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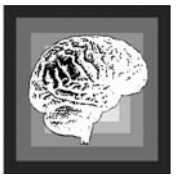
History of Psychiatry, 19(1): 047–067
[200803] DOI: 10.1177/0957154X06075949



The Mental Treatment Act 1945 in Ireland: an historical enquiry

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The Mental Treatment Act 1945 had a decisive influence on the provision and development of psychiatric services in Ireland. This paper examines: (a) the historical and psychiatric backgrounds to the introduction of the Mental Treatment Act 1945; (b) the main provisions of the Act; and (c) the international context of the Act, especially in relation to institutional and legislative trends in other jurisdictions.

Keywords*: commitment of mentally ill; history; Ireland; legislation; mental health services; 20th century*

The Mental Treatment Act 1945 (Department of Health, 1945) had a decisive influence on the provision and development of psychiatric services in the Republic of Ireland in the latter half of the twentieth century. This paper examines:

(a) The background to the Mental Treatment Act 1945
(b) The main provisions of the Act
(c) The international context of the Act.

Background to the Mental Treatment Act 1945

The opening decades of the twentieth century were a period of considerable political and social change in Ireland. During the first decade of the century, Sinn Féin was established as a political party with the aim of achieving self-government in Ireland, and the Irish Socialist Republican Party began to advance reformist socialist analyses of Ireland's situation. In 1911 the British

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government declared its intention to pass another Home Rule Bill, prompting renewed Unionist resistance in the North and the establishment of the Ulster Volunteers. In 1916 the Easter Rising took place in Dublin and the subsequent execution of its republican leaders generated increased sympathy for Ireland's Republican cause. Following the victory of Sinn Féin in the 1918 election, 'Dáil Éireann' (the Irish parliament) met in Dublin and declared Irish independence. This was followed by the 'war of independence' with Britain, the 'Anglo-Irish Treaty' (1921) and the Irish 'civil war' (Ferriter, 2004); in 1922, the Irish Free State came into being. The subsequent post-war reconstruction of Ireland's economy was an especially challenging task, owing not only to the effects of sustained conflict and the recession of the 1930s, but also the development of a 'trade war' with Britain in the 1930s. In 1937 a new constitution was passed by referendum, but it was not until 1949 that the Republic of Ireland came into being; the Republic comprised 26 counties in the 'South' of Ireland and excluded 6 counties in 'Northern' Ireland.

These political and economic developments, and especially the movement towards Home Rule, had a substantial influence on the development of medical and psychiatric services in Ireland throughout this period (Finnane, 1981). On the one hand, Irish politicians were generally wary of expanding services and increasing the financial challenges they would face in the event of self-government (Barrington, 1987), while on the other hand the English were hesitant about any trade-off on Home Rule they might have to make in order to ensure Irish support for reform (Healy, 1996). Notwithstanding these tensions, there were several significant changes in medical services during this time, including two major reviews of the poor law and medical relief system in Ireland, performed by the Viceregal Commission on Poor Law Reform (1906) and the Royal Commission on the Poor Laws and Relief of Distress (1910). The National Health Insurance Act was introduced in 1911, aiming to provide widespread health cover underwritten by the State and a system of benefits to cover care in sanatoria (Barrington, 1987).

As in many other countries, World War I presented considerable challenges to health services in Ireland, and government involvement in this sector continued to grow into the 1920s. The Dáil Department of Local Government was central to public service reforms during this period, while at the same time the passage of the Public Charitable Hospitals Act 1930 permitted the establishment of the Hospitals Sweepstakes which enhanced financial support for voluntary hospitals (Barrington, 1987). The 1930s saw the development of an improved network of hospitals throughout Ireland, followed, in the 1940s, by renewed debate about the direction of Irish health services – a debate that was informed by both Catholic social teaching and Britain's movement towards a National Health Service. In 1945 the Report of the Departmental Committee on Health Services, submitted to the Minister for Local Government and Public Health, presented a series of radical proposals for the Irish Health Service, suggesting that Ireland should double its spending on health services and aim to provide a

free national health service for all (Barrington, 1987). The same year also saw a landmark development in Irish mental health services with the introduction of the Mental Treatment Act 1945 in Dáil Eireann.

'Insanity in Ireland' (1944)

In 1944, the year when the Mental Treatment Bill was presented to the Dáil for its second reading, an anonymous psychiatrist wrote an article on 'Insanity in Ireland' in *The Bell,* a prominent Irish literary journal ('A Psychiatrist', 1944). The author summarized the history of mental health care in Ireland in the 1940s:

> The history of insanity in this country does not differ from that in others. Its incidence was about the same; its causes were similar; the attitude of the public towards it was equally callous and the absence of any attempt at scientific treatment equally noticeable. In the early decades of the 19th century some differences became apparent. Neighbouring countries began to do something about it and their Governments took active steps in providing 'Asylums' for the mentally afflicted, but the Irish [*sic*] Government lagged behind and, even though many years have passed, that lag is still apparent.

