THE TWENTY-SEVENTH MAUDSLEY LECTURE: 
THE UNWILLING PATIENT.
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Part I.—Original Articles.

CORRIGENDA

In Vol. XCIX, No. 414, January, 1953, please delete the words “tension syndrome” under the graph on page 99.

... and rigorous confinement away from other human beings. Some of the ancients maintained the existence of spirits of different qualities, and held that an intercourse existed between the material and spiritual worlds. It was believed that in some instances the mind was merely deranged by a malignant influence of a demon. In others, when a change of characteristics was more evident and more complete, it was thought that there was an actual exchange of soul. The insane person was either consulted as an oracle or shunned as possessed of an evil spirit. These ideas gave way in the Greek and Roman period to equally strange theories of the physical origin of mental disease, but the unusual and bizarre quality of the illness continued throughout the ages to justify the belief that some outer or other world influence was at work. Thus the patient became in turn the victim of religious ceremonies intended to cure him and of confinement and neglect. These theories of demon possession which determined the mode of treatment were in no way inconsistent with the essential love of mankind for man.

- Rosalind in "As You Like It" (Act III, Scene 2) is made to say: "Love is merely a madness and deserves as well a dark house and a whip as madmen do." The dark house and the whip indicate two methods to be used in the care and treatment of mental illness—confinement and coercion, a combination of isolation in darkness and punishment. Although the most famous physician of the eighteenth century, Pinel, denied the advantages of restraint in treatment of insanity, he wrote thus on the art of counteacting human passions and diseases by the use of force: "The doctrine in ethics of balancing the passions of men by others of equal or superior force is not less applicable to the practice of medicine than to the science of politics, and is probably not the only part of resemblance between the art of government of mankind and that of healing their diseases." In his Treatise on Insanity (1806) he relates the treatment of a French nobleman (shortly after the French Revolution) who suffered from melancholia and who recovered under treatment by the "bath of surprise." During the process of bathing in cold water (his hands and feet were tied) the patient’s fury was greatly increased by the mortifying consideration that owing to the Revolution his rank was neglected and ignored. Notwithstanding the violence with which he resisted the treatment it was practised on him for some time. The patient recovered, and as continued treatment during...
convalescence he was induced to take a warm bath as a preventative. Thus was the nobleman brought at last to accept the bath as an unpleasant but necessary implement of cure. Pinel, however, deplores the use of unnecessary force, and describes his ideal psychiatrist as "one who conceals with great address the means of constraint to which he is compelled to resort, yields to their caprices with apparent acquiescence, eludes with dexterity their inconsiderate demands, soothes with coolness and kindness their intemperate passions, turns to advantage every interval of their fury, and meets with force their otherwise incalculable extravagances."

When I read through the accounts of treatment given to patients as late as the middle of the nineteenth century by honest and earnest physicians I marvel at the toughness of the patient, and wonder what has become of all the stalwart men and women who treated life as a contest to enjoy and did not trouble too much about a little physical pain or discomfort. The same attitude is well illustrated by Francis Galton, who in his *Art of Travel* (1872) wrote regarding the use of lucifer matches, "in a steady downpour of rain you may light a match for a pipe under a horse's belly," and again in illness, "for want of proper physic drink a charge of gunpowder in a tumbler of water or soapsuds and tickle the throat."

Nevertheless, for the unwilling victim of mental illness there was no easy way out, and the patient who had been dealt with as a dangerous lunatic was treated with great severity. Dr. Crowther in 1838 used an apt quotation: "there is nothing so easy as entrance, nothing so tardy as deliverance."

As to the incidence of mental disorder, there appears to be no reliable estimate made during the nineteenth century. After 1840 or so figures of those confined were available, but this was not the whole story. In Cheyne's *English Malady* (1737) I read that "nerves, distempers, spleens, vapours and lowness of spirit are in derision (by all our neighbours on the Continent), and called the English Malady. Thus nervous disorders are computed to make almost one-third of the Complaints of the People of Condition in England." After an interval of 200 years we find Russell Fraser making a similar estimate!

I will not weary you with an account of the medicinal treatment of insanity through the ages. Suffice it to say that the patients suffered much. My main purpose is to give you some details of the way in which the unwilling patient has been handled during the past 150 years, and to show how treatment was often interpreted in terms of management. In the nineteenth century many learned and honest physicians had no great faith in any form of treatment. Cure was a natural phenomenon which they could not control. For them there was—

"The toil
Of dropping buckets into empty wells,
And growing old in drawing nothing up."

