3

Self-Harm Becomes Epidemic: Mental Health (1959) and Suicide (1961) Acts

At the end of Stengel's 1952 paper, 'Enquiries into attempted suicide', he speculates about the potential scale of this behaviour:

> [I]f the appeal character is such an important feature of the suicidal attempt as we have made it out to be, is there not a likelihood that this powerful and dangerous appeal will be used more and more, especially in a society which has made every individual's welfare its collective responsibility? I think that this danger can easily be overestimated. 'Attempted suicide' is a behaviour pattern which is at the disposal of only a limited group of personalities.[1]

Two things deserve comment in this passage: the statement about society, welfare and collective responsibility, and also how Stengel is incorrect about the potential for the phenomenon to spread. We can see that Stengel is aware of a possible connection between the collective approaches to welfare and a socially embedded 'appeal'. He sees this in rather practical terms as potential to be exploited. We can see it slightly differently – as a connection between the political climate and a psychological object. A concern about social life, welfare and social work brings this object to light and constitutes it through the practical ministrations (interviews, home visits, follow-up and so on) detailed in the previous chapter. We shall return to this explicit connection of collective responsibility for welfare and this particular form of self-harm in the Conclusion – contrasting it with emergent neoliberal approaches that gain traction in the late 1970s.

The second point is that hindsight proves Stengel wrong, but sociologist Raymond Jack argues that criticism on this basis is unreasonable.[2] Stengel is not alone in this lack of foresight. A 1958 speech by Kenneth

Robinson, the most active Parliamentary agitator for suicide law reform shows how the problem of attempted suicide is small, even then. He claims that 'I am not suggesting that this is a vast problem, but our attitude to it in some ways symbolises what we think about human frailty and about mental illness'.[3] Rather than critique or excuse a lack of predictive power, this chapter asks a different kind of question: How is attempted suicide transformed from a behaviour pattern available only to a 'limited group of personalities' in the early-to-mid-1950s, to what one clinician calls 'a major epidemic' by the mid-1960s?[4]

This way of approaching the epidemic opens up a philosophical (ontological) question around what we mean by 'incidence'. When the recorded number of attempted suicides increases, what is happening? What is the relationship between the statistics and the real number of people performing this action? This question is unanswerable, and I do not think that it is particularly useful to conceive of these issues in this way. It is more useful to analyse how the numbers come to increase, how people become more aware of the problem, and how institutions become more adept at recording these ambiguous attendances at hospital.

The increased availability of mixed psychological and somatic scrutiny allows ambiguous intent to be projected – in a consistent and routine way – into incidents of self-harm presenting at hospitals. The epidemic remains fundamentally constituted by the practices through which it is recorded and administered. This chapter shows how the integration promoted by the Mental Health Act (1959) and the opportunities for government regulation presented by the Suicide Act (1961) combine to lay the foundations for epidemic self-harm in Britain.

By removing all legal obstacles to the treatment of mental illness in general hospitals, the legal changes contained in the Mental Health Act (1959) enable the further integration of mental and general medical therapeutics. Even the separateness of the observation ward is considered undesirable by some after 1959. The Suicide Act (1961) decriminalises attempted suicide, which had only arbitrarily been considered a police matter even in the 1920s, and even more rarely after the inauguration of the NHS in 1948 (this is the sense in which the problem is 'not vast' for Robinson). However, the law change means that the government finally feels able to act in a prescriptive way, intervening in the management of attempted suicide and actively promoting psychiatric attention, something that is much more difficult when the act is technically a common-law misdemeanour.

Government intervention aims to make referral to a psychiatrist from A&E consistent on a nationwide scale. This multiplies the possibilities for

an epidemic (although without providing any extra resources). Attempted suicide as communication thus becomes a coherent national concern, but the resources available are insufficient to project a consistent social constellation around the physical injury. However, this basic coherence means that wherever appropriate resources are provided, the object can be found in abundance: an epidemic.

The Mental Health Act (1959): psychiatry into the 'mainstream of medicine'

Self-conscious efforts to achieve the equivalence of mental and physical medicine reach their zenith during this period, but have a broad history and continuing contemporary relevance under the banner 'parity of esteem' between mental and physical healthcare.[5] Whilst in one sense these concerns span the twentieth century and before, they remain contextually specific. Integrative efforts in the 1950s and 1960s based around psychiatric provision at general hospitals deserve special consideration; they are exceptionally self-conscious attempts at integration. The observation ward remains important in this process: many wards become treatment units in line with the prescient 1930s views analysed in Chapter 1 (as well as psychiatric liaison and referral services becoming more established). More broadly, the slowly changing functions of observation wards (see the previous chapter) play a key role in a re-articulation of attempted suicide. All these moves towards increased psychiatric provision enable the transformation of a physical injury arriving at a hospital into an interpersonal disturbance.