There were, however, some signs of change:

> First had to come the knowledge that insanity was not due to possession by evil spirits. It gradually oozed into the minds of the public that insanity was a disease. So, in time, the gaoler with the whip was replaced by the doctor … Today the treatment of mental disease is in its infancy and it is no wild hope to say that the mental experts of 2000 AD will write of 'the crude, unscientific treatment of mental disease in 1943'.
>
> In the two decades before the outbreak of the present war, Ireland began to gain lost ground in hospitalization generally, and a great impetus to the provision of modern buildings was given by the Government in sponsoring and controlling the Irish Hospital Sweepstakes. Not alone were many suitable additions made to existing Mental Hospitals, but the general public became aware that something could be done towards the treatment of mental disease. ('A Psychiatrist', 1944)

The anonymous psychiatrist went on to outline the principles of treatment in the early 1940s:

> There are many types of mental disease and it is to be understood that each type has to be treated in its own way. Nevertheless there are certain principles which govern the treatment of all cases. These in the main are: removal from home and relatives; rest; adequate diet; sleep. These can be achieved only in an Institution with a trained staff, and the sooner these can be had the more likelihood of speedy recovery.
>
> Modern special methods of treatment have from time to time received a lot of publicity in both the medical and lay Press. So much so that

> almost everyone has heard of Insulin treatment and Convulsive or 'shock' treatment, either medical or electrical. One with experience of these different methods can safely say this: 'In selected cases one or other of these methods of treatment may give excellent results. They are not cure-alls, and if used indiscriminately will do harm by lessening the enthusiasm of the workers and by killing the faith of the relatives of patients on whom they have been tried.' Most early cases will, however, respond favourably to one or other modern method. ('A Psychiatrist', 1944)

Mental health care in Ireland prior to 1945

Notwithstanding the criticism of the anonymous psychiatrist writing in 1944, Irish mental health care had undergone considerable changes in the century preceding the introduction of the Mental Treatment Act 1945. It is beyond the scope of the present paper to provide a comprehensive history of mental health services over this period; detailed accounts of various aspects are provided by Clare (1998*a*, 1998*b*), Finnane (1981), Healy (1996), Kelly (2004), Malcolm (1989), McCarthy (1998), McClelland (1988), Mulholland (1998), Prior (1996), Reuber (1996), Robins (1986), Smith (1990), Torrey and Miller (2001), Walsh (1992), Walsh (2004), Walsh (2006), Walsh and Daly (2004), Williamson (1992).

A brief overview of early Irish mental health services was given to the Dáil on 29 November 1944, when the Parliamentary Secretary to the Minister for Local Government and Public Health, Dr Ward, presented the Mental Treatment Bill 1944 for a second reading:

> It is stated that in medieval times lunatics were treated in monastic hospitals, but to what extent those hospitals dealt with the problem of lunacy it would now be impossible to say. Subsequent to the suppression of the monasteries, the earliest provision for the institutional accommodation of the insane took the form of cells in workhouses or houses of industry. The first of these were provided in the Dublin House of Industry about the year 1728. Cells had been provided in the year 1711 in the Royal Hospital, Kilmainham, for soldiers who were mentally deranged. During the course of the next century the authorities of houses of industry continued to provide cells or wards for the insane. In some few cases asylums were provided at the houses of industry. In connection with the Cork House of Industry, an asylum was erected in 1787 which subsequently became the Cork District Lunatic Asylum. In that year, also, a Prisons Act was passed containing a section which empowered grand juries to raise moneys for the support of wards for destitute insane persons in houses of industry. In 1815 there was established in Dublin an asylum which subsequently became the Richmond Asylum, and many of the insane persons in the house of industry were transferred to it.

Dr Ward also briefly outlined the legislative background to the 1944 Bill:

> Acts were passed in the years 1817 and 1820 providing for the establishment of asylums for lunatics. These were superseded by the Lunacy (Ireland) Act, 1821, which provided for the formation of asylum districts and the

> establishment of district asylums. This Act formed the basis of the legal code under which lunatic asylums were established and maintained.
>
> An Act passed in 1845 provided for the removal of all lunatics from the houses of industry to the lunatic asylums. Section 15 of that Act gave power for the establishment of an asylum for each of the provinces to be appropriated to any particular class or classes of lunatics. The object was to permit the establishment of asylums for chronic and harmless patients. Section 9 of the Lunatic Asylums (Ireland) Act, 1875, authorised the reception into workhouses of such chronic lunatics as were not dangerous and might be transferred thereto from lunatic asylums.
>
> No advantage was taken of Section 15 of the Act of 1845. It was repealed by the Local Government (Ireland) Act, 1898, Section 76 of which gave power to asylum authorities to establish auxiliary asylums for the reception of chronic lunatics who, not being dangerous to themselves or others, were certified not to require special care and treatment in a fully equipped lunatic asylum. Where an auxiliary asylum was so provided Section 9 of the Act of 1875, relating to the accommodation of chronic lunatics in workhouses, ceased to apply. The Act of 1898 also imposed a duty on the county councils to provide and maintain sufficient accommodation for the lunatic poor.

The provision of psychiatric care to prisoners, offenders and the violent mentally ill presented particular cause for concern at this time:

> Towards the end of the eighteenth century a large number of violent lunatics and wandering idiots were committed to the county prisons, a separate portion of each prison being set apart for them. By direction of the Government of the day, given in the year 1816, admission to lunatic cells or wards in the Dublin House of Industry was restricted to such patients as were deemed incurable and had previously been received into the lunatic asylum. Although the Act of 1821, to which I have already referred, provided that all the lunatic poor within an asylum district were to be maintained and taken care of in the asylum for the district, the only provision it contained governing admission to those asylums was one providing for the admission of prisoners found insane.
>
> Dangerous lunatics were dealt with by an Act passed in 1838 for the prevention of offences by insane persons. It empowered two justices of the peace to commit a person to gaol on his being found to be a dangerous lunatic or a dangerous idiot. The Lord Lieutenant could at his discretion order the removal of any such person from the gaol to the district lunatic asylum. Committal of dangerous lunatics to gaols was prohibited by the Lunacy (Ireland) Act, 1867, Section 10 of which empowered any two justices of the peace to commit to the district lunatic asylum any person apprehended or discovered under circumstances denoting derangement of mind and a purpose of committing an indictable crime. The purpose of the section was to provide a substitute for the committal of dangerous lunatics to gaol, but the provisions of the section have been very widely availed of and by far the greater number of poor persons admitted to public institutions are committed in pursuance of that section.