During the years that restraint and seclusion were giving place to "moral treatment," the patient was still forced into a mental subordination as an essential prerequisite to recovery. I quote Pinel's account of Dr. Willis, a famous English physician of the late eighteenth century: "Of the celebrated Willis it has been said, that the utmost sweetness and affability is the usual expression of his countenance. But, when he looks a maniac in the face for the first time he appears instantly to change character. His features present a new aspect such as commands the respect and attention even of lunatics. His looks appear to penetrate into their hearts, and feel their thoughts as soon as they are formed. Thus it is he obtained an authority over his patients, which afterwards co-operating with other means, contributed to restore them to themselves and their friends."

I propose now to consider some developments in psychiatry in this country as they appear in the enactments relating to lunacy, and through the eyes of the Commissioners in Lunacy, of whom Lord Shaftesbury was chairman for forty years (1845-85). It is a wide field, and I have therefore found it wise to limit myself to the treatment of the unwilling patient, with special reference to restraint, seclusion and detention, adding asides on matters which may be of interest to you in the light of our practice at the present time.

In the eighteenth century the state of the insane poor in England can be inferred from the dreadful circumstances of private patients who were confined in hospitals and licensed houses, and whose condition became from time to time the subject of public comment and parliamentary investigation. So little indeed was the
question understood that the first Act which notices the pauper lunatics (1744) enabled any two justices to cause him to be apprehended and be "locked up" in some secure place and "there chained." Mechanical restraint by chains, cuffs and bars was continued well into the nineteenth century. In December, 1842, the Commissioners reported that at Wreckenton Asylum, near Gateshead, chains were attached to the floor in several places, and it was the practice to chain patients by the leg, upon their first admission, in order, as it was said, to see what they would do. Iron frames were used at Kingsdown House, which did not allow the freedom of hand locks. A patient was chained by her legs to a wooden seat in a paved passage to prevent her, as it was stated, hurting herself in her fits. In the same period restraint was used by means of jackets, dresses, gloves, belts and other similar contrivances which limited the patients' movement or activity. At St. Peter's Hospital, Bristol, in addition to the jacket and leg locks, an open mesh of leather passing round the face and also around the forehead to the back of the head was at one time used for such patients as were in the habit of biting. In 1843 it was noted that the bitters' mask had not been used for some time.

The Commissioners in Lunacy in an attempt to reduce the amount of restraint proposed separate rooms for the temporary seclusion, during short periods only, of those who suffered the paroxysms of excitement or violence (paded rooms were already in use). On the other hand they gave details of cases to show the danger of the total disuse of mechanical restraint in the management of patients. In 1844 they sought the views of medical superintendents throughout the country on the subject of restraint. Opinion appeared generally to be against it, though some few regarded it as a necessary evil; it was sometimes valuable as a precaution and beneficial as a remedial agent. Three doctors considered it less irritating than holding with the hands, and one of them preferred it to seclusion. Those who favoured restraint held that it was necessary to acquire as soon as possible a certain degree of authority and influence over the patient, and to enforce obedience to such salutary regulations as might be laid down for his benefit.

Support for those who were against any form of restraint came from Lincoln Lunatic Asylum (now known as The Lawn), opened in 1828. It is here that the practical abolition of mechanical restraint as a method of treatment was first advocated and carried into effect by Dr. Charlesworth (with whom, in 1835, was associated the house-surgeon, Dr. Gardner-Hill). They succeeded to such an extent that the percentage of cases so treated was reduced from 54 in 1829 to 1.5 in 1837. The principle of non-restraint, with which Dr. Connolly was also identified from his appointment as Medical Superintendent of Hanwell in 1839, was discussed at length in the final report of the Metropolitan Commissioners in 1844, in which opinions on each side of the question will be found fully set forth. But the adoption of non-restraint brought its own problems, and in 1846 and 1847 there was a lively correspondence between the Commissioners and the Governors of Lincoln Asylum. The former complained that there were no rooms in which excited patients could be isolated; that there was no adequate segregation of the sexes; inadequate classification had led to the mixing of quiet and excited patients, with the result that during the course of the previous year almost every injury had resulted by blows given in exchange between patients. They commented, too, on the indiscriminate admission of strangers to the hospital, attention to whom appears to have taken up much of the time of the house-surgeon. There were three visiting physicians, one of whom, Dr. Charlesworth, was also a Governor. A bitter feud seemed to have existed between him and another of the visiting physicians, Dr. Nicholson, who protested against the abandonment of restraint with the consequent indiscriminate mixing of patients. There was, as well, a difference of opinion on the issue of porter to certain patients. But Dr. Charlesworth, with the assistance of the three lay Governors, had his way and restraint was no longer used.

