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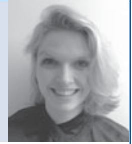
Editorial

Return of the asylum



Jane Gilhooley and Brendan D. Kelly

Summary

Rates of involuntary admission are increasing in England. Personality disorder should be excluded as a criterion for involuntary admission; stronger restraint reduction programmes should be instigated; and involuntary care should be based on treating illness (something we can do) and not on predicting violence (something we cannot).

Declaration of interest

None.

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Introduction

The history of psychiatry in many countries is dominated by the emergence and dissolution of large public asylums for people who are mentally ill.[1] With growing emphasis on delivery of care in the community in the 1960s and 1970s, it was hoped that restrictive practices such as disproportionate loss of liberty, enforced medication, restraint and seclusion would decline and remain at low levels. But although the majority of psychiatric institutions were indeed closed during the latter part of the 1900s, there are now unsettling trends to suggest that psychiatric institutions and institutional practices are returning, or that they never really went away, in many countries, including the USA and England.

Rates of involuntary psychiatric admissions

In the USA, Sisti and colleagues point to persistent problems with trans-institutionalisation, arguing that as the asylums closed people with mental illness ended up in nursing homes, general hospitals, emergency departments and prisons.[2] Similar trends are reported elsewhere,[3] and Sisti and colleagues, although warning against a return to long-term institutionalisation, call for the provision of safe, supported living arrangements for individuals who are mentally ill.[2] Their call is both urgent and important because evidence is mounting that, in the absence of proactive provision of supported, integrated community residences, custodial psychiatry is reappearing by stealth.

There is much evidence to support this concern in England too. In 2015/2016, the rate of involuntary psychiatric admission in England was 120 involuntary admissions per 100 000 population per year, an increase of 9% since 2014/2015 and an increase of almost half (47%) over the preceding decade.[4] That is more than double the rate of involuntary admissions in neighbouring Ireland, which stands at 46.7 per 100 000 population per year and is relatively steady.[5]

In England, the use of 'short-term orders' (with a maximum duration of 72 h) increased by some 15% in 2015/16 compared with 2014/15. Neither 'short-term orders' nor 'community treatment orders' exist as such in Ireland, so all patients subject to compulsion of any description in Ireland are included in the figure of 46.7 per 100 000 population per year, indicating an even deeper contrast between the two jurisdictions.

It is, however, important to note that, over the past decade, the number of people removed from a public place by the police in England and brought to a hospital under Section 136 of the Mental Health Act 1983 rose from 5495 in 2005/06 to 22 965 in 2015/16, an increase of 318%. Between 2014/15 and 2015/16 alone, the increase was 18%. This, however, might well be a positive trend because use of police cells has fallen substantially since 2011, as use of Section 136 has continued to increase.

Use of restraint

There is, however, evidence of widespread use of coercion following psychiatric admission. Mind and the National Survivor User Network report that in England in August 2015, across all mental health trusts and 15 independent mental health service providers, there were 9600 uses of restraint, of which 16.5% were prone/face-down restraint.[6] There were also increases over time: in Aneurin Bevan in Wales, there were more than five times as many uses of restraint as the year before, and Hywel Dda's figures quadrupled between 2010 and 2013.

Agenda, an alliance of more than 70 voluntary sector organisations for women and girls at risk, analysed data on physical and face-down restraint in 51 trusts in England in 2014/15 and found that approximately 20% of women and girls admitted to mental health facilities were physically restrained, with some 6.3% of women and 6.9% of men experiencing face-down restraint.[7]

Although physical restraint can be clinically necessary, it can also have significant emotional and psychological consequences, including possible re-traumatisation of people who were assaulted or abused in the past.[7] In addition, the Care Quality Commission reported that 16 deaths occurred within the 7-day period following physical restraint in England 2015/2016.[8] The verdict of the coroner had not yet been given for three cases; for the remaining 13 none were found to be related to the restraint itself.

Personality disorder and involuntary admissions

Looking at rates of involuntary admission overall, the roots of the contrast between England and Ireland relate, in significant in part, to mental health legislation. The evolution of English mental health law over recent decades has been strongly driven by public safety concerns, centred chiefly on a small number of high profile killings by people with mental illness.[9] The result is the perpetuation and intensification of a set of legal arrangements that is notably

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coercive by international standards, permitting, for example, involuntary treatment for personality disorder. In Ireland, by contrast, public safety is entirely absent from discussion of mental health law; reform is driven almost exclusively by promotion of the human rights of individuals with mental illness; and personality disorder is explicitly excluded as a criterion for involuntary admission and treatment under the Mental Health Act 2001 (Section (8)(2)(a)).

Combined with various service deficiencies, current legal arrangements in England have facilitated the emergence of a notably coercive psychiatric regime, with consequent rises in rates of detention and restraint. Interestingly, and despite present contrasts, Ireland has been down this road in the past, most notably with the tragically misguided Dangerous Lunatic Act (1838) that followed from the murder of Nathaniel Sneyd, a bank director, by a person with apparent mental illness.[1] Passed without parliamentary debate, the primary purpose of the 1838 Act was to protect the public from the dangers allegedly posed by people with mental illness. Its terms of confinement were extremely vague; the person did not need to commit an offence to be declared 'dangerous'; the police (and not the family) had responsibility for transporting the patient to the asylum; and the asylum was under an obligation to accept the patient, even if it was full. Although many other social forces also underpinned growth of the Irish asylums, the 1838 Act was the single greatest driver of admissions: committal rates rose dramatically after 1838 and by the early 1900s Ireland had more asylum beds per head of population than any other country in the world.

The legacy of the Irish asylums was difficult to abolish, but Ireland's rates of involuntary admission are now relatively low. Like all other countries, Ireland still has problems with homelessness and imprisonment among individuals with mental illness, but, overall, the Irish mental health system is now substantially less custodial than it was, and dramatically less custodial than that of England.

Conclusions

Legal reform must lie at the heart of positive change. Personality disorder should be explicitly excluded as a criterion for involuntary admission, not least because evidence for therapeutic benefit or risk reduction is not sufficient to justify the loss of liberty involved. In addition, a stronger, statutory restraint reduction programme should be instigated, along the lines of that introduced in Ireland in 2014, in order to ensure that use of restraint in psychiatric facilities is safe, legal and rare.

And finally, we should be clearer with law-makers and the public about our extremely limited ability to assess risk.[10] Involuntary care should be based on treating illness (something we can do) and not on predicting violence (something we cannot).

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