A detailed consideration of the official debate regarding the 'criminal lunatic' in nineteenth-century Ireland is provided by Prior (2004).

Overall, the nineteenth century had seen a relatively large number of pieces of mental health legislation implemented in Ireland, including the Lunacy (Ireland) Act 1821, the Criminal Lunatics (Ireland) Act 1838 and the Private Lunatic Asylums (Amendment) Act 1842. Owing to widespread abuse of the Criminal Lunatics (Ireland) Act 1838, which based committals on information provided while not under oath, the Central Criminal Lunatics Asylum Act 1845 was subsequently passed, requiring that evidence be given under oath prior to committing an individual to an asylum (O'Neill, 2005). Nonetheless, committal abuses persisted throughout the nineteenth century (Prior, 2003) and, as a result, the Lunacy Act 1867 was passed, allowing two magistrates to commit an individual to an asylum under specified conditions only if they obtained a certificate from a dispensary medical officer. Introducing the Mental Health Bill to the Dáil in 1944, Dr Ward summarized the process of 'committal in pursuance of Section 10 of the Lunacy (Ireland) Act, 1867' as follows:

> The committal order was made by two peace commissioners or a district justice after the person concerned had been certified as a dangerous lunatic by a dispensary medical officer. The expenses connected with the committal, including the payment to the medical officer for his services, were defrayed by the local public assistance authority.

In addition, the Lunacy (Ireland) Act 1867 permitted medical staff to discharge patients without recourse to higher authorities following their course of treatment at the asylum (O'Neill, 2005). While the Lunacy Asylums (Ireland) Act 1875 brought further reform by permitting the admission of private patients to district asylums, a three-person commission established by the Lord Lieutenant in 1891 still identified a clear need for reform in this area and recommended, among other measures, the introduction of a voluntary admission status (O'Neill, 2005).

Deficiencies in mental health care

Notwithstanding various public health measures to address mental illness throughout the eighteenth and nineteenth centuries, and the establishment of private institutions such as St Patrick's Hospital in 1746 (Clare 1998*a*, 1998*b*; Malcolm, 1989), the standard of psychiatric care in Ireland remained uneven and generally poor during this time (Kelly, 2004). In 1893 the Inspector of Lunatics (Ireland) reported that:

> The accommodation in District Asylums in this country continues quite inadequate to supply the wants of the insane population. We have again to repeat the statement made in former reports that the overcrowding is rapidly increasing, and that the necessity for further accommodation is becoming more and more urgent.

The Inspector was also concerned about the number of 'pauper lunatics and imbeciles residing in Workhouses' who:

> have not always received that attention which their helpless condition requires … Their condition in many of these establishments continues to be far from satisfactory, notwithstanding the interest as regards this class which the Local Government Board and its Inspectors have shown. In many workhouses they continue to be practically untended, their only attendants being pauper inmates, while the accommodation provided is inadequate to meet their requirements, and, as a result, proper attention is not in all cases given to personal cleanliness. (Inspector of Lunatics, 1893)

The Inspector's general observations about the level of mental health care in workhouses are confirmed by contemporaneous historical records including, for example, the records and minutes of Ballinrobe Poor Law Union, County Mayo (a rural area in the west of Ireland), which demonstrate substantial deficiencies in the provision of medical, psychiatric and social care in workhouses in the latter part of the nineteenth century (Kelly, 2004). Little was recorded about the outcome of mental or medical illness in Ballinrobe workhouse; this is consistent with the observation of the Inspector of Lunatics (1893) that 'as regards the remaining inmates of unsound mind in Irish workhouses, we have no returns showing admissions, discharges and deaths'.

In the context of the United Kingdom, Bartlett (1999) argues that the plight of the destitute mentally ill was determined chiefly by inadequate or inappropriate statutory and administrative responses to their situation. In Ireland too, the Inspector of Lunatics (1893) highlighted the absence of adequate legislative provision for the destitute mentally ill:

> These results are due as much to the want of proper legislative enactments for the protection of these persons as to the fault of local authorities, who have not the requisite knowledge of the requirements now demanded for the proper care of the insane poor, while, owing to the same deficiency of law regarding the status and recognition of lunatics in workhouses, the Local Government Board possess very insufficient powers to compel Boards of Guardians to make adequate provision for the care and treatment of the insane and imbecile inmates under their charge.

In the following year, Tuke (1894) added to the scale of concern about these problems by arguing, in the *Journal of Mental Science*, that there was a substantial increase in the number of individuals with mental illness in Ireland. Having examined statistics from 1875 to 1893, Tuke concluded that the number of 'certified lunatics' in Ireland had increased by 60% over this period compared with an increase of not more than 22% in England and Wales. This apparent increase in the levels of insanity in Ireland was a cause of considerable concern not only in other professional journals, such as the *American Journal of Insanity* (Anon., 1861), but also in the reports of the Irish Inspectors of Lunatics, who

were increasingly concerned about worsening overcrowding and understaffing in the asylums (Torrey and Miller, 2001).