In 1847 the Commissioners were requested by the Secretary of State for the Home Department to prepare a code of Asylum Rules for the whole country. After submitting them to some experienced medical officers of asylums they were put up for approval. The main objects in framing Rules were set out under three headings, the third of which sought to effect the separation of the sexes; a proper classification of the patients to ensure to them the means and opportunities of exercise, employment and amusements; to provide them with a sufficiency of attendants; to prevent their suffering from harshness and unnecessary restraint; to give facili-
ties to the visits of their friends, and in every respect to ensure as far as may be their health, tranquillity and general comfort. In the same year (1847) they write that personal restraint is diminishing, and even where it is still employed its severity is greatly diminished. It is evident that restraint was coming to be regarded not as a satisfactory method of treatment but merely as an economic necessity. Licensed houses promised that their private patients would not be restrained and, in fact, one licensed house in an advertisement declared that restraint was not and never would be used. The Commissioners, ever on the alert, discovered that in this same place restraint was in fact constantly used but was not recorded or reported.

In 1850 at Fisherton House, Salisbury, the Commissioners heard of a practice which was incautiously referred to as "day sheets." Thinking that this was a new form of restraint analogous to the wet and dry pack they inquired into the practice, and found that it was the habit to place clean sheets on certain beds during the day and to remove them at night. They felt it their duty to remonstrate strongly with Dr. Finch, the proprietor, against a practice which had the effect of deceiving the Commissioners, Justices, and other Visitors to the establishment, by giving a fictitious appearance of comfort to the patients' beds. In the following year the Commissioners were able to report that the practice of using day sheets had been entirely discontinued; and that at Camberwell House also day sheets were no longer permitted to be used.

The steady improvement in the quality and the number of attendants on the insane led the Commissioners to say in 1852 and again in 1860 that there was a great improvement in that there was diminished use of restraint as a form of treatment. In 1873 there was noted a general consensus of opinion against coercion, but the abolition of restraint by consent rather than by legislation was favoured. There was, however, one outstanding exception. At a visit by Commissioners to Colney Hatch in 1873 the amount of restraint was remarked upon as being without precedent in any English asylum, and the hope was expressed that some less objectionable mode of dealing with violent and destructive propensities would be adopted. The Committee of Visitors replied: "Setting aside the mere question of expense, manifestly unjustifiable, it is impossible to conceive a more galling and irritating kind of restraint than the ceaseless surveillance of a bad attendant of uncertain temper. A false estimate of the uncomfortableness of 'gloves' and other mechanical restraints is frequently formed by assuming that the condition of the sane (who judge) is identical to that of the insane (who are judged). As a rule, with but few exceptions, the enjoyment of the latter is not in any way lessened by a process which would be as disagreeable and degrading to the former as the habits for which it is the obvious corrective." The Visitors added that they agreed with Dr. Sheppard that when it became the choice between some slight restraint and continuous struggling with an attendant, both the safety and comfort of the patient were promoted by the adoption of the former alternative. A long correspondence followed, and I believe had some effect in reducing the use of restraint.

In 1889 and 1890 the Commissioners were still bothered about the continued use of restraint in a few hospitals. They referred particularly to the use of mechanical restraint in the treatment of patients in Bethlem. They disapproved of any form of mechanical restraint used with a view to economy of attendants or simply to prevent destruction of dress or bedding, and they advocated frequent intermission of restraint where it must be employed. Under Section 40 of the Lunacy Act, 1890, new regulations governing restraint were issued; those regulations are well known to you all.

During the period 1840–1845 the use of restraint had greatly diminished and in consequence a new problem arose. Buildings did not lend themselves to the grouping of patients according to type and behaviour. Consequently seclusion came to be regarded by some as the only alternative to restraint in the management of troublesome patients.

It is probable also that the use of seclusion of the insane patient was based not only on the necessity for putting aside dangerous patients, but because it was thought that the "dark house" might have some beneficial effect on the disease. The need for seclusion seems to have been broadly accepted, but from time to time there appeared in the reports of committees and in writings on psychiatric subjects suggestions that the use of isolation had been abused to an extent which, even in the early nineteenth century, none could suffer to continue. The subject was dis-
cussed by the Metropolitan Commissioners in 1844. In order to reduce the necessity for bodily coercion they had pressed, in the Metropolitan district, the division of patients into classes, the separation of those who were excited or dangerous or with offensive habits from those who were quiet and agreeable. They further recommended the erection of separate rooms for the temporary seclusion, within short periods only, of those who were subject to paroxysms of excitement or violence. Finally, recommending seclusion as a proper treatment, they went on to illustrate by examples the dangers attending the total disuse of mechanical restraint.