Two narratives: the dominance of 'asylum-community' and economic concerns

The historiography of the Mental Health Act (1959) significantly underplays its role in these integrative efforts. At the time, Kenneth Robinson draws out two distinct threads, noting that although the Percy Commission's Report and subsequent 1959 act are complicated, two more or less simple threads run through both: first, 'all distinction, legal, administrative and social, between mental and physical illness should as far as possible be eliminated'. Second, people who do not require long-term inpatient care should 'receive care and treatment while remaining in the community'.[6] It is this second thread that dominates the historiography of mental health in the twentieth century – the move from 'asylum to community'. The report and the 1959 act are conventionally

and broadly seen as marking a shift from 'institutional' or 'asylum' to 'community care' (termed deinstitutionalisation or decarceration).[7] This narrative also centrally acknowledges that 'the aspirations of the Percy Commission were never fully supported in legislation since ... no additional money was made available'.[8] The mobilisation of political concerns around this idea of a gap between the idealism of the report, and the financial provision for community care is one reason why the institution–community binary remains durable.[9]

This focus, oscillating between institutions and the community, sits uneasily with this account of attempted suicide as it neglects general hospitals and observation wards. Rogers and Pilgrim retain the emphases of asylum and community even when discussing general hospitals. Their assessment of District General Hospital (DGH) psychiatric units is that 'asylum theory and practice [are transposed into] DGH units and no new evidence of staff involvement with the communities of the patients they admitted'. Notions of asylum theory and a neglected community structure the analysis. Even more strikingly they characterise the Royal Commission on Lunacy and Mental Disorder of 1924–26, as containing an 'emphasis in 1926 on outpatients' clinics and observation beds in general hospitals (i.e., not in asylums)'. Their clarification of the significance of 'beds in general hospitals'– not in asylums– is revealing of their focus, between asylum and community: general hospitals are significant because they are not asylums and are bundled in with outpatient clinics.[10] Instead of making the DGH part of an asylum–community narrative, the present approach draws from Nikolas Rose's argument that 'rather than seeking to explain a process of de-institutionalisation, we need to account for the proliferation of sites for the practice of psychiatry'.[11] Different sites mean different contexts that require and sustain different kinds of practice. Focus on the DGH is an important part of the answer to Eghigian's question: '*[W]here* is psychiatry taking place?'[12] The clinical object, 'attempted suicide', emerges at the interface of psychiatric and general medical fields, and this is reconstituted by the 1959 act. Thus, much of the specific mental health policy discussion is not immediately relevant.[13]

The standard (somewhat neglected) narrative of integration, described in the Introduction, runs almost seamlessly from the Mental Treatment Act (1930), through the NHS (1948) to the Mental Health Act (1959). Charles Webster casts the 1959 act as tying up the loose ends left by the NHS in the march towards (presumably) fully integrated, comprehensive healthcare. He argues that 'the major loose end that was left by the NHS was the law relating to lunacy, and this was duly undertaken in

1959, following the Royal Commission on the Law relating to Mental Illness and Mental Deficiency'.[14]

In 1957 this commission (the Percy Commission) publishes its report, which contains the clearest and most widely circulated statement that psychiatry should become integrated with general medicine: 'Disorders of the mind are illnesses which need medical treatment … most people are coming to regard mental illness and disability in much the same way as physical illness and disability'.[15] It is stated in the text of the Mental Health Act, 1959, that '[n]othing in this act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital'.[16] Barbara Wootton demonstrates the sheer number of groups that are rhetorically committed to the integration of mental and physical medicine during the 1950s, citing evidence submitted to the Percy Commission. This includes testimony on behalf of the Association of Municipal Corporations ('it is now agreed that mental illness is a medical condition requiring the same amount of care as any other medical condition'); and the Royal College of Physicians ('the procedure for treatment of the mentally ill should approximate as far as possible to that of the physically ill'). The County Councils Association make 'suggestions for "accelerating" the "process of gradually placing the treatment of medical or physical illness on a similar footing"'; and the Association of Psychiatric Social Workers takes it as read that to bring 'the treatment of nervous and mental disorders more closely in line with that of physical illness' is a positive step. Wootton is clearly justified in stating that '[t]he wish to assimilate the treatment of mental and physical illness is thus widely supported'.[17]

This assimilation is broadly attempted by providing for the treatment of mental disorders in the same places as physical disorders – general hospitals. The increase in attempted suicide as communicative self-harm is founded in general hospitals. The vast majority of the time, it is the uncontroversially physical aspect of attempted suicide that first brings it to medical attention. Even when arguing in 1963 that all attempted suicides should be investigated by a psychiatrist, David Stafford-Clark remarks that it 'has surely never been suggested' that 'general physicians were to be wholly excluded from the management of these cases'.[18] Neil Kessel notes in 1965 that 'it is as a general medical problem that the poisoned patient first presents'.[19] This management, be it surgical or toxicological, is not performed in – nor is particularly relevant to ideas of – the community; it is vital not to conflate processes of integration with those of decarceration or community care. The emergence of a psychiatrically inflected attempted suicide in the second half of the

twentieth century in Britain does include a sense of 'community'– the psychosocial setting – but one that cuts across canonical mental-health histories.

Ad hoc referrals and eclectic clinicians

This wider rhetoric of integration informs a number of idiosyncratic and ad hoc practices that bridge the separate regimes of general and mental medicine. A number of studies of attempted suicide are carried out at general hospitals in the late 1950s but not in observation wards. Therapeutic regimes are negotiated in various ways, turning physical injuries into psychosocial disturbances to varying degrees. Whilst the late 1950s and early 1960s seem to represent the rhetorical height of integration, the picture is much messier in terms of practical arrangements and clinical objects. What remains key is the intellectual, practical, interpretive labour that inscribes this 'attempted suicide' into casualty records, undercuts the significance of somatic injuries and constructs psychosocial environments around the attempts.

