defence but rather to stop constant harassment. From the psychiatric perspective the rules represented a retrogressive step though more defensible than the wild beast test. The alienists expressed two main sets of concerns. First, this view of insanity was oversimplistic. Mental illness often presented with symptoms other than delusions and the expectation that someone with a delusion would be able to act normally in all other respects, just assuming the content of the delusion were true, was misguided and a misunderstanding of the depth and pervasiveness to which delusions and mental illness could influence behaviour.

The second concern focused on the role given to the jury to decide a defendant's sanity. Many physicians believed that injustices were inevitable as a trial was just not long enough to explain the range of issues involved to an untrained audience. To counteract this ignorance James Duncan published a little book in 1853 intended to increase the general knowledge among jurors about insanity. He was particularly keen to educate them about irrational and irresistible propensities and impulses to commit crimes such as occurred in pyromania and kleptomania (Duncan 1853). An alternative solution was proposed by several other leading nineteenth-century alienists, including Charles Bucknill, Forbes Winslow and Harrington Tuke. They were concerned that the adversarial system inherent in English law courts was not conducive to arriving at a well-considered opinion on matters of insanity. They argued that the courts ought to appoint independent medical experts to examine and decide the sanity of defendants. The credibility of their argument was damaged by a number of court cases highlighting the lack of agreement about insanity among physicians and illustrating how incomprehensible the ideas of alienists were to many in the general population. Perhaps, the most infamous of these cases was the trial for murder of George Victor Townley.

In 1864 Townley savagely stabbed his fiancée after she jilted him. Forbes Winslow had argued in court that there was a family history of insanity and that Townley had an 'inherited predisposition to insanity' and that he was 'morally insane' as manifest by his excessive temper and excitability. The defence of insanity failed and he was condemned to death. Townley's family

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were affluent. They obtained a certificate of insanity signed by two doctors and three Justices of the Peace and the Home Secretary ordered his transfer to Bethlem before the allotted time for the execution. The public response was to accuse everyone concerned of corruption. The psychiatrists were publicly divided on the issue of Townley's insanity with Maudsley and Lockhart Robertson strongly disagreeing with Forbes Winslow. The Home Secretary ordered another examination of Townley by three physicians all of whom pronounced him of sound mind. Townley was promptly returned to prison but his death penalty was commuted to penal servitude for life. Townley committed suicide (Forshaw and Rollin 1990). Maudsley later varied his view.

English physicians continued to express concern about the harsh guidelines contained within the McNaughton rules throughout the remainder of the nineteenth and the first half of the twentieth centuries. Despite the judges' provisory remarks that the answers they had given to their Lordships questions following McNaughton's trial applied only to cases of partial insanity, the rules became the standard test of insanity in English courts.

A review of reported cases suggests that despite various high-profile cases, precedents and rulings in the nineteenth century, there was no dramatic increase in the number of individuals acquitted on the grounds of insanity (Walker 1968).

In 1878 Simon Fraser killed his young son at night. He claimed he was asleep at the time and so he pleaded not guilty at his trial for murder. A doctor tried unsuccessfully to argue that Fraser had been temporarily insane. However, after hearing the evidence, the judge instructed the jury to consider a verdict to the effect that Fraser had killed his son but he had been 'unconscious of the act due to somnambulism'. The jury accepted the judge's suggestion. Fraser was allowed to go free after pledging to sleep alone in future. The defence of automatism had been established and complemented the insanity defence.

A nineteenth-century Scottish case was to ultimately offer a more satisfactory resolution to the debate around the insanity defence. In 1867 Alexander Dingwall was tried in Aberdeen for the murder of his wife on Hogmanay. Before she died from her knife wounds she had insisted that Dingwall had not known what he was doing at the time and that he was only ever violent after he had been drinking. He had been dependent on alcohol for at least a decade as evidenced by his suffering from delirium tremens. He was a middle-aged ex-soldier from a respectable family. He had stabbed his wife in the early hours of the morning sometime after returning from a night's heavy drinking. The judge instructed the jury to consider that though Dingwall was sane they could return a verdict of 'murder with extenuating circumstances' implying manslaughter. The jury complied. This Scottish finding was less controversial to the public than the English verdicts because it was clearly not an acquittal. The plea was to be called diminished responsibility in subsequent years but it would not find its way into English Law for nearly another century (Smith 1981).