The legislature at this time required a register of restraint to be kept but not yet of seclusion. At Hanwell Asylum, however, they had already adopted a method of recording seclusion, and the requirement was printed in the rules of the asylum. The rules contained elaborate details relating to the care of patients, and, in particular, their occupation during the day. Notwithstanding these signs of progress there is in 1858 a reference to the widespread use of seclusion in the workhouses of the country; the "dark strong cells constructed for the solitary confinement of refractory paupers are used for the punishment of the insane, merely to prevent trouble, and even the dead house has been made to serve the purpose of a seclusion room!" Seclusion used in this way was described as merely another method of restraint employed usually at the discretion of nurses or attendants, and without the knowledge of the Medical Officer or of the Master of the workhouse. The public asylums were, on the whole, better conducted, though in 1859 the amount of seclusion used at the West Riding Asylum was noted and suggestions made for its diminution. The Commissioners were better pleased in 1860: they commented on the steps that were being taken to reduce the amount of seclusion, which was formerly frequent and prolonged.

Seclusion was defined as any amount of compulsory isolation in the day-time whereby a patient is confined in a room and separated from all associates. The definition gave seclusion a wider interpretation than some would have liked, but attention being called to it there resulted a gradual discontinuance of the practice, leading to a more satisfactory condition of the patients. Notwithstanding the Commissioners’ efforts the practice of locking up patients alone was still carried on in a few asylums, not always it was alleged for medical reasons but often as a matter of convenience and perhaps of economy. Many medical men, however, regarded seclusion as a most valuable agent in the treatment of insanity and there was a general desire that it should be permitted, but a record should be kept to prevent its being adopted for other than medical reasons. Such views were expressed in 1858, notwithstanding that under Section 39 of the Act of 1845 the law required a record of seclusion to be kept in all institutions where it was used. Apparently the requirement had been ignored.

On 20 May, 1866, an anonymous letter was received by the Board of Commissioners and in consequence of it a special visit was paid to Colney Hatch Asylum. They found that destructive patients were secluded in a room by day and by night without bedding of any kind with only bare boards and brick walls and entirely naked. One had been thus shut in for as long as 10 nights and one for several weeks. It appears that such a system was quite unknown in the other asylums in this country. Dr. Sheppard, the physician to the hospital, not only admitted the charge as substantially true, but informed them that a similar treatment had been adopted in a series of cases where patients were destructive of clothing and bedding. He defended the practice on the grounds that the skins of these patients were of such an unnaturally high temperature that they were quite insensible to cold; that all covering was painful and irksome to them, and that their own choice was to remain naked. The doctor was so sure of his ground that he wrote in some of the leading medical journals vindicating a form of treatment which the Commissioners had condemned. After much correspondence he agreed to the request of his Committee of Visitors not to repeat the practice he had justified. In 1873 it is recorded that in Durham, Stafford, Brentwood and Brookwood Asylums seclusion was no longer employed, and in thirteen other asylums it was very rarely used. The Commissioners expressed the now general opinion by questioning the utility of seclusion on the ground that its remedial value was much exaggerated, and that in many instances it was employed unnecessarily and to an injurious extent for periods which were quite unjustifiable. They had no doubt that the patients were often put in seclusion as a punishment, and that the effect it produced could be obtained by treatment of
a less repressive character. From this time on seclusion was used less frequently, and only by the direction of a medical officer. At Hoxton House in 1899 a nurse was dismissed for excluding a patient without medical order, and ignoring the rules of the establishment that the patient's clothes should be removed and the patient visited at intervals of 15 minutes. This attitude reflects the position as it exists to-day. Better nursing with good classification of patients have made the use of seclusion unnecessary. Seclusion is rarely used, and except in an emergency it is not generally thought to have any advantages as a means of treatment.

Turning now to the question of detention under care it is important to distinguish between the private patient and the person who was a charge on the parish. The 1774 Act referred only to private patients. Paupers were not included, but were sent to asylums without any medical certificate and without any authority except that of their parish officers. Up to the year 1808 the only enactments affecting pauper lunatics were certain provisions in the Vagrant Acts authorizing the detention of dangerous lunatics. By the 1828 Act no pauper patient could be received without a medical certificate. Under Section 67 of the Act of 1833 the relieving officer or overseer of the parish brought him before a justice, or if this were inconvenient, before an officiating clergyman. One medical certificate was also required. Under certain circumstances (not properly taken care of or cruelly treated) two justices were required in place of one.