Concerns about standards of accommodation and care were to persist well into the twentieth century: in 1924, for example, E. Boyd Barrett, SJ, painted a very similar picture of public psychiatric care in an article published in *Studies: An Irish Quarterly Review*. He wrote:

> Thanks to the indifference of the public, our asylums are in a bad way. They are over-crowded. They are both understaffed and inefficiently staffed. Curable and incurable cases are herded together. There is practically no treatment. The percentage of cures remains at a very low figure. Public money is wasted. The asylums are unsuited for their purpose in almost every respect. The rate of committals to asylums goes on increasing, and there exists no means of treating cases of incipient insanity. Curable nerve cases are allowed to develop into incurable cases. The public, ignorant and indifferent as regards mental disease, gives no encouragement to the setting up of nerve clinics or to the practice of the new methods of psychotherapy …
>
> The most lamentable feature of the present asylum system is the absence of treatment. Apart from the many hardships that the unfortunate patients have to put up with – the poor and monotonous diet, the repulsive prison-like surroundings, the dreary exercise yards, the hideous clothing, the punishments for refractory patients, the uncongenial associates, the nerve-racking cries, the dirt and general gloom, the almost total absence of amusement and recreation – there is this appalling difference between the mental hospital (as an asylum should be) and the ordinary hospital, that in the latter each kind of disease is carefully treated by the best modern methods, whereas in the former no type of mental disease is fully treated … To put it bluntly, the patients committed to asylums are condemned to a degrading and miserable imprisonment for life. (Boyd Barrett, 1924)

The association between imprisonment and psychiatric admission was perpetuated by the absence of any legislative provision for 'voluntary' admission, prior to the introduction of the Mental Treatment Act 1945. The anonymous 'A Psychiatrist' (1944) paid particular attention to the need for a 'voluntary' admission status in public psychiatric institutions:

> Many cases reach institutions at least one year too late to have a reasonable hope of recovery. In many of these the delay is due to the existing laws regarding admission of patients to public Mental Hospitals. Before admission, each case must be certified by one or two doctors, and one or two Peace Commissioners or a District Judge. In its simplest form, certification of a patient needs one doctor and one PC, and unless the case is a bad one, relatives are slow to take action. It is not too much to hope that legislation in the near future will remedy this and provide for the admission of voluntary patients.

The need for voluntary admission status had been previously emphasized in 1927 by the *Report of the Commission on the Relief of the Sick and Destitute Poor including the Insane Poor*, which recommended the establishment of a system of auxiliary mental hospitals in old workhouses, the development of outpatient clinics and the introduction of a voluntary admission status (O'Neill, 2005). These recommendations, along with legislative developments in other countries (e.g., United Kingdom), had a significant influence on the drafting of the Mental Health Bill 1944.

Interestingly, the 1944 Bill was ultimately tabled without significant consultation with interested parties, although some of the reforms discussed at the Conference of the Irish Asylums Committee in 1903, especially those related to community care, were advanced by the new Act (Healy, 1996). In addition, the government had sanctioned a Committee of Investigation in 1933 to examine mental health services internationally, and many of this committee's recommendations (e.g., outpatient services, voluntary admissions, research facilities) were reflected in the new Act (Reynolds, 1992). Finally, the Act also reflected some of the reforms that certain psychiatrists had recommended repeatedly over many years previously; for example, Dr Conolly Norman of Grangegorman Mental Hospital, Dublin, had repeatedly promoted the idea of 'boarding out' for patients with mental illness (Reynolds, 1992) and this measure was ultimately addressed in some detail in the Act (Department of Health, 1945).

In any case, by 1945 it was clear that the problem of the increasing numbers of involuntary psychiatric inpatients was reaching crisis level. In 1804 a parliamentary committee had recommended the establishment of asylums throughout Ireland and within 30 years asylums had been built in Dublin, Derry, Belfast, Limerick and Armagh (Reuber, 1996; Williamson, 1992); further asylums had soon been opened at Killarney in 1852, Kilkenny in 1852, Omagh in 1853, Mullingar in 1855 and Sligo in 1855 (Walsh, 2006). In parallel with this structural expansion, the number of inpatients also increased substantially throughout the latter half of the nineteenth century and the first half of the twentieth century, interrupted only by two short-lived declines during the World Wars (Walsh and Daly, 2004). By 1945, the year in which the Mental Treatment Act was introduced, there were some 17,708 individuals resident in asylums in the Republic of Ireland (Walsh and Daly, 2004).

The main provisions of the Mental Treatment Act 1945

The Mental Health Act 1945 aimed to address legislative deficiencies in Irish mental health law and to strengthen the delivery of appropriate care to individuals with mental illness. Introducing the Mental Treatment Bill 1944 for a second reading in the Dáil, Dr Ward noted that some of the legislation governing mental illness dated 'back as far as the year 1821. The general consensus of

opinion with persons engaged in administration favours the replacement of those Acts by one complete measure.' Dr Ward went on to note that:

> The Commission on the Relief of the Sick and Destitute Poor, including the insane poor, in their report, which was published in 1927, said:
>
> 'The law governing lunacy is as we have shown, to be found in numerous statutes passed in the course of a century. These statutes do not form one consistent whole; they are in some respects obsolete, defective, and even contradictory. We, therefore, recommend that all the existing lunacy Acts be repealed and that new legislation take the form of an amending and consolidating Act.'
>
> That commission made other suggestions for the amendment of the law, particularly in regard to the procedure by which admission to mental institutions was obtained and to the question of provision for early treatment of incipient mental disease. Their views in these matters are endorsed by medical practitioners engaged in the treatment of mental disease. They support the opinion that the law on the subject requires radical reform. There is no provision in the law to enable a poor person to submit himself voluntarily for mental treatment, nor is it possible for a patient to be admitted to an institution for treatment for temporary mental disorder. Furthermore, very little latitude is given as to the nature and kind of mental institutions which may be provided by mental hospital authorities.
>
> In the Bill before the House it is proposed to remedy these defects and to make other amendments in the law to secure for mental patients the benefits of the advances made in medical science and treatment in the present century. It is proposed in the Bill to substitute for the law at present in force relating to the prevention and treatment of mental disorders a new code in harmony with modern views on the treatment of mental illness.