Studies of attempted suicide issue from a group of casualty departments in Gateshead (1953–7), Guy's Hospital in London (1958) and Birmingham (1959).[20] These studies negotiate the institutional obstacles between mental and general medicine in hospitals by arranging referrals of casualty patients to psychiatrists, enabling socially directed explanations for self-harm to various degrees that they term attempted suicide. The most colourful (and seemingly commonsense) analyses emerge in a study by John Lennard-Jones and Richard Asher from Central Middlesex Hospital (1959). They coin the term 'pseudocide' for these actions. The following illustrations show how quite socially embedded these attempts are, and how much questioning is necessary to situate them in this way. Under '[d]oubtful suicide attempts' they set out a detailed case-study description of a social situation, both before and after the 'attempt':

> A Hungarian girl, aged twenty, took 15 aspirins because she felt lonely when her Irish boy friend did not visit her at the weekend, and had been offhand when she telephoned him. She took the aspirins impulsively and was glad when she came to no harm. Next day a solicitous boy friend escorted a smiling girl from hospital. *Comment*: Suicide may have entered her mind, but the appeal value of her action was enormous.[21]

Under 'Spurious Suicide Attempts', they bring preceding and subsequent social situations to relevance again:

> An Irish maid of twenty, working in a hotel, gave in her notice and was due to leave the next day. Having no friends in England and only a week's wages she felt that desperate action was needed. She swallowed a bottle of aspirins and then, having told the manageress what she had done, she undressed and went to bed. The doctor, urgently summoned, found her sitting up in bed combing her hair, but as he entered the room she fell back groaning … *Comment*: A silly girl who liked showing off.[22]

These descriptions are folksy and idiosyncratic, but draw upon Asher's well-established interest in psychology. The intent in these cases is articulated through common-sense ideas of communication: 'appeal value' and 'showing off'. Despite the casual tone, the practices used to elicit these objects are remarkably labour-intensive. The information used to construct the above case histories is only fully obtained 'after carefully, and sometimes repeatedly, questioning patients and their relatives'.[23]

Thus at Guy's and the Central Middlesex in London, in Gateshead and in Birmingham, 'attempted suicide' emerges. Referral enables a series of transfers between separated therapeutic regimes. In Asher's case, it is his eclectic (boundary-crossing) interests that are crucial. The object appears with increasing frequency, and yet the irregular, impermanent nature of the practices negotiating the split makes these clinical objects seem like so many miscellaneous, disconnected occurrences. There is certainly not much sense from the articles surveyed that attempted suicide is a national problem. The potential for an epidemic is clearly there, but it requires more high-level coordination and intervention to be fully realised.

As the provision of mental-healthcare is rethought and reconstructed in the late 1950s, new objects appear. Too great a fixation on 1959 is unhelpful because the act removes restrictions to mental treatment. These are largely irrelevant, in one sense because this particular phenomenon presents first as physical injury. The 1959 act does not enact integration, it merely removes legal obstacles. Whilst the 1961 retraction of the law from suicide and attempted suicide is similar in one sense, the government is much more pro-active, prescriptive and practical, so the Suicide Act repays this kind of closer scrutiny.

Suicide Act 1961: complex intent, legal reform and government intervention

The decriminalisation of suicide and attempted suicide in 1961 decisively ends some longstanding medico-legal debates around suicide.

These debates are important, as several legal-reform arguments bring complex intent to prominence, and the resulting retraction of the law initiates a far-reaching shift, enabling an openness and formality around the treatment and recording of attempted suicide. After the act is passed, the Ministry of Health recommends, on a national scale, that all cases of 'attempted suicide' seen at casualty or by GPs are considered for referral for psychiatric assessment. This positive intervention thus multiplies the possibilities for the (re)articulation of this phenomenon. Rates of psychiatric referral of 'attempted suicide' are actively followed up, policed and collated by the Ministry of Health; hospital groups have to account for any significant number of patients not directed to psychiatric scrutiny. The rhetoric around 1959 encourages integration, but these developments prescribe crossover, fuelling the growth of this phenomenon from a 'limited number' to an 'epidemic'.

The Suicide Act as a tale of two conflicts

The Suicide Act of 1961 has yet to receive sustained attention from historians. It is instead viewed as a minor part of the clutch of legislative changes and government reports seen to constitute the first 'permissive moment' in post-war Britain, under the reforming Conservative home secretary, Richard Austen Butler, between 1957 and 1962. (The second of these is related to Roy Jenkins's time at the Home Office, 1965–7.) Butler's time as home secretary sees discussions around 'how far to liberalise social constraints (if at all), particularly in relation to gambling, licensing, Sunday observance, suicide, censorship and the law governing sexual behaviour'.[24] These discussions play out against the intellectual backdrop of the most famous jurisprudential debate of the twentieth century, between Lord Patrick Devlin and Professor Herbert Hart.

The debate is sparked by the 1957 publication of the Wolfenden Report, which recommends (among other things) that 'homosexual acts' be decriminalised between consenting adults in private.[25] This debate snowballs into something much more general: in Peter Hennessy's apt summary, 'at issue was the power of the state to outlaw private practices it deemed immoral even if they harmed no one else'.[26] Devlin, a judge and later a Law Lord, argues that the law must be involved with moral questions because there can be no theoretical limit to society's powers to police itself. He argues that 'the criminal law could not operate without a moral law'.[27] Hart, a philosopher and professor of jurisprudence at the University of Oxford, counters that moral questions are outside the legitimate remit of the criminal law, unless they involve harm to another person (following such nineteenth-century liberal philosophers

as John Stuart Mill). The Suicide Act of 1961 features explicitly in this debate, as Hart praises the decriminalisation of suicide as 'the first Act of Parliament for nearly a century to remove altogether the penalties of the criminal law from a practice both clearly condemned by conventional Christian morality and punishable by law'.[28]

Mark Jarvis's study of the reforming Conservative government of the late 1950s and early 1960s is subtle and discerning, but rather rushes through the reform of the law relating to suicide, allotting it fewer than three pages. The act figures most prominently for Jarvis as a site of personal/political tension, an opportunity for the expression of the differing political dispositions of Butler and Prime Minister Harold Macmillan. Although the act is strictly out of the time period of Hennessy's *Having it So Good: Britain in the Fifties*, he uses the act in a very similar way. Both analyses pivot around an exchange between Macmillan and Butler. Macmillan asks: 'Must we really proceed with the Suicides [*sic*] Bill? I think we are opening ourselves to chaff if, after ten years of Tory Government, all we can do is to produce a bill allowing people to commit suicide'.[29] Butler counters: 'The main object of the Bill is not to allow people to commit suicide with impunity … It is to relieve people who unsuccessfully attempt suicide from being liable to criminal proceedings'.[30]

For Jarvis, this emphasises 'a wider sense of tension between the Home Secretary and Prime Minister … In his flippant attitude to reform of the suicide law, the Prime Minister showed how detached he had become from social reform, and antagonised Butler with his lack of insight at a time of major change'.[31] Hennessy prefaces the exchange with the contention that 'Macmillan's detachment, verging on insouciance, really irritated Butler'.[32] Both accounts go beyond the accessible and human narrative around personalities to make both this exchange and the act function as sites for the Hart–Devlin debate. Jarvis argues that 'in the case of the law governing suicide, Butler had modernised regulation by shifting it from a religious basis towards a more clearly defined border between law and private morality'.[33] For Hennessy, this exchange shows that 'Butler was, by nature and intellect, in the Hart camp'.[34]

Suicide law reform is thus placed firmly in the context of the Hart–Devlin debate, as a jurisprudential and parliamentary expression of moral libertarianism. This obscures much of its complicated resonance. Instead of positioning it within a programme of liberal reforms, or as a barometer of political instincts (liberal utilitarianism versus moral paternalism) lurking beneath political rivalries (reformist home secretary versus traditionalist prime minister), or even as an expression of

a celebrated jurisprudential debate, the analysis here shows how the act initiates changes in hospital practices, setting in train processes that enable, constitute and sustain a specific epidemic of self-harm as communicative overdose. It is important to draw a distinction between the retreat of the criminal law from concerns articulated in moral and psychological language, and the much larger retreat of the state from social management and support in the 1980s. This 1950s legal reform is carried out in the context of a sustained commitment to social and psychological support – as will become clear.

Stengel, legal reform and complex intent

The roots of the 1961 act can be most clearly seen – purely in parliamentary terms – in the repeated questions of Kenneth Robinson, Labour MP for St Pancras North, whose richly varied reforming political career involves: being the first chairman of the National Association for Mental Health; minister for health in the Labour government of 1964–8; sponsor of a Private Member's Bill to legalise abortion in 1961; and member of the Homosexual Law Reform Society's executive committee. Robinson begins asking questions of Butler on 6 February 1958. Butler's initial response is that he is 'not satisfied that any change in the law is desirable'. When Robinson counters that 'considerable and growing opinion in the medical and legal professions, and among the general public' is in favour of a change, Butler neatly refocuses the issue away from medical and legal professionals, and onto what he imagines to be much safer ground: 'the present concept of suicide as a crime has its roots in religious belief'.[35]

Robinson's reference to 'growing opinion' denotes a late-1950s surge in debates around the law on suicide. This includes Glanville Williams's *The Sanctity of Life and The Criminal Law* (1958), the British Medical Association and Magistrates' Association Committee's (BMA-MA) second report (1958) in just over a decade (having also produced a memorandum on suicide law in 1947) alongside a contribution from the Anglican Church, *Ought Suicide to be a Crime?* (1959). A brief look at these and other texts shows that as well as being explicitly influenced by Stengel's work, legal arguments in favour of reform promote visions of complex and ambiguous intent driving 'suicidal' actions.

Against this model, perhaps the earliest post-war contribution in favour of decriminalisation – that the sanction of the law is no deterrent because that person concerned expects to be dead – implies an attempted suicide modelled upon straightforward, genuine intent. The

British Medical Association's 1947 memorandum, prepared by their Committee on Psychiatry and the Law, explicitly downplays the significance of communicative or so-called hysterical attempts:

> Whether the prospect of police court proceedings is in any way a deterrent to the would-be suicide is a question which may be asked. Except in respect of hysterics whose motive, though they may not be aware of it, might be to attract attention, the large majority of those who attempt suicide do so in the expectation of completing the act. Thus it is probably true to say that would-be suicides are not likely to be deterred by fears of police court proceedings, since they believe they will be dead before the issue arises.[36]

The power and significance of the deterrence argument in this case is connected to debates circulating at that time about the non-deterrent effect of the law on capital punishment. Although hysterical attempts are downplayed in the context of these arguments about decriminalisation, there is still an acknowledgement that suicidal intent can be complicated.

Glanville Williams, eminent legal scholar and conscientious objector to the Second World War, publishes his controversial *The Sanctity of Life and The Criminal Law* in 1958. The book ranges widely, examining the philosophy behind prohibitions of contraception, sterilisation, artificial insemination, abortion, suicide and euthanasia. His arguments for the decriminalisation of suicide are noted by the Home Office and in Parliament, adding considerable intellectual muscle to reform arguments. His position shows how the concept of communicative attempted suicide can complicate (and critique) the law in a new way. The idea of self-harm as communication gains traction in the law-reform movement because it is used to undermine the law by scrutinising suicidal intent. Williams argues that '[m]uch light has been shed upon [attempted suicide] ... by a recent medical study made by Professor E. Stengel and Miss Nancy Cook'. He also draws upon Lindsay Neustatter's *Psychological Disorder and Crime* (1953). One of Neustatter's examples in which the police will take action and prefer criminal charges is when 'repeated attempts have been made, and it is evident that these are not genuine, but due to sensation-mongering: e.g. a girl several times threw herself down into shallow water where she could not possibly drown'. Williams's keen legalistic analysis brings out a tension in the law's operation: 'If an attempt is not seriously intended, it is not, in law, an attempt, and neither a prosecution nor a conviction is justified. There

is no crime of attempted self-manslaughter by knowingly running the risk of death'.[37]

Part of Williams's critique of operation of the criminal law is thus based upon his reading of Stengel and Cook. He argues that under the umbrella of suicidal acts there are three important sub-categories: the genuine, the demonstrative, and between those lies the gamble, which Williams claims is 'consciously an attempt at suicide, but unconsciously a gesture':

> The three kinds of suicidal acts call for separate consideration from a legal point of view. Genuine attempts at suicide are offences under present English law. Suicidal demonstrations are not, as such, offences. The legal status of the third group is undetermined; indeed, no court has yet had to pronounce upon unconscious motivation in criminal law. It seems probable, however, that such motivations, even if proved to the satisfaction of the court, will be ignored, on the ground that legal sanctions can only deal with the conscious mind.[38]

Whilst only one of the three categories is conclusively deemed ineligible through Williams's mobilisation of Stengel and Cook, the ambiguously motivated attempted suicide popularised by them has specific traction in the reform arguments. In Williams's hands it involves a statement that the law as it stands is not relevant to a gestural kind of attempted suicide.

Geoffrey Fisher, the Archbishop of Canterbury, forms a Church of England committee chaired by J.T. Christie, his direct successor as headmaster of Repton public school. In 1959 this committee issues the booklet *Ought Suicide to be a Crime?* A key member of the committee is Doris Odlum who, as a psychiatrist and magistrate (and later a president of The Samaritans), also sits on the joint BMA-Magistrates' Association committee. The booklet is written in three parts, with distinctly legal, psychological and religious arguments marshalled in turn.

In the legal section there is the argument that undercuts the law's application, as in Williams' and Neustatter's analyses: 'The man who repeatedly throws himself under a 'bus is plainly a public menace, but there cannot be many such men. It is doubtful whether, as a matter of law, anyone can be properly convicted of attempted suicide unless it is proved that he or she intended to kill themselves'. Again, the law is seen to be of ambiguous relevance when intent is scrutinised. Even the section that approaches the question from an explicitly moral and religious angle invokes an elastic notion of a 'complex mental history'

to question the idea of intent: 'Much more is now known about suicidal tendencies and about the complex mental history that can mobilize a potential suicide. It would seem as if there are not many suicides which can nowadays be regarded as wholly voluntary and deliberate'. Psychiatric advances are mobilised to question whether a legal response is appropriate: 'As a result of the development of psychiatry, it can be granted on all sides that many cases of suicide and attempted suicide should never be legally assessed at all, nor religiously condemned'.[39]

This 'development of psychiatry' is most likely a reference to the removal of legal formalities in the 1959 Mental Health Act. As a July 1959 speech on this bill in the House of Lords shows, the issues of suicide and mental-health law reform are connected, as 'one of the commonest kind of mental patients coming before the court ... [is] the attempted and unsuccessful suicide'.[40] The Mental Health Act is concerned with the relationship between legal sanction and psychiatric treatment. This brings attempted suicide to prominence because that action is considered a psychiatric problem and is also against the law. Thus law-reform arguments can bring to new prominence complicated or ambiguous intent around suicidal actions.

Returning to passage of the bill, on 6 March 1958 Robinson informs Parliament that he has obtained over 170 signatures to a motion for reform of the suicide law. He argues pointedly that his motion had been signed by those 'of all shades of religious opinion'. Butler again attempts to deflect rather than deal with the issue directly, suggesting that '[i]f the Opposition would wish to find time on a Supply Day for this or any other similar general question, it would be an interesting subject for the House to discuss'. Undeterred, Robinson submits a question a week later, asking 'on what evidence he bases the view that amending legislation to remove suicide and attempted suicide from the list of criminal offences would not be generally acceptable to public opinion'. Rather testily, Butler's reply is that '[e]xperience suggests that changes in the law on matters which involve religious and moral issues are likely to be contentious'. However, he is publicly more open about the possibility for legislative change, adding that 'I have not closed my mind on this Question and am continuing to study it carefully and sympathetically'.[41]

At the end of May, Robinson applies more pressure, mentioning the memorandum issued by the Joint BMA-MA Committee; in October, he criticises the law on the grounds that it is no deterrent: 'Clearly, the fact that suicide or attempted suicide is an offence against the law has very little, if any, effect on the mind of the would-be suicide'.[42] Butler directs the Criminal Law Revision committee to look into the practical

aspects of changing the law in 1959, and Robinson keeps up the pressure, eight times posing oral and written questions about the progress of the committee. The bill is introduced in the Lords on 14 February 1961 and is finally enacted on 3 August that year.

Hospital Memorandum HM(61)94 – Prescribing referral between therapeutic regimes

After attempted suicide is officially decriminalised in August 1961, in September the Ministry of Health issues Hospital Memorandum HM(61)94 'Attempted Suicide'. It asks 'hospital authorities to see that all cases of attempted suicide which come to their notice receive adequate psychiatric care'.[43] Attempted suicide is again inextricably bound up with negotiation between separate therapeutic regimes – from the acute, somatic medicine of casualty departments to psychiatric care. However, no extra resources are provided to casualty departments to enable this referral. In any case, similar to the previous chapter's analysis of A&E, the intensive scrutiny required for this object to flourish remains ill-suited to the administrative co-ordinating that occurs in 1960s casualty departments. Simply providing for referral or crossover is insufficient to sustain a psychosocial attempted suicide. However, it does attempt to coordinate referral on a nationwide (potentially epidemic) scale.

The idea behind HM(61)94 is first mentioned in correspondence between the Home Office and Ministry of Health on the final day of 1958. The latter department assumes responsibility for the promotion of psychiatric referral in cases of attempted suicide. Civil servants consult widely in mainland Europe and North America, asking their health department counterparts how such cases are dealt with under various legal arrangements. At a subsequent meeting between representatives from the Home Office, Health Ministry, British Medical Association and Magistrates Association. It is noted that

> in a great many cases the person would have been admitted to hospital to receive treatment for his physical injuries. At present, however, many of these persons were discharged without a psychiatric examination. The nature of the offence suggested that such an examination would be advisable in all cases … this was a matter on which the Minister would be prepared to give guidance to hospitals.[44]

The purpose of the memorandum is to ensure that the physically injured attempted-suicide patient obtains psychiatric assessment at general

hospitals. Government intervention is needed to integrate the two therapeutic regimes that formally and legally become equal after the Mental Health Act 1959.

This cause receives extra impetus in November 1960 when the Royal Medico-Psychological Association (RMPA) produces a report on Casualty and Accident Services, written by W. Linford Rees and John S. Stead. At this point, Rees is chairman of the Research and Clinical Section of the RMPA, having spent formative War years at Mill Hill conducting research at the Effort Syndrome Unit, the start of his work on psychosomatic disorders. He is remembered as facilitating 'the work of psychiatrists within the context of the general hospital'.[45] This document is part of a more general early 1960s concern about casualty departments, which leads to the publication of a number of critical and anxious reports.[46]

Rees and Stead are critical about the general level of psychiatric care: 'In only thirteen of the forty nine hospitals was the casualty officer able to call in a psychiatrist to advise on disposal'. More disturbingly: 'Few of the hospitals in the regions and few of the London teaching hospitals felt that they had adequate psychiatric advice available for assessment and appropriate disposal of patients'. All the recommendations concern the integration of psychiatric and general medical expertise in general hospitals, covering the provision of initial advice, facilities for short-term psychiatric-diagnostic observation, and arrangements to transfer patients to either a psychiatric unit or psychiatric hospital.[47] Concerns about the practicalities of integration – specifically the number of consultant psychiatrists – are also present in the 1958 British Medical Association and Magistrates' Association Report on attempted suicide.[48]

Wider integration and legal opportunity: common ground between 1959 and 1961

Arrangements for the hospital memorandum on attempted suicide are taken in hand later in November 1960, primarily because '[n]ow that the government have announced their intention of amending the [suicide] law ... the time has come for us [Ministry of Health] to issue a hospital memorandum urging hospital authorities to see that all cases of attempted suicide which reach them are given a psychiatric investigation'.[49] Senior civil servant Patrick Benner adds that '[i]t seems all the more necessary to go ahead with this fairly soon in view of the recent report of the Royal Medico Psychological Association suggesting

that this is a matter on which a good many hospitals are not doing very well'.[50]

The two broad reasons – the opportunity provided by a government-sponsored bill to change the suicide law, and an appreciation that psychiatric advice in casualty departments is not all it should be – show up consistently in the memorandum negotiations and revisions. Instead of seeing the HM crudely, as solely enabled by the Suicide Act, it is significantly concerned with the wider integration promoted by the Mental Health Act 1959.

The Suicide Act might be a convenient prompt, but Benner argues that '[t]he general points we need to make to [hospitals] are valid even in advance of the legislation [because] our aim is to produce, in advance, the requisite degree of medical and social care'.[51] It is also claimed that there is 'good reason to think that hospital practice is in need of improvement now and this depends in no way on the outcome of the [Suicide] Bill'.[52] Whilst part of MH(61)94 is prompted by the legal change, integration of therapeutic regimes ('improving hospital practice') is a significantly wider issue. This is the shared territory between the 1959 and 1961 acts.

Stengel takes a narrow legalistic line, rather than credit the government with any serious acknowledgement that psychiatric facilities are inadequate in A&E. He writes:

> The role of the psychiatrist in the management of attempted suicide in the general hospital has for the first time been officially defined. Apparently, once the problem of suicide was taken out of the hand of the law, the Ministry of Health considered that the health authorities had to accept responsibility and to advise how it should be discharged.[53]

The transformations in the previous chapter at observation wards are here promoted at accident and emergency departments. After 1961, the possibilities for the emergence of communicative attempted suicide are transformed in size and scope, the foundation for a problem of epidemic proportions and national significance.

The text of the memorandum is centrally concerned with integrating psychological scrutiny into the overwhelmingly somatic focus of casualty departments. It is stated that '[t]hese cases often come to hospital casualty departments for urgent lifesaving physical treatment ... after physical treatment the patient is sometimes discharged without any psychiatric investigation of his condition [which is] of major importance in most cases of attempted suicide'. It continues, offering suggestions

heavily influenced by Rees's and Stead's report: 'Hospital authorities are therefore asked to do their best to see that all cases of attempted suicide brought to hospital receive psychiatric investigation before discharge ... Where the hospital has no psychiatric unit, it may be necessary to arrange for liaison with a neighbouring psychiatric hospital'.[54] Again, arrangements negotiating the split between psychiatry and general medicine are necessary for this clinical object to thrive.

Stengel does not see the potential for attempted suicide to multiply exponentially as a result of the Suicide Act, rather curiously focusing instead on coroners and completed suicide figures: 'Psychiatrists do not expect the law to lead to an increase in suicidal acts, but a slight rise in the suicide figures will not be surprising ... some coroners may be less hesitant about giving a verdict of suicide rather than an open verdict'. He does make a concession:

> It is also possible that the number of attempted suicides diagnosed as such in the hospitals may show a slight increase. If so, this should not be taken at its face value ... Some hospital doctors were known to refrain occasionally from referring to the suicidal attempt in their diagnostic formulations, in case their patients should suffer inconvenience. For the same reason, the protestations of some patients that they had taken overdoses of dangerous drugs without suicidal intention may have been accepted too readily. Small increases in the numbers of suicides and attempted suicides in the next few years can therefore be regarded as artefacts.[55]

Unsurprisingly, Stengel remains within traditional ideas of incidence, seeing institutional change as effecting variations upon a real total number. Instead, the argument pursued here is that changes in organisation are fundamental to the kinds of numbers that are produced. The Ministry of Health also does not see this as a problem on a huge scale, as when the hospital memorandum is finally issued, it is decided not to alert the press because '[t]he documents are self-explanatory, and the subject, though important, is of limited scope'.[56] With hindsight, the foundations are there, but traditional ideas of incidence obscure the epidemic potential from even the most vocal publicist for attempted suicide.

Psychiatric resources and ministry follow-up

The A&E department is the site at which the Ministry of Health seeks to intervene, to entrench referral practices between general medicine

and psychiatry. However, there are no extra resources provided for the proposed extension of psychiatric referral. Stengel optimistically believes that HM(61)94 will be a stimulus for the establishment of psychiatric outpatient departments and DGH psychiatric units, and for social and community services in general:

> Considering the large number of consultations required by the Ministry of Health [Hospital Memorandum] ... The pressure for additional psychiatric staff and for the creation of more psychiatric outpatient departments is likely to increase. This will be all to the good because it will make the community aware of the inadequacy of the psychiatric services and will speed up plans for creating psychiatric departments in general hospitals. Thus, attempted suicide, that last and supreme appeal for help, may act as a powerful stimulus for the improvement of psychiatric and social services.[57]

This again shows the link between the two acts of Parliament analysed in this chapter. However, the idea that a newly decriminalised attempted suicide might stimulate the integration of mental and general medicine is rather back-to-front. The much broader efforts attempting the integration of therapeutic regimes are what enable this object to be constituted – that are fundamental for the emergence of this supreme appeal for help. S.W. Hardwick of the Royal Free Hospital writes to the ministry and makes the same point as Stengel, that there are insufficient resources to carry out all these referrals: 'If I am right in my interpretation of the H.M., a considerable amount of additional work and responsibility will have to be undertaken by the Psychiatric Department, which may mean a requisition for extra staff'.[58] The government's approach to integrating general and mental health in this specific case seems consistent with the broader (lack of) financial provisions around the Mental Health Act 1959. Stengel hopes that

> doctors and hospital authorities who have found the Ministry's recommendations impracticable will say so in no uncertain terms. It would be against the interests of patients to adjust the attempted suicide figures to the psychiatric resources available instead of adjusting the resources to the real demands.[59]

Given the importance that is placed throughout this book upon the high intensity of scrutiny necessary for this psychosocial self-harm to emerge consistently, casualty again seems like an unlikely candidate.

It is possible to glimpse the level of impact that the HM has on casualty services, because the Ministry of Health decides to follow up the recommendations. Benner sends a note to government statistician G.C. Tooth stating that whilst 'it is not our practice to follow up all H.Ms by any means ... this is a rather important subject where I think some kind of action from us would be reasonable'.[60] Benner expands upon the importance of this statistical enquiry. He appreciates that the whole problem of attempted suicide has been passed to the health service and therefore 'it seems right that we should know how they are dealing with it'. Tooth agrees, emphasising that it is important for the ministry to have a sense of how many patients have been seen by psychiatrists before they are discharged from hospital – having had first aid for their injuries.[61] Integration of psychiatric and general medicine for scrutiny of patients arriving at casualty is not simply prescribed, but actively policed after the change in the law. Regional hospital boards are asked to submit the number of attempted suicides seen by a psychiatrist in the twelve months since the issue of the hospital memo. They are asked for the approximate number of cases, the proportion seen by a psychiatrist and details of any measures to improve rates of follow-up.[62] This is a concerted effort to prompt and shape casualty department practice. This information is collated and written up in an internal document in January 1964.[63]

The Ministry expresses broad satisfaction because although 'replies from Boards vary considerably ... most managed to report that 75% of admissions were seen by psychiatrists'.[64] The memorandum prompts a number of diverse practical changes in various hospitals concerning psychiatric liaison. These are glossed illustratively here to give a flavour of the different ways in which the therapeutic divide is constituted and negotiated in the same move. The Sheffield Regional Hospital Board (RHB) report that the Sheffield No.1 Hospital Management Committee (HMC) has the lowest rate of referral to a psychiatrist in that region (65%). The hospital psychiatrist 'suggests a special form for all patients admitted for attempted suicide' as a remedy.[65] Grimsby HMC, under the same board, reports that '[s]ince HM(61)94 a rota of Mental Welfare Officers has been arranged whereby one sits in at each clinic and follow-up and all cases are referred to Consultant Psychiatrist in the Group'.[66] Under the North-West Metropolitan RHB, the Luton and Dunstable Hospital reports: 'During the last year the number of days on which there is a psychiatric out-patient clinic has increased from 2 to 3 a week, so that psychiatrist are more readily available to see these patients'. Under the same RHB, Mount Vernon Hospital achieves only 35% referral, and the psychiatrist

concerned comments that 'unless he is relieved of some other commitments he will not have time to see all of the cases that should properly be referred to him'.[67]

This board claims in its covering letter that '[w]here the information ... shows a markedly inadequate service ... the possibility of improvement [will] be discussed with the members of staff concerned'.[68] For the Wessex RHB,'[t]he Board has taken action to bring the Salisbury Hospital group with a 39% return into line' and although the Isle of Wight reports that only 50% of cases have been psychiatrically assessed over the past year, '[i]n future all such cases will be seen by a Psychiatrist'.[69] These are uneven, ad hoc, idiosyncratic practices, despite the best efforts of the Ministry of Health. Referral arrangements involving mental welfare officers and psychiatric out-patient clinics exist alongside new memoranda, renewed efforts at referral to psychiatric consultants and mental hospitals that, despite their differences, are all attempting to move towards integration.

However, not everything goes so smoothly – Cardiff RHB even interprets the guidance in such a way as to decrease the visibility of communicative attempted suicide.[70] Stengel has other problems with it and implies that the return is less than useless. His letter to the Ministry of Health is unfortunately no longer in the file, but there remains a copy of one he sends to the Superintendent of the Royal Infirmary, Sheffield. In it he argues that 'I have not been able to comply with your request ... patients who have made suicidal attempts are not usually diagnosed as "attempted suicide" but under some other heading ... The only way to provide the required information would be for the Ministry to request hospitals to put "attempted suicide" into the diagnostic index'.[71] He says that 'it would be a pity if the Ministry should accept information which cannot possibly be valid [and] dangerously misleading'.[72] This is a significant problem for the emergence of a consistent, epidemiological object of attempted suicide.

As Stengel's criticism highlights, without either a customised structure for its record, or the labour-intensive scrutiny of research psychiatry, attempted suicide is exceptionally difficult to pin down. Specialised research projects begin to record it during the early 1960s. W. Malcolm Millar, George Innes and Geoffrey Sharp design a research questionnaire in the early 1960s that includes the question: 'Has a suicidal attempt formed any part of the present illness? Yes/No'.[73] Peter Sainsbury and Jacqueline Grad prepare a clinical record sheet for psychiatrists to record reasons for deciding upon a certain disposal option. Next to 'previous mental illness' there appears the phrase '(N.B., Suicide Attempt)'.[74] This

reminds psychiatrists that a suicide attempt is to be considered as part of a mental illness (even perhaps a trivial one, apt to be dismissed as a gesture). However, recording attempted suicide here requires a special record sheet or specialised psychiatric research project. It becomes clearer why the ministry-backed crossover is insufficient on its own.

Finally, Medical Officer John Brothwood proposes to the Ministry of Health a statistical study of attempted suicide at A&E. It involves distributing a form to casualty departments in order to ascertain the methods and motivations behind attempted suicides. Several objections are raised about the definition of attempted suicide (by Eileen Brooke). Equally damaging questions about the practicability of obtaining the information are raised by a Dr. Otley: 'Many of the questions ... would be unanswerable or answerable on very scanty information "at the time of consultation"' by the medical officer in casualty. The scheme fails to gain approval because the casualty department is unsuited to the project, allowing only a small and inadequate amount of information to be collected. The complex definitional problems that circle around intent, which could enable the intent to become communicative, require those with background – inescapably social – knowledge.[75]

The limitations of casualty differ from those in some observation wards, where treatment and