Many legal reformers called for the incorporation of the Scottish diminished responsibility plea into English law throughout the closing years of the nineteenth century and into the twentieth. The situation finally changed in response to the recommendations of two influential inquiries into legal reform: the Royal Commission on Capital Punishment 1949–53, chaired by Sir Ernest Gowers, and the Committee of the Inns of Court Conservative and Unionist Society, chaired

by Sir Lionel Heald. Both the Gowers and Heald Reports advised the acceptance of diminished responsibility pleas in English courts. The Homicide Act 1957 (5 & 6 Eliz II c.11) introduced the plea into English Law.

The development of secure psychiatric facilities

The arguments for admitting insane offenders into asylums in the nineteenth century were straightforward. Admission permitted the individuals to receive care and treatment. Also, it was felt inappropriate and inhumane to detain someone in prison or gaol, where conditions were generally much worse than in the asylums, particularly if they had been acquitted on the grounds of insanity. However, the admission of insane offenders into asylums raised many concerns, such as the shortage of places.

Hadfield's case quickly highlighted a serious problem. He was admitted to Bethlem after the passing of the Act of 1800. He escaped. After his recapture he was returned to prison. Another obvious concern was for the immediate physical safety of the other patients in the asylum when potentially dangerous mentally disordered offenders were admitted to their company. This issue would have presented a significant difficulty for the total non-restraint movement if separate accommodation had not been arranged. Some relatives expressed a more subtle concern. They were anxious that the presence of criminals in the midst of their loved ones might have some sort of morally corrupting or bad influence. This became a particular concern after the Act of 1816 permitted the transfer from prison of criminals who became insane while serving a sentence. The Metropolitan Commissioners in Lunacy wrote, in their report of 1844, 'Some consideration, moreover, is due to the feelings of the relatives of patients, who have reasonable ground to complain of atrocious criminals being forced into their society'. This led to a natural concern on behalf of asylum managers that an institution admitting insane offenders would have difficulty in attracting private patients of the 'refined classes' (O'Donoghue 1914). The asylum managers were also concerned about the extra cost of providing additional security measures to prevent escapes and ensure the safety of other patients and staff.

The obvious solutions to these problems were the confinement of insane offenders either in separate asylums dedicated to the care of insane offenders or in purpose-built wings within large general asylums. The Select Committee reports of 1807 and 1815–17 had recommended that a separate asylum for the criminally insane should be built (Sharpe 1815). This recommendation was often repeated over the next 40 years. The cost of such a project was considered too high at that time. However, Bethlem in Moorfields was in a dreadful condition in the first decade of the nineteenth century and the asylum managers had decided to build new premises in St George's Fields on the current day site of the Imperial War Museum in London. The government approached the managers and negotiated the building of two criminal blocks on the grounds of the new asylum to the rear of the main building. These opened in 1816. The male wing accommodated 45 patients and the female block was designed to house 15. Each block had a basement and three floors. The passages from the main

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hospital opened onto galleries that, in the male block, were divided into cages by metal wires and rods and opened into a sleeping room. Hadfield was returned to Bethlem.

The discharge of patients from the criminal blocks was under the jurisdiction of the Home Secretary. Concern that discharged patients might relapse and reoffend ensured that the politicians responsible for making the decisions about a patient's liberty wanted to see a period of stability after the patient's mental state had improved before agreeing to discharge. The period required depended on the seriousness of the offence that the patient had a 'propensity to commit' (Forshaw and Rollin 1990). The effect of this policy was that the blocks filled to capacity. An extension for another 30 patients was completed in 1837 but these were quickly filled. The Metropolitan Commissioners noted in their report of 1844 that though Bethlem housed 85 criminal patients there were another 139 distributed around other private and public asylums. The proprietors of Fisherton House near Salisbury agreed to build a separate criminal ward in 1848 to take patients who were considered less dangerous than those sent to Bethlem. By the fifth annual Report of the new Commissioners in Lunacy in 1851 the number of criminal patients in ordinary private or public asylums had increased to 264 and the Commissioners described the relief offered by Fisherton as inadequate. The Chairman of the Commissioners, the Earl of Shaftesbury, again advocated the building of a separate asylum for insane offenders but to no avail.