Definitions, inspector of mental hospitals, mental hospital authorities

The formal preamble to the Mental Health Act 1945 states that the Act aims 'to provide for the prevention and treatment of mental disorders and the care of persons suffering therefrom and to provide for other matters connected with the matters aforesaid' (Department of Health, 1945). The Act was divided into 19 parts, comprising 284 sections. Part 1 of the Act was concerned with 'preliminary and general matters' including definitions of expressions used throughout the Act. For example, Section 3 defined a 'temporary patient' as:

> a patient either (a) who is (i) suffering from mental illness, and (ii) is believed to require, for his recovery, not more than six months suitable treatment, and (iii) is unfit on account of his mental state for treatment as a voluntary patient, or (b) who is (i) an addict, and (ii) is believed to require, for his recovery, at least six months preventive and curative treatment. (Department of Health, 1945)

A 'voluntary patient' was defined as 'a person who, acting by himself or, in the case of a person less than sixteen years of age, by his parent of guardian, submits himself voluntarily for treatment for illness of a mental or kindred nature.'

Part 2 of the Act allowed the Minister for Local Government and Public Health to appoint an 'inspector of mental hospitals and assistant inspectors of mental hospitals'. Part 3 divided the country into 'mental hospital districts', each with a defined 'local administrative authority' (i.e., county council, county borough corporation or a specially appointed 'joint board'). Part 4 outlined the duty of the 'mental hospital authority to provide treatment, maintenance, advice and services' to individuals living in the 'mental hospital district' who developed mental illness and could not otherwise afford treatment.

Part 5 of the Act outlined the obligation of the 'mental hospital authority' to 'provide and maintain proper and sufficient accommodation for carrying out their functions' and permitted mental hospital authorities to establish 'consulting rooms or clinics for affording advice and preventive and curative treatment'. It is beyond the scope of the present paper to provide detailed summaries of all of the provisions in these parts of the Act. Nonetheless, it is worth noting that Part 9 contained a range of 'miscellaneous provisions relating to mental hospital authorities' and stated, for example, that 'there shall be a chief medical officer for a district mental hospital' to be known as the 'resident medical superintendent'. In addition, 'a mental hospital authority shall from time to time appoint a committee to visit their district mental hospital and the other institutions and accommodation maintained by them' in order to hear complaints by patients and to report to the authority on abuses they observe during their visit.

Private institutions, authorized institutions

Part 10 of the Act concerned 'private institutions' which were institutions or premises 'in which one or more than one person of unsound mind is or are taken care of for profit'. This part of the Act directed that the Minister for Local Government and Public Health keep a register of private institutions and outlined a range of detailed regulations governing private institutions. Part 11 concerned 'private charitable institutions' which were institutions 'for the care of persons of unsound mind' which were 'supported wholly or in part by voluntary contributions' and 'not kept for profit by any private individual'.

Part 12 concerned 'authorized institutions' which were defined as institutions 'authorized by special Act or other enactment (including a charter) for the care, maintenance, and treatment of persons of unsound mind, not being the Dundrum Central Criminal Lunatic Asylum'. The Act directed that there be a register 'in which the prescribed particulars in regard to every person of unsound mind taken care of in the institution shall be entered'. Similarly, Part 13 outlined regulations in relation to 'approved institutions' which included 'any institution or premises … for the reception of persons as voluntary patients, or

for the reception of persons as temporary persons and the reception of persons as voluntary patients.'

Involuntary admission procedures for 'persons of unsound mind'

Part 14 of the Act concerned 'reception orders' governing admission to psychiatric hospitals. Chapter 1 of this part concerned 'chargeable patient reception orders' where 'it is desired to have a person received and detained as a person of unsound mind and as a chargeable patient'. In essence, 'person of unsound mind' status permitted involuntary detention for an indefinite period without automatic review of status. An application for such admission can be made '(a) by the husband or wife or a relative of the person to whom the application relates, or (b) at the request of the husband or wife or a relative of such person, by the appropriate assistance officer, or (c) subject to the provisions of the next following sub-section, by any other person.' It is necessary that the applicant is 'at least twenty-one years of age and has, within fourteen days before making the application, seen the person to whom the application relates'.

The next step involves the 'authorized medical officer' who:

> shall within twenty-four hours after receipt of the application (a) visit and examine the person to whom the application relates, and (b) after such examination, either (i) if he is satisfied that it is proper to make the recommendation and is of the opinion that the person to whom the application relates will, if received, be a chargeable patient, make the recommendation in the prescribed form, or (ii) in any other case, refuse the application.

