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Research Article

A Brief History of Psychiatry- Applications for Current Practice

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Abstract

This article describes moral treatment as practiced in the late 1700's in France and in the United Kingdom **(UK),** compared to the ethical framework described by the UK Royal College of Psychiatry in 2014. The history of treatments and evolution of legislation and safeguarding processes to protect the mentally ill and disabled in the UK are described, alongside developments in the 1920's leading to 'mercy killing' of institutionalised patients. Issues impacting on contemporary psychiatric practice are described, alongside potential solutions such as co-production and compassionate leadership training of clinical leaders. **Learning objectives**: at the end of this article, you will be able to

- Understand the evolution of moral therapy since Pinel in 1795
- Describe the components of the current ethical framework for contemporary psychiatric practice
- Understand principles of co-production and compassionate leadership

Introduction

The ethical framework for psychiatric practice has been outlined in 'Good Psychiatric Practice' compiled by the Royal College of Psychiatry, involving

- Respect dignity of patients
- Not exploiting a patient's vulnerability
- Providing the best attainable psychiatric care and
- Maintaining confidentiality of patients.

Similar sentiments have been described by the World Psychiatric Association in 2011; beneficence, user autonomy, improving practice, and promotion of mental health.

However, since these reports, other issues have surfaced including the role of psychiatrists in preventing deaths from suicide, on seeking consent for drug research, use of patient data for commercial research and on deciding capacity when applications for medical assistance in dying are considered. Furthermore, there has been repeated evidence of vulnerable patients being abused, neglected and exploited [1]; mainly within units caring for adults with learning disability and autism. There is also evidence of abuse of patients with dementia by care staff in community units [2].

These issues suggest the need to review the ethical framework of ongoing psychiatric practice [3], including revisiting the original (and revolutionary at the time) 'moral treatment'; which focussed on the importance of promoting kindness, respect and freedom from abuse of incarcerated patients.

History

The originator of 'moral treatment' (best described as morale enhancing treatment) was Phillippe Pinel, a psychiatrist who headed the Bicêtre, a hospice for men in Paris between 1793 and 1795, and thereafter the Salpêtrière, a hospice for women for a further 3 years. Pinel was guided in this approach by his colleague Jean Baptiste Pussin, who replaced chains with straightjackets

when needed to restrain challenging behaviour to avoid self-harm.

Pinel described his work in a book titled 'Memoir on Madness'. His treatment included kindness, patience, recreational walks and pleasant conversation instead of physical punishment for challenging behaviours. He also recommended the use of careful observation of behaviour, understanding precipitants and noting changes over time to arrive at diagnoses. He rejected the proposition that mental illness was through by demonic possession, a commonly accepted causation at the time.

Moral therapy thereafter influenced practice in the UK in the early 1800's, especially for fee-paying patients in purpose-built asylums such as the Royal Asylum in Edinburgh [4] and the Retreat in York [5]. It was thought that architectural design of asylums assisted patient's recovery alongside exercise and work. Patient's letters describing their experiences and views about treatment at the Edinburgh asylum were published [6] However, conditions for non-fee-paying patients (called pauper lunatics) - remained unsatisfactory [7], with frequent moves between asylums and workhouses. There was also evidence of gross overcrowding in both types of institutions.

Thereafter, in Germany during the early 1900's, Emil Kraepelin, Karl Jaspers and Arthur Kronfeld used Pinel's use of prolonged observation to determine symptom syndromes and patterns of illness separating the outcome of schizophrenia from bipolar illnesses. However, the gross overcrowding in institutions and restricted state funding prompted publication of an article titled Die Freigabe der Vernichtung Lebensunwerten Lebens (Allowing the destruction of life unworthy of life) by Karl Binding, a law professor at the university of Leipzig and Alfred Hoche, a professor of psychiatry at the University of Freiburg [8]. Hoche described people who were brain damaged, intellectually disabled and psychiatrically ill as 'mentally dead', 'human ballast' and 'empty shells of human beings' suggesting that killing them would be 'useful'.

This idea became increasingly popular in medical and political establishments during the Weimar Republic leading to progressive restrictions in food for inmates in institutions, non-treatment of infections and finally, death by infusions of Potassium Chloride or by exposure to Carbon Monoxide [9]. The subsequent National Socialist regime made this process more efficient as 'Aktion T4', resulting in the death of around 250,000 people in psychiatric institutional care.