The power to place private patients in a house set apart for the treatment of persons of unsound mind, always subject to certain limitations, remained with the relatives or friends. The manner of admitting patients on the ground of lunacy in the eighteenth century appears to have been subject to the whim or greed of the person keeping the house and, indeed, it would appear that any patient could be put away by a relative who seemed to the proprietor of the house to have some semblance of authority. Giving evidence before a Committee of Inquiry in 1773, Dr. Battie gave it as his opinion that private mad-houses required some better regulation; that the admission of persons brought as lunatics is too loose and too much at large, dependent upon persons who are not competent judges. On being asked if he had ever met a person of sound mind in confinement for lunacy, he said it frequently happened. He related the case of a woman perfectly in her senses brought as a lunatic by her husband to a house under the doctor's direction, whose husband, upon Dr. Battie insisting that he should take his wife home, justified his action by frankly saying that he thought the house was a sort of Bridewell or House of Correction. A Mrs. Horley, having been invited in an affectionate letter by her mother and husband to go on a party of pleasure to Turnham Green, was carried by them to a mad-house at Chelsea kept by Turlington. She alleged that she was shut up night and day in a chamber locked and barricaded, refused the use of pen and paper and treated with severity. She was never visited by her mother and remained in confinement until, following action by some friends, she was granted by Lord Mansfield a writ of habeas corpus and so achieved discharge.

The report on the investigations of the Select Committee of the House of Commons, 1773, led to the passing of the Act of 1774. Thereafter houses were licensed, and the President and members of the College of Physicians for the time being elected annually five Fellows as Commissioners for granting such licences. The Commissioners so appointed were to visit the houses they licensed at least once a year to examine their state and the condition of the inmates. This applied only to the Metropolitan area, i.e., the Cities of London and Westminster and within seven miles thereof and within the County of Middlesex. Corresponding duties for the provincial areas were to be carried out by Justices of the Peace appointed at Quarter Sessions. Another Parliamentary Committee of Inquiry which sat in 1815 and 1816 carried out a most rigid inquiry into the condition of the insane. The result of that investigation fully satisfied every person of importance that immediate legislative interference was necessary. Nevertheless, matters were allowed to remain in this state until 1828, when Mr. R. Gordon submitted a motion to the House for leave to bring a Bill to amend the law relating to the regulation of lunatic asylums. This Bill became the Act of 1828. Some of the provisions may be of general interest. The Act provided that no person, other than a parish patient, should be received into any house kept for the reception of two or more insane patients without a certificate. Every such certificate was to be signed by two medical practitioners who had separately visited the patient. The physician was merely
called upon to certify to the abstract fact of the presence of unsoundness of mind in any given case. It was not until 1853 that he was required to state the facts upon which his opinion was founded.

In order further to protect the interests of the patient, the Secretary of State of the Home Department was directed to appoint on 1 June every year, or within ten days following, not less than fifteen persons to be Commissioners for the Metropolis, of which Commissioners, five at least had to be physicians, or surgeons. They were to be allowed £1 for every hour employed in visitation, exclusive of travelling expenses, provided that the number of Commissioners did not exceed three for one visitation. The Justices sitting at Quarter Sessions were to appoint three or more of their number and also one or more physician or apothecary to perform the corresponding duties outside the London area.

While important progress was made as a result of legislation in 1828, it is quite clear that patients were received sometimes on inadequate grounds and sometimes illegally. As late as 1843 a lady found confined in a licensed house at Derby was represented as a visitor and not a patient. She was later proved to have been brought from another asylum where she was a certified patient. The proprietor had, for financial reasons, given a certificate of detention so that the trustees could pay to her husband dividends to which she was entitled. She was liberated after the Commissioners had protested that her detention was improper.

The Act of 1828 provided also that every licensed house containing 100 patients should have a resident physician, surgeon or apothecary. Pressure was put on the County Asylums authorities also to observe this sensible provision. At the Norfolk County Asylum in August, 1843, there being no resident doctor the lay superintendent was asked what he would do in cases requiring immediate attention and treatment. His answer was that he would not venture upon the responsibility of applying remedies, that he could not bleed and had no knowledge or experience, medical or surgical. Upon being asked again what steps he would take in such cases he said that he would send to Norwich, the nearest place three miles distant, for one of the medical Visitors. He subsequently directed the Commissioners' attention to a pony on the lawn which, he said, was constantly ready to be saddled as occasion required.