Within 'seven clear days' of the making of the 'recommendation for reception' the 'applicant for the recommendation or any person authorized by him or … any member of the Gárda Síochána [Irish police force] may … take the person to whom the recommendation relates and convey him to the district mental hospital.' At the hospital,

> the resident medical superintendent of the hospital or another medical officer of the hospital acting on his behalf shall, on the arrival of the person at the hospital and on presentation of the recommendation, examine the person, and shall thereupon either (a) if he is satisfied that the person is a person of unsound mind and is a proper person to be taken charge of and detained under care and treatment, forthwith make in the prescribed form an order … for the reception and detention of the person as a person of unsound mind in the hospital, or (b) in any other case refuse to make such an order.

When the chargeable patient reception order is made, the mental hospital authority, resident medical superintendent or 'the other officers and the servants of such hospital' may 'receive and take charge of the person to whom the order relates and detain him until his removal or discharge by proper authority or his death'.

Chapter 2 of Part 14 of the Act concerned 'private patient reception orders' where 'it is desired to have a person received and detained as a person of unsound mind in a private institution, an authorized institution or a private charitable institution' or 'as a private patient in a district mental hospital'. The Act outlined the procedure for making the application and the reception order which, in the case of a private patient, required 'two separate examinations' by registered medical practitioners. In all cases, the 'person of unsound mind' status allowed detention of indefinite duration without automatic review.

Involuntary admission procedures for 'temporary chargeable patients'

Chapter 3 of Part 14 of the Act concerned 'temporary chargeable patient reception orders and temporary private patient reception orders'. In essence, 'temporary chargeable' status permitted involuntary detention for up to six months. An application can be made '(a) by the husband or wife or a relative of the person to whom the application relates, or (b) at the request of the husband or wife or a relative of the person to whom the application relates, by the appropriate assistance officer, or (c) subject to the provisions of the next following sub-section, by any other person.' The application must be accompanied by a:

> certificate in the prescribed form of the authorized medical officer certifying that he has examined the person to whom the application relates on a specified date not earlier than seven days before the date of the application and is of the opinion either (a) that such person (i) is suffering from mental illness, and (ii) requires, for his recovery, not more than six months suitable treatment, and (iii) is unfit on account of his mental state for treatment as a voluntary patient, or (b) that such person (i) is an addict, and (ii) requires, for his recovery, at least six months preventive and curative treatment.

In the case of a private patient reception order, the 'certificate' must be 'signed by two registered medical practitioners certifying that each of them has examined separately the person to whom the application relates' and the person fulfils the criteria outlined above. This certificate cannot be signed 'by a registered medical practitioner who is (a) the person in charge of the approved institution in which the person in respect of whom the certificate is given is to be received, or (b) a person in the employment of the person in charge of such institution, or (c) a person having an interest in such institution.'

Following completion of the 'certificate', 'the applicant for the order or any person authorized by him may, not later than seven days after the date on which the order is made, take the person to whom the order relates and convey him to the approved institution.' At the approved centre, the person in charge, or 'his officers, assistants, and servants and any medical officer of such institution' may 'receive and take charge of the person to whom the order relates and detain him until the expiration of a period of six months'. The period of detention can be extended 'by a further period not exceeding six months or by a series

of orders … by further periods none of which shall exceed six months and the aggregate of which shall not exceed eighteen months'.

Voluntary admission procedures

Part 15 of the Act introduced the concept of 'reception of persons into approved institutions as voluntary patients'. This was the first piece of legislation to make specific provision for this group of patients. The Act stated:

> Where it is desired to have a person received as a voluntary patient and as a chargeable patient … the appropriate applicant may make application in that behalf in the prescribed form to the person in charge of such institution … An application under this section shall be accompanied by a recommendation by the authorized medical officer stating that such officer has examined the person whose reception is sought on a specified date not earlier than seven days before the date of the application and is of the opinion that he will benefit by the proposed admission.

If an individual is under sixteen years of age, 'the parent or guardian of such person' is the 'appropriate applicant' in this process; in all other cases, the 'appropriate applicant' is 'such person himself' (i.e., the patient).

Regulations concerning persons detained under reception orders

Part 16 of the Act presented detailed regulations concerning persons detained under reception orders, including the necessity to notify the Minister about various matters (e.g., the 'escape, removal, discharge or death' of a detained person). This part of the Act made provision for 'absence on trial' whereby a detained person may 'be absent … upon trial for any period not exceeding thirty days, and may extend that period'. If the person does not return by the expiration of the period, 'he may at any time within twenty-eight days after the expiration of such period or extended period be retaken in like manner as if he had escaped from such institution.'

Section 205 stated that 'a mental hospital authority … may (a) transfer a patient detained in such hospital to any other institution maintained by them, and (b) transfer a patient detained in an institution (other than such hospital) maintained by them to such hospital or to any other institution maintained by them.' Section 206 stated that if the mental hospital authority was 'of the opinion that it would be for the benefit of the health of a person detained in such hospital … or that it is necessary for the purpose of obtaining special treatment for such person, that he should be temporarily transferred to another district mental hospital.'

Section 207 stated that if a detained person 'is charged with an indictable offence' and 'evidence is given which, in the opinion of the justice, constitutes *prima facie* evidence (i) that such person committed the offence, and (ii) that he would … be unfit to plead, the justice shall by order certify that such person is suitable for transfer to the Dundrum Central Criminal Lunatic Asylum.'

Subsequently, 'where the resident governor and physician of the Dundrum Central Criminal Lunatic Asylum and the Inspector of Mental Hospitals agree and certify that [the person] has ceased to be of unsound mind, the said governor and physician shall discharge such person.'