Around the same time, 'physical therapies' targeting the brain were introduced, including frontal lobotomy (leucotomy) by Egaz Moniz in Portugal around the mid 1930's [10]; mainly used on people with 'positive' manifestations of psychosis with associated challenging behaviour. Thereafter, Electro-Convulsive Therapy **(ECT)** was introduced by Cerletti and Bini in Italy [11]. Insulin coma therapy introduced by Sakel in the 1920's continued up to 1950's, to induce a seizure similar to ECT; but longer lasting in effect. These therapies received widespread support from psychiatrists at the time [12], despite a 5% mortality rate from leucotomy and Insulin coma therapy. However, these procedures did not result in reducing the overcrowding in psychiatric institutions, simply making psychotic patients more docile and less prone to challenging behaviour.

The Psychopharmacology Revolution

The start of psychopharmacology commenced with the use of Chlorpromazine (a repurposed anaesthetic agent) by Laborit in 1951, followed by Delay and Deniker using this drug for Schizophrenia and Manic states [13]. It was clear that this drug was significantly more effective than previous treatments described above, resulting in significant numbers of patients being released from asylums back to their families. Chlorpromazine as a tranquiliser was also used to restrict challenging behaviour ('chemical straightjackets').

Since then, variations on Chlorpromazine have been developed largely to reduce parkinsonian side effects, up to the current use of 'atypical' antipsychotic agents commencing with Clozapine in the 1980's followed by Olanzapine, Quetiapine and Risperidone, the mainstay antipsychotics in use today. However, the Glucose Transporter blocking potential of these drugs [14] has resulted in frequent diabetic, cardiovascular and thrombo-embolic consequences, often not discussed with patients and carers prior to commencement.

The other modification in antipsychotic use has been depot (long acting) injectable antipsychotics providing a treatment gap of 2 weeks up to 3 months. There has been evidence of depot antipsychotics reducing the number of readmissions in early stages of psychoses [15], although ethical concerns about the use of depot medication in young patients have persisted.

On electrical stimulation of the brain, instead of ECT, repetitive Transcranial Magnetic Stimulation **(rTMS)** has been developed [16] as a less invasive alternative to treat chronic depression unresponsive to multiple antidepressants. The latest innovation in treating mood, anxiety and obsessional disorders as well as Post Traumatic Stress Disorders has been the use of psychedelics such as Psilocybin, either in an individual or group setting [17].

Legislative Ethical Underpinnings

In the UK, mental health legislation commenced with the Lunacy Act of 1890, followed by the Mental Treatment Act of 1930, followed by Mental Health Acts of 1959, 1983 and 2007. A further revision of the Mental Health Act was introduced to Parliament

in November 2024. The overarching theme has been to restrict the criteria to incarcerate people with mental health conditions to psychiatric institutions. Exclusion criteria for incarceration have included primary substance and alcohol abuse (the 2007 act) and neuro divergence and learning disability (the 2024 act), albeit accepting the use of the act when these conditions are co-morbid conditions, in the context of major psychiatric illnesses.

Legislation governing community psychiatric treatment is currently limited to the 'Community Treatment Order' **(CTO)** permitting recall to hospital due to non-engagement with community psychiatric supervision including not attendance for treatment. However, the Oxford Community Treatment Order Evaluation Trial **(OCTET)**; a comprehensive analysis of CTO use [18] could not demonstrate reduced re-admissions over 36 months. Furthermore, some patients have perceived coercion from staff and families when a CTO is applied, to maintain drug (depot antipsychotic) treatment. It is also probably the case that CTO use was motivated by the need for public safety and for reducing hospital stays, rather than benefits to individual patients [19]. Furthermore, it is likely that being placed on a CTO reduces face-to-face staff involvement (as found by OCTET), alongside reducing access to psychological interventions.

Local Authority Safeguarding Processes.

The UK has multiple pieces of legislation and mandatory procedures, designed to protect the mentally ill and neuro divergent (including children and older people) and the mentally impaired (learning disability and neuro divergence especially people with autism). Legislation commenced with the Children's Act (1989) and includes, Sexual Offences Act (2003), Safeguarding Vulnerable Groups Act (2006), Children and Families Act (2014), the Children and Social Work Act (2017) and the Digital Economy Act (2017).