Sir William Hood, superintendent of Bethlem for a decade from 1852, managed to free 40 beds in Bethlem's male criminal block by moving the more settled patients to another ward (O'Donoghue 1914). The vacated beds were quickly filled. In 1854, Hood publicly recommended a separate asylum for the criminally insane in his book. By 1856 conditions in the criminal blocks in Bethlem were unacceptable and decried as 'radically bad' in the tenth Report of the Lunacy Commissioners published that year. In contrast, the same report described conditions in Bethlem generally as 'altogether creditable'.

The Act of 1844 had resulted in counties building their own facilities for the insane and pauper patients were being admitted to these asylums rather than to Bethlem, which increasingly found it had to attract private patients. Hood was keen to see the criminal blocks in Bethlem close as he considered that their presence tainted the reputation of Bethlem and discouraged the private patients (O'Donoghue 1914).

The debate in England about the most suitable accommodation for managing the criminally insane was paralleled by a similar debate in Ireland. The Report on the District, Local and Private Lunatic Asylums in Ireland for 1845 recorded that there were 84 criminal lunatics in various asylums around Ireland and a further 21 detained in gaols. The following year's report urged the building of a central criminal asylum. Dundrum Central Criminal Asylum was built in 1850 with 120 places of which 80 were for males. Dundrum had more space for its patients than the cramped criminal wings in Bethlem. Security in Bethlem's blocks needed to be visibly closer to the patients than in the new special hospital with its secure perimeter wall. The space available within Dundrum allowed a less oppressive management. In 1857 it was reported that no mechanical coercion had been used over the preceding two years. The expectation that a separate criminal asylum would be more conducive to moral management and total non-restraint was confirmed.

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The continuing inadequate conditions in England for the care of the criminally insane led to renewed calls during the late 1850s for the opening of a separate criminal lunatic asylum in England. The success of Dundrum added extra support to the arguments. In 1860 the Act for the Better Provision for the Custody and Care of Criminal Lunatics (23 & 24 Vict c.75) passed into law and provided the legislative authority to build the Broadmoor Criminal Lunatic Asylum in Berkshire. It was built to accommodate 400 men and 100 women and opened in 1863 (Partridge 1953). It was not long before it was realised that the beds tended to be blocked by convalescent patients whom the Home Secretary was reluctant to release. However, the ending of the transportation of convicts to the colonies in the late 1860s may have contributed a little to the increased demand on asylum places. Certainly, the effect on prisons was considerable (Hughes 1987). Broadmoor started to add extensions to accommodate the growing numbers. In 1867 an extra 50 female places were added and by 1903 the hospital housed nearly 760 patients. However, the Lunacy Commissioners noted that there were 109 criminally insane patients still distributed around the other ordinary asylums in England and Wales in that year. Between 1908 and 1913 a print shop in the grounds of Her Majesty's Prison Parkhurst was temporarily converted to the Parkhurst Criminal Lunatic Asylum for 50 male patients. It closed a year after the opening of the second Criminal Lunatic Asylum, Rampton, in Nottinghamshire.

The learning disabled offender was often described as presenting a different range of clinical and security problems to the mentally ill. The Board of Control was established by the Mental Deficiency Act 1913 (3 & 4 Geo V c23). It was charged with the responsibility of providing and maintaining specialist asylum-based care for 'dangerous mental defectives'. As with the criminal lunatic services, decisions about admission and discharge remained with the Home Secretary. An old inebriate's asylum, Farmfield in Surrey, was converted into the first separate facility for dangerous mental defectives and remained open between 1914 and 1922. It housed 90. The Board of Control obtained the Moss Side site near Liverpool with the intention of opening a larger facility but it was transferred to the War Office after the start of the First World War. It was used as a Military Hospital for Nervous Disorders. After the war it was briefly used as a hospital for the 'dangerous mentally impaired' until 1920. Moss Side was then leased to the Ministry of Pensions as an 'epileptic colony' before being returned, once again, to its originally intended use in 1933.