Section 208 stated that where a mental hospital authority is of the opinion that a detained person 'requires treatment (including surgical treatment) not available save pursuant to this section, the authority may direct and authorise the removal of such person to any hospital or other place where the treatment is obtainable ...'

The remainder of Part 16 of the Act was concerned a range of issues that pertained to detained patients including arrangements for 'boarding-out in a private dwelling' and for the discharge of a detained person who 'becomes capable of expressing himself, and does express himself, as desirous of being received as a voluntary patient in an approved institution'. Other regulations in this Part of the Act related to orders for independent examinations of detained patients; visiting discharged persons so as to provide 'advice as to any mental treatment' they may need; and the role of the Inspector of Mental Hospitals in relation to detained persons.

The remainder of the Act concerned the 'recovery of costs of maintenance and treatment in district mental hospitals' (Part 17), the precise 'powers and duties of the Inspector of Mental Hospital' (Part 18) and various 'miscellaneous' matters (Part 19), including the establishment of inquiries into complaints relating to mental institutions (sections 277 and 278). Part 19 also contained the stipulation that 'where mechanical means of bodily restraint are applied … full particulars of the application shall be entered forthwith in a book to be kept for that purpose' (section 264). Detailed examinations of these parts of the Act are beyond the scope of the present paper; it is hoped to address some of these areas in greater depth in future papers.

The international context of the Mental Treatment Act 1945

Ireland's Mental Treatment Act 1945 was introduced at a time of considerable change and reform in mental health services, both in Europe and elsewhere. For the purposes of this discussion, these reforms can be considered in terms of (i) the trend towards institutionalization of the mentally ill, and (ii) the legislative context.

(a) Institutionalization

The nineteenth century saw a considerable rise in the number of individuals confined to psychiatric institutions in many countries. In 1800 there were relatively low numbers of individuals in asylums, with well-known asylums such Bedlam in London housing hundreds rather than thousands of patients (Shorter, 1997). By the end of the 1800s, however, the London region alone had 16 asylums, some with more than 2000 patients. In 1891 France had 108 asylums. By 1904 there were some 150,000 patients in asylums in the USA,

accounting for two individuals for every thousand population (U.S. Bureau of the Census, 1975). A similar pattern was evident in Ireland: throughout the nineteenth century a large number of asylums were opened at multiple locations throughout the country. Undoubtedly there were myriad reasons for the increasing confinement of the mentally ill over this period, including better recognition of mental illness, evolving concepts of the mind and various other inter-related societal, political and demographic factors; a full consideration of these issues is beyond the scope of the present paper but detailed explorations of some of them are provided by Torrey and Miller (2001), Porter (2004), Scull (1993), Shorter (1997) and Stone (1998).

One of the aims of Ireland's Mental Treatment Act 1945 was to reduce the numbers of persons in asylums. When Dr Ward presented the Bill for a second reading in the Dáil in 1944, he stated:

> It is the considered opinion of specialists engaged in the treatment of mental disease that to reduce the numbers in the mental institutions attention should be focused on the treatment of early cases of mental disorder and that failure to make provision for the treatment of such cases must result in an increase of the numbers suffering from mental afflictions and requiring prolonged or permanent treatment in mental institutions.
>
> The arguments already put forward in favour of the establishment of consulting rooms and clinics apply with equal force to the provision of facilities for the treatment of voluntary patients. Persons suspecting symptoms of mental or nervous disease should be encouraged to seek advice and treatment in the early stages before the disease is too far developed. It is essential, therefore, to remove all formalities such as certification and formal committal to mental institutions which are likely to deter or discourage patients from seeking treatment of their own accord.

The Mental Treatment Act did not prove effective in reducing inpatient numbers: by 1960 this had risen to 20,506. In some towns, the asylum continued to dominate the local economy: in 1951, for example, the town of Ballinasloe had a total population of 5,596 of whom 2,078 were patients in the asylum (Walsh, 2006). By 1961, one in every 70 Irish people above the age of 24 was in a psychiatric hospital bed (Healy, 1996; Lyons, 1985). In October 1968, the *Irish Times* published an influential series of articles by Michael Viney highlighting the broad range of problems related to mental health care and, in particular, the large numbers of individuals who still remained in Irish asylums at that time (Viney, 1968).

One area in which the Mental Treatment Act 1945 was arguably more successful, and which may help to account for its failure to reduce inpatient numbers, was its efforts to reduce the stigma associated with mental illness. In particular, the new Act saw the removal of the term 'lunatic' from mental health legislation and its replacement with terms such as 'person of unsound mind' which were less stigmatizing at that time. The reduction of stigma was one of the express aims of the new Act: in the Dáil, Dr Ward had pointed out that

'it is proposed to depart entirely from the term "district lunatic asylum" and to continue the use of the term "mental hospital" provided for in Section 79 of the Local Government Act, 1925. It is proposed also to use the term "person of unsound mind" instead of the term "lunatic".'

In addition, the introduction of a new voluntary admission status and the centrality of medical rather than judicial personnel in the detention process may have further helped reduce stigma and increase patient numbers. The introduction of various 'modern physical methods of treatment' (e.g., convulsive treatment, insulin coma treatment and psychosurgery) may have also had an effect on public perceptions of psychiatry (Dunne, 1950). Various other social and historical factors in the 1950s and 1960s (e.g., emigration of younger people) undoubtedly also played a role in determining admission rates, but a full consideration of these factors is beyond the scope of the present paper.