In 1842 the Metropolitan Commissioners were given authority to visit places for the insane in the whole of England and Wales. Some of their reports showed that all was not well. The high incidence of bad practice observed made it clear that the visits of the magistrates had not had the effect of correcting all the irregularities and abuses existing at many establishments, nor of putting an end in a few instances to cruelty of the most flagrant character. In referring to the work of the Visitors, they suggested that subjects of inquiry to which hitherto full attention had not been given were the state of mind of the patient in reference to his fitness for liberation, the nature and effect of the employment provided for the patients with a view to diverting their disease, the character of the medical reports as indicative of the care and intelligence bestowed on the mental condition of the patients by medical officers, and the rate of payment made for the patients and the attention bestowed upon them by their parish officers.

After their first visit to The Retreat, near York, the Commissioners paid a tribute to Mr. Samuel Tuke. They complimented him as "a gentleman well acquainted with the management of the principal lunatic asylums, and who has, for many years, made the treatment of lunacy the subject of his especial observation; and he called our attention to the necessity of the more frequent and vigorous supervision of all asylums. As he has already expressed his sentiments on this subject, in a publication relating to hospitals for the insane, we have thought it right to lay them before your Lordship." The visit to the asylum at West Auckland in December, 1842, did not end so happily. Although there were only thirteen males and sixteen female patients, the space available out of doors was so small that when one sex was in it the other was locked up. In the men's room, with only one (unglazed) window, five men (of thirteen) were restrained by leglocks called hobbles, and two were wearing, in addition, iron handcuffs and fetters from ankle to wrist. They were all tranquil! The Commissioners who first visited the asylum wrote that, in their opinion, the place was entirely unfit for the reception of insane persons. On the day following their visit two local magistrates made this minute in the Visitors' Book: "We have to-day visited the asylum and found the Commissioners had just left it. We found
everything in good order." At the second visit in 1843 only one patient was under restraint. On this occasion they learned that the medical attendant considered bleedings, blisters and setons were the principal resources of medicine for relieving excitement.

During the years following the Acts of 1842 and 1845 the question of the liberation of patients by their friends or by parish officers was frequently raised and great irregularity in practice was alleged. The Commissioners referred to the many occasions when liberation was obtained by the importunities of the patient or took place in order to save the expense of his confinement in a lunatic asylum. They were, however, mainly concerned with the dangers attending the release of dangerous lunatics. It was not proposed at any time to limit the powers of the friends of the private patient, but rather to give to some persons full authority to bar the discharge of dangerous patients with, at the same time, power to insist on the discharge of those who need no longer be detained.

Section 99 of the 1845 Act enumerates those who are to be protected at law from the consequences of their action in contributing to the certificates and detaining the patients, i.e., the medical man, the keeper of the asylum and servants, but leaves out the person authorizing the detention. Such person was only protected at common law if the patient confined was, in fact, a lunatic. The Times of June, 1849, gives an account of an action for damages for the incarceration of the plaintiff, a maiden lady, in a licensed house for lunatics, under the pretence that she was of unsound mind when, in fact, she was perfectly sane. Miss Nottidge, with two married sisters, joined a religious society, the members of which lived together in an establishment called The Abode of Love. She was forcibly taken away by the defendants, her brother-in-law and brother, was brought to London and was placed in a licensed house at Hillingdon, where she was detained for seventeen months, and then liberated by the direction of the Commissioners in Lunacy. There was a verdict for the plaintiff with damages of £50. The Jury expressed the view that the defendants were not actuated by any unworthy motive. During the course of this trial, and in particular during a conversation between the Lord Chief Baron of the Exchequer (the Presiding Judge) and Mr. Milne, one of the Commissioners, his Lordship was understood to express an opinion that no person ought to be confined as a lunatic unless he was dangerous to himself or others. It was pointed out by the Commissioner that this opinion was not consistent with the wording of the Lunacy Acts. Now everybody was alarmed, and his Lordship's opinion led to discharge by the relatives of a large number of patients who, by common consent, should have been under care. The Annual Report of the Royal Edinburgh Asylum shows how fearful friends of lunatics had become: "there seemed to be a general apprehension that all lunatics who were not actually and immediately dangerous to themselves or others were forthwith to be set at large to vex the World with their Follies and to expose themselves to Insult, Imposition and Injury. The influence of the Decision referred to seems to have so far affected the better judgment and experience of some Parties, that not a few Removals from asylums were the Consequence: for during the past year not less than four patients were admitted into this asylum who had been dismissed from Confinement (I should rather say deprived of protection) under this Nottidge mania, and had subsequently been breaking windows, knocking down Policemen, carrying loaded Pistols on their Persons to shoot Doctors with, or wandering through the streets under the belief that they were royal or divine personages." Here then was an occasion when the rightness of an Order to detain a person who was harmless was questioned by a noble judge with much effect on the people who assumed responsibility for the detention of patients in licensed houses and registered hospitals.

The following case illustrates another point of view: In 1862 a Member of the House of Commons who was under care in a licensed house was given leave of absence to record his vote on a matter before the House. From the certificate it appears that the gentleman was subject to delusions impelling him to violence rendering him dangerous to others. On the morning of the Division the Medical Superintendent with the patient went to consult the proprietor (himself a medical man) on the propriety or otherwise of permitting the patient to take part in the vote that evening. He was warned of the consequences, but the medical superintendent, on his own responsibility, gave the patient leave from 8 p.m. to 2 a.m. When the matter came to the ears of the Commissioners there was an inquiry, the
medical officer was found guilty of a grave breach of professional trust and was required to resign his post. The problems relating to the detention of patients who are not immediately dangerous have, on several occasions throughout the century, been considered by the House of Commons through Select Committees. There has appeared from time to time an expression of feeling that many patients are unnecessarily detained, and that there should be some stricter form for securing the detention of patients, and closer supervision to ensure that no patient is retained under Order for a moment longer than the social necessities demand. Medical requirements were apparently not given much attention, largely because there was a suspicion that a patient unless he were dangerous could be treated as well out of hospital as under the strict régime of an establishment for lunatics. In the Parliamentary Session of 1877 a Select Committee of the House of Commons was appointed "to inquire into the operation of the Lunacy Laws so far as regards the Security afforded by it against violation of personal liberty." The Committee reported in March, 1878.

As to the liberty of the subject, they considered that although the present system of certification was not free from risk, allegations of mala fides or of serious abuses were not substantiated. Nevertheless with the object of correcting abuses, they made certain suggestions. The Commissioners were unhappy about these recommendations. They were not disposed to advocate any radical changes in existing law, and were satisfied that the present system of certification, both of private and pauper lunatics, provided adequate safeguards. They were satisfied, too, that the visitation of places where patients were received afforded in practice ample safeguards as well against the admission of persons not of unsound mind as for the discharge of the insane patients without undue detention. But they thought some improvement could be made by modifying existing regulations. As the law stood the request in private cases might be signed by anyone who chose to take the responsibility and who had seen the patient within a month. He must state his relationship, and if no relation, his other circumstances in connection with the patient. It sometimes happened, though not frequently, that in the urgency of the case no relative could be found, so that the request might be signed by a friend or other acquaintance, or occasionally even by a servant. Great exception had lately been taken to this and they thought that it should where possible be avoided. At the same time they were unable to recall any instance in which they had occasion to question the good faith of Orders so made.

The new proposal, based on the Select Committee's Report, which was made, in a private Bill in 1880, providing that no person should be sent to an asylum except upon an Order granted by a Justice of the Peace of the district, was strongly opposed by the Commissioners on the ground that the certain result of the measure would be to increase in many cases the reluctance, already very great, to place a relation under early treatment. The Bill sought also to provide that the petition must be signed by a relative or by a solicitor on his or her behalf duly authorized, or a relieving officer, accompanied by certificates signed by two registered practitioners, one of which must be the Medical Visitor of the district. The Commissioners wrote that "the proposal seemed to them to depend on constantly reiterated assertions that further safeguards are needed for the liberty of persons alleged to be insane. The existence of such a feeling is doubtless to be regretted, but it would be entirely contrary to sound principle to alter the law in an important particular without evidence of recent abuse." The Bill did not pass the House.

Notwithstanding the Commissioners' reservations in 1880 the Act of 1890 included a provision that except in cases of urgency no private patient should be received except on an Order. The Act introduced for the first time a public functionary termed the "Judicial Authority" as the authority for the reception and detention of the private patient. For pauper patients a justice or an officiating clergyman had long been required to sign the "order." The Commissioners were strongly opposed to these new provisions. They gave their own views and called to their aid those of the late and deceased Chairman, Lord Shaftesbury, as to the expediency of the change. A similar recommendation had been made by the Select Committee of 1878 when the Commissioners had opposed it. They now expressed the hope that the change involving the more complicated and difficult procedure for obtaining Orders might not lead to the results they feared, namely, the placing of an impediment in the way of early treatment, so important in the care of
insanity, and to the withdrawal from official cognizance and supervision of many insane persons.

Another innovation was introduced during this period. Hitherto certificates had remained in force so long as the patient was detained, but by the Lunacy Amendment Act of 1889 the authority for the detention of all patients, pauper as well as private, was made terminable at various periods during the detention unless renewed by a prescribed process.

The provisions relating to voluntary patients, as they are known to-day, were born in 1854 through an Amending Act which, amongst other things, empowered proprietors and superintendents of licensed houses, with the consent of the two Commissioners, to entertain and keep as a boarder any patient desiring to remain after his discharge, and any relative or friend of a patient. There was, however, a severe limitation. The Commissioners were not to consent until they had, by personal examination of the patient, satisfied themselves of his desire to remain. Any two Commissioners, might from time to time, by any writing under their hands extend or revoke any such assent. The tight hand was seen in the further provision in Section 6 of the Act that every such patient so retained after discharge and every such relative or friend so accommodated shall, if required, be produced to the Commissioners and Visitors. Apparently the experiment succeeded, because the Lunacy Acts Amendment Act, 1862, extended the provision to any person who may have been within five years preceding a patient in any asylum, hospital or licensed house or under care as a single patient.

As there was no provision in the Lunacy Acts expressly prohibiting or regulating the reception of boarders into hospitals or such provision being confined exclusively to licensed houses, it was hoped that the voluntary boarders' provision might be extended to the hospitals called "registered hospitals." With this in view the Commissioners sought Counsel's opinion whether, in the circumstances, persons ("being conscious of want of power, of self-control or an addiction to intemperate habits, or fearing an attack or recurrence of a mental malady"), being free agents in all respects, are desirous of residing as voluntary boarders in an institution for the insane with a view to medical treatment and supervision may be admitted to Registered Hospitals. Counsel agreed and thereafter voluntary boarders were admitted to registered hospitals.

The Select Committee of the House in 1878 made suggestions as to the removal of restrictions on voluntary boarders. The Commissioners protested that the existing system of admitting boarders had answered quite well. They were prepared to extend it to any person who at any time had been an inmate of an institution for the insane or had been a single patient, but they did not recommend the indiscriminate admission of persons never certified as insane. Their objections were based on the fear of attempts at evasion of the law by introducing as boarders persons who ought to be under certificate, by the fear of the introduction of mere drunkards, and by the fear of crowding the houses to the inconvenience of insane persons. They insisted that the prior consent of themselves or the Visitors should be required. Even in the Act of 1890 the admission of voluntary boarders was confined to Licensed Houses and only by implication to Registered Hospitals, though the conditions relating to reception were slightly modified: the consent of the Commissioners or Justices was still required. Provision for any relative or friend of the patient was continued. Thus the facilities relating to voluntary boarders were extended very, very slowly, and we had to wait until 1930 before voluntary patients could be admitted to hospital without the consent of the central department.

I have endeavoured to trace the development in this country of certain aspects of illness, and to show how society dealt with some of the problems which are always associated with a mental breakdown. It has not been possible to do more than indicate briefly the direction in which we are moving. It is, however, clear that we need new laws and new provision for the mentally ill. These I have no doubt will come in due course. Your support and your enthusiasm will ensure that when it comes it will be in a form which will enable medical and social treatment to be carried out under the conditions you desire.

In concluding this lecture I would like very briefly to express my own views on two points of major importance to psychiatry. The first relates to the certification of patients as persons of unsound mind. In the period immediately prior to 1890 there was a strong feeling expressed by a Select Committee of the House of Commons
that the intervention of some legal authority was necessary before a private patient could be committed to a hospital for treatment. I have been unable to ascertain the exact reasons for the proposal, except only that it had for a long time been required for the detention of pauper patients. In spite, however, of the Commissioner's protests, a new provision with this requirement was included in the Act of 1890. That may have been a step backwards. Since 1930 we have experimented with a system of temporary detention made on the recommendation of two doctors, but it applied only to patients who were unable to express themselves as willing or unwilling to receive treatment. Consequently it could not be widely used. It is possible that if such a provision were extended to cases where the patient is unwilling because he is mentally ill, we should often avoid using the greatly feared process of certification.

My second point relates to the voluntary patient. The Mental Treatment Act, 1930, provided for the first time for the voluntary admission of a patient seeking treatment though he has to give three days' notice of departure. This was a long step forward, but the proportion of voluntary patients admitted varies so widely—between 45 and 94 per cent.—that it is evident that in some hospitals the provision is not being fully used. Nevertheless the experience since 1930 has been so encouraging that many of us would like to go further and admit suitable patients into mental hospitals under the same informal conditions that govern admission to hospitals for the treatment of physical disease. I believe with Galton that "treatment is a chain of eventualities each of which must be a success." The doctor's relationship with the patient depends on confidence, and it would be a further great advance if conditions of any kind were imposed only where it is shown to be absolutely necessary. Society is ready to use new paths in psychiatry; it is hoped that psychiatrists will show the way.
The Twenty-Seventh Maudsley Lecture: The Unwilling Patient

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