In order to back these pieces of legislation, local authority social work departments have evolved to prioritise safeguarding as its core function, with an evolution of policies and procedures - for example Working together to safeguard children (2018). The overall inspectorate of mental health services in England is the Care Quality Commission **(CQC)** with similar bodies in the other regions of the UK.

Despite the legislative and organisational interventions, repeated evidence of abuse and neglect of care involving mentally ill and disabled people have continued to surface, especially in privately run care institutions, as described above. NHS mental health units have not escaped poor practice and excess in-patient deaths, for example in Essex; leading to the Lampard inquiry.

Implication of Moral Treatment on Current Mental Health Services

The obvious difference in practice compared to the original work embodying moral treatment has been the dissolution of large asylums and a move to 'care in the community' involving reductions in psychiatric bed numbers and expansion of multi-disciplinary teams in the community, both generic (including crisis resolution) and condition specific, (for example eating disorders and gender dysphoria). The other change is a mixture of legislation and procedures to protect people with mental illness and neuro disability, instead of relying on ethical values underpinning treatment and incarceration.

Furthermore, there has been a move towards 'episodic care' of mental health illnesses, contributed to by the split between in-patient and community specialists with prompt discharge to primary care. However, limitations of these 'top down' moves are apparent, especially for people with severe psychoses, dementias and neuro disability, leading to a pattern of revolving door admissions with failure to maintain consistent community care. It would help if a single consultant traversing community and institutional care, as part of bed management to care for this relatively small group of revolving door patients.

Respect dignity of patients. This aspect is difficult to legislate for, as respect involves a culture associated with appropriate values across the whole of mental health services. As described above the problem has been toxic micro-cultures, often involving care of people with intellectual disability, neuro divergence and dementia. Respectful culture requires local clinical leaders (such as consultants and matrons), articulating and demonstrating values of respect and kindness alongside willingness to learn from service users. Alongside this, increased sensitivity to whistle-blowers is also necessary alongside disciplinary action against rogue staff. A practical application on improving respect towards patients and carers is the practice of co-production in treatment planning (see Box 1). However, limited research has been carried out on this topic [20]. Some mental health organisations are basing co-production practices as part of compassionate leadership development.

The other application of respect is reducing restrictive practices, including restraint and seclusion. Research in this area suggests an inexplicable variation in these practices in mental health settings [21]. Overall, in England it is estimated that around 17 restraints occur per 1000 occupied bed days in mental health wards (CQC, 2021). There is specific concerns about 'prone restraint' risking physical health consequences including fractures and hypoxic deaths. Most hospital services are attempting to reduce restrictive practices, although there could be an increase of patient violence towards others including staff as a consequence [22].

Co-production in mental health practice

- A way of working that involves people who use mental health services, their families, friends, and carers as equal partners with service providers.
- Based on the idea that people with lived experience are often best able to advice on what services and support will help them.
- Can be a single doctor-patient episode up to service users contributing to team strategy, service improvements and clinical research projects.
- Practical aspects include

1. Involving people in the design, development, and evaluation of services
2. Sharing power and resources with people who use services and carers
3. Valuing the assets of people who use services, carers, and staff
4. People involved receiving something in exchange for their contributions

Useful resource: National Collaborating Centre for Mental Health:

https://www.rcpsych.ac.uk › working-well-together

Box 1: Description of Co-Production

The concept of 'living wills' (advance directives on treatment) has been NHS policy since 2005 as part of the Mental Capacity Act. This includes a currently capacitious person to refuse a specific mental health treatment in the future, even if this results in death [23]. An advance directive can be revoked if the person is placed under a Mental Health Act treatment order, although it is expected that the treating clinician provide sufficient rationale to justify this revocation to a Mental Health Tribunal.

Not exploiting patient vulnerabilities. The main area of concern is violence directed at vulnerable patients within in-patient settings by other patients, and at times by staff (as detected by covert video recording). There is evidence that ward busyness, noise, and limited staffing is related to violence directed at patients [22], alongside features of agitation and persecutory beliefs held by patients who are assaultive. There is no evidence that restraint or seclusion prevents subsequent violence during an admission [24]. Increasingly mental health units are utilising body cameras worn by staff and closed circuit monitoring for early intervention regarding violent behaviours. The latest approach has been to apply 'Trauma Informed Care' to reduce harm to self and to others within ward settings [25].