With the foundation of the National Health Service in the 1940s, the ownership of Rampton, Moss Side and Broadmoor Hospitals passed to the Ministry of Health during the closing years of the decade. The Board of Control took on the responsibility for their management though decisions about admissions and discharges remained with the Home Secretary. The Mental Health Act 1959 (7 & 8 Eliz II c.72) saw the dissolution of the Board of Controls and the handing over of its responsibilities to the Department of Health and Social Security (Parker 1985). Park Lane Special Hospital was built in the 1970s and subsequently merged with Moss Side opposite to form Ashworth Hospital. The management of the special hospitals recently passed to nearby National Health Service Trusts while discharges and leaves of restricted patients fall under the province of the new Ministry for Justice.

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From the 1950s onwards the priority for mental health service provision shifted from care in large asylums to care in the community. It quickly became apparent that there was a need for secure beds outside those available within the special hospitals. Individuals who would have been managed in the locked wards of the old asylums still needed to be managed in secure facilities for their own protection and/or the protection of the public. However, they did not need conditions of high security as found in the special hospitals. The Glancy Report (Department of Health and Social Security 1974) on disturbed and dangerous patients and the Butler Report (Home Office and Department of Health and Social Services 1975) on mentally abnormal offenders led to the development of such units. The Butler Report (1975) recommended that each National Health Service Region should have a unit and they were originally called Regional Secure Units. This term is largely redundant now as many regions have more than one Medium Secure Unit. The first Interim Medium Secure Unit was opened in Merseyside in 1980 and the Regional Secure Unit in Norwich was the first purpose-built unit to be opened. The Butler Report (1975) and the more recent Reed Report (1992) set out the core principles of secure provision (Kennedy 2002).

The 1990s and early years of the new millennium witnessed a period of intense political interest in forensic mental health. In 1992 the first of two inquiries into Ashworth Hospital (Blom-Cooper *et al.* 1992) reported which concluded that the hospital was an abusive, authoritarian institution and, as a result, the practices of the special hospitals were closely scrutinised and modernisation began. For example, patients were still being locked in their bedrooms and dormitories at night, a practice more akin to prisons than hospitals. Seven years later a second inquiry into Ashworth Hospital was commissioned (Fallon *et al.* 1999). Fallon investigated and confirmed complaints of patients trading in pornographic material, a young child visiting dangerous paedophiles and being 'groomed', patients running ward businesses, misuse of drugs and alcohol, and gross lapses in security. A review of security in all three English Special Hospitals followed. The Tilt Report (Tilt *et al.* 2000) recommended greater levels of security including the recording of patients' telephone calls, greater use of random searches of patient quarters and improvements to perimeter and internal security systems. However, the issues relating to levels of security are covered elsewhere in this volume.

The penal reforms of the nineteenth century led to the development of physical and mental healthcare services within the prisons. During the twentieth century various therapeutic programmes and units were developed within the prisons including services for personality disordered individuals and addicts. Since the 1990s there has been a determined effort to involve National Health Service providers in the provision of healthcare within the prisons in a variety of areas including mental healthcare units and addiction services. The development of various court diversion schemes and community forensic services in inner-city areas in recent decades ensures that forensic mental health now has a broad base. However, these developments are more properly the concern of other chapters in this volume.

Concluding remarks

Forensic mental health grew out of the asylum era. The structural foundations were laid in the early criminal lunatic wings and asylums. The conceptual frameworks evolved from an amalgam of the clinico-pathological approach, the social and legal reform movements, and the ideas about criminal responsibility debated in the various high-profile trials of the nineteenth century. Since the emergence of effective pharmaceutical and psychological treatments during the twentieth century there has been a growing impetus to manage the mentally ill offender in the lowest possible conditions of security. The influx of practitioners into the expanding medium and lesser secure services has ensured the field has proliferated and reached its present day maturity.

Selected further reading

The classic text by Hunter, R. and MacAlpine, I. (1963) *Three Hundred Years of Psychiatry 1535–1860*, Oxford: Oxford University Press presents the history of psychiatry in a series of commentaries and extracts from historical works arranged in chronological order with comprehensive indices permitting the reader to track the development of various different themes and topics,

The monograph by Smith R. (1981) *Trial by Medicine. Insanity and Responsibility in Victorian Trials*, Edinburgh: Edinburgh University Press explores in depth the evolution of criminal responsibility in the nineteenth century.

The two volumes of Walker, N. (1968) *Crime and Insanity in England*, Edinburgh: Edinburgh University Press provide a readable and comprehensive account of the development of the 'English Approach' to the problem of the mentally disordered offender from the perspective of criminology.

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