(b) The legislative context

In the decades leading up to Ireland's Mental Treatment Act 1945, both the United Kingdom (1930) and Northern Ireland (1932) had introduced relatively liberal mental health legislation which included, among other measures, voluntary admission status (O'Neill, 2005). This trend towards substantial reform of mental health legislation was apparent in many jurisdictions during this time: in 1936 and 1939, for example, Switzerland passed laws that drew an increasingly clear distinction between *admissions libres* which were requested by the patient and other admissions which were requested by third parties such as parents, authorities, etc. (Gasser and Heller, 2003). Some twenty years earlier, Japan too had started to reform its system of psychiatric care, replacing its Mental Patients' Custody Act 1900 with a Mental Hospitals Act 1919 which heralded a substantial expansion of hospital-based care for individuals with psychiatric illness (Suzuki, 2003). In India, a division of the Royal Medical Psychological Association was formed in the mid-1930s, and in 1946 the Health Survey and Development Committee performed a survey of psychiatric services, also recommending substantial reform in the provision and administration of care in India (Jain, 2003).

The 1940s also saw considerable legislative change in the USA with the introduction of the National Mental Health Act of 1946. The aims of this Act were to: (a) support research into the aetiology and treatment of neuropsychiatric disorders; (b) support training of mental health workers by awarding fellowships to individuals and institutions; and (c) provide grants and assistance to States in order to establish treatment centres for neuropsychiatric disorders (Brand, 1965). This Act stemmed in part from the particular emphasis placed on neuropsychiatric disorders by Vannevar Bush, director of the US Office of Scientific Research and Development who advised the US president, Franklin D. Roosevelt, that there were approximately seven million persons in the USA with mental illness, resulting in considerable costs to the public purse (Bush, 1945). Bush's report coincided with growing public interest in

mental illness, which was attributable to a number of factors, including the publication of Clifford Beers' autobiography *A Mind That Found Itself* in 1908 (Beers, 1981) and increased recognition of the prevalence of mental illness as a result of the systematic medical inspection of immigrants in New York (Brand, 1965). World War II also generated increased interest in mental illness as some 1.1 million men were rejected for military duty owing to neurological or mental illness; the practice of military psychiatry also later demonstrated the effectiveness of multidisciplinary treatment involving psychiatric nurses, psychologists and social workers (Menninger, 1946).

The US National Mental Health Act of 1946 was also consistent with the legislative trend demonstrated in the US Public Health Service Act of 1944, which increased health assistance to States and broadened the remit of the Public Health Services (Brand, 1965). Ultimately, the 1946 Act not only authorized a broad Federal programme to treat mental illness and promote mental health, but also provided for the creation of a National Neuropsychiatric Institute, which was established as the National Institute of Mental Health in 1949.

Like the US National Mental Health Act of 1946, Ireland's Mental Treatment Act 1945 aimed 'to provide for the prevention and treatment of mental disorders and the care of persons suffering therefrom and to provide for other matters connected with the matters aforesaid' (Department of Health, 1945). The Irish legislation also made clear reference to the importance of research, stating, for example, that 'a mental hospital authority may, with the consent of the Minister, and shall, if the Minister so directs, provide and maintain a laboratory for research in connection with mental and nervous diseases' (section 25). The Irish legislation, however, failed to provide for the establishment of a national 'Institute of Psychiatry' to promote research into the causes and treatment of mental illness at a national level. While recent years have seen the establishment of an 'All Ireland Institute of Psychiatry' (comprising the Irish College of Psychiatrists and the Northern Ireland Division of the Royal College of Psychiatrists), the concept of a research-oriented Irish Institute of Psychiatry has not yet materialized in Ireland, despite occasional considerations of the idea (Clare *et al.*, 1990; Daly, 1990).

Conclusions

In the decades since the introduction of the Mental Treatment Act 1945, the international legislative environment has changed considerably in response to myriad factors including increased formal recognition of the rights of the mentally ill (United Nations, 1991) and the development of specific legislative initiatives such as the Human Rights Act (Armstrong, Cummings, Gledhill and Edwards, 2000). In this context, Cooney and O'Neill (1996) point out that Ireland's Mental Treatment Act 1945 allows the involuntary committal of people who are not alleged to be dangerous to self or others, and recommend that legislation should place a greater emphasis on patients' rights; they go on to outline a proposed statutory bill of rights for psychiatric patients.

Some of these concerns may be addressed, at least in part, by the passage of the recent Mental Health Act 2001 in Ireland (Department of Health and Children, 2001; Kelly 2002), although the implementation of the new legislation has proven to be a lengthy, complex process (Daly, 2005; Ganter, 2005; Lawlor, 2005; O'Neill, 2005; Owens, 2005). In the meantime, the Mental Treatment Act 1945 has remained in force as the central piece of legislation governing the organization and provision of psychiatric care in Ireland. Even when the Mental Treatment Act 1945 is fully repealed, it is likely that its substantive influence on the development of mental health services in Ireland will continue to echo through mental health services for many decades to come.

Acknowledgements

Quotations from E. Boyd Barrett (1924) Modern psycho-therapy and out asylums, *Studies*, 8, 29–43, are reproduced by kind permission of the editor of *Studies: An Irish Quarterly Review*. Quotations from the Official Report of the Dáil on 29th November 1944, when Dr Ward (Parliamentary Secretary to the Minister for Local Government and Public Health) presented the Mental Treatment Bill 1944 for a second reading, are Copyright Houses of the Oireachtas (1944).

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