The other key area where patients are vulnerable is provision of physical health monitoring and treatment, including screening for drug side effects (for example venous thrombo-embolism and impaired glucose tolerance), as well as avoiding psychotropic polypharmacy. In some localities, primary care services have declined to carry out physical health monitoring associated with psychotropics, and anti-hormonal drugs initiated in secondary care, with patients falling between services.

Psychotherapy, both short term Cognitive Behaviour Therapy and longer duration psychodynamic psychotherapy, if practiced without due supervision, can lead a vulnerable patient to making unwise choices in lifestyle, religious beliefs and relationships. However, research on the efficacy of supervision on patient outcomes is limited despite 30 years of practice [26]. There has been controversies involving 'false' retrieved memories as part of psychotherapy [27].

Providing the best attainable psychiatric care. The main examples of less than optimal treatment involves under usage of 'gold slandered' drugs such as Clozapine [28], Lithium [29], Electro-Convulsive Therapy [30] and CBT [31]. There is a multiplicity of reasons for these findings including public opinion, lack of local access, prescribing caution, complexity of initiation (including the necessity of in-patient beds) and easy access to medication such as atypical antipsychotics and antidepressants.

Best psychiatric care also includes information on treatment options. Often patients and carers are not provided options for treatment in digestible form leading to acceptance of clinician opinion. However, increasing use of the internet and availability of advocacy services could enhance service user awareness of alternative treatment options, and lead to co-production as described above. Good psychiatric care also involves adequate follow up and robust physical health monitoring in the community.

Maintaining patient confidentiality, whilst maintaining communication with patients and families. On confidentiality, there has been a long-standing tendency to restrict information to family members on the basis of patient confidentiality, which can increase the likelihood of risk. The notion of 'implied consent' has been used at times as part of common law, especially in situations when patient capacity to decide on disclosing information is lost [32].

The comprehensive digitisation of mental health documentation, accessible to non-mental health staff (such as local authority social workers) on a 'read only' basis does create risks but also benefits. Furthermore, digitally stored NHS information is prone to hacking by criminals. Anonymity of records for research purposes can be undermined by the availability of NHS numbers. More positively, utilising pattern recognition and machine learning, insights can

be gained about emerging psychiatric syndromes, patterns of risky behaviours and potentially effective repurposed medication including useful combinations of treatments.

Inadequate communication by health care professional is not restricted to psychiatry, but arguably poor communication in mental health care risks more harm; including breakdown of trust, non-concordance and relapse [33]. Good psychiatric practice should involve a continuing dialogue with services users as to working diagnoses, treatment options and progress of treatment (including interventions which have not been successful and on errors in application).

Prospects and Risks

The main emerging development (largely positive) is the growth of independent advocacy groups attempting to remedy issues associated with current psychiatric practice. Influence of these groups (often family led) can lead to public inquiries such as the current Lampard Inquiry on in-patient deaths.

There appears to be more involvement of spiritual care in mental health [34], led by an expanding chaplaincy service. This is currently restricted to in-patient units, although the potential for early interventions in primary care is likely. The reduction in church attendance, can free up more pastors (accompanied by imams and rabbis) to work within psychiatric facilities. Clearly, psychedelic treatments have spiritual repercussions, highlighting the need for pastoral care for debriefing and follow up. A forgotten phenomena are people leaving 'cult like' religious groups, who need pastoral support, if they present to mental health services in a decompensated state.

Related to spiritual care is the rise of countries legislating on 'Physician assisted Suicide' **(PAS)** open for capacitious patients with untreatable and debilitating conditions to access. Conditions include terminal cancer, systemic arthritis and neurodegeneration, at times accompanied by depression. Some countries are considering providing this service to people with some untreatable psychiatric conditions; specifically, personality disorders [35]. Some jurisdictions are considering a brooder category of patients with psychiatric illnesses [36], for example dementias.

Conclusion

This article makes a case for reflecting on historical psychiatric approaches to review the current model of biopsychosocial formulations and treatment. The most realistic approach is application of 'Compassionate Leadership Training' for clinical leads (both medical and professionals allied to medicine) focussing on genuine co-production to promote respect and sovereignty of patients and their families. The expansion of family advocacy can assist this process.

It is important that history of psychiatry commencing with Pinel et.al. (Including the more controversial practices in the 1920's) should be part of the curricula to train all workers involved in mental health care [37,38]. There needs to be a considered debate on the expansion of criteria to access physician assisted suicide in the light of overcrowding of mental health institutions alongside restricted state funding, as was the case in 1920's Germany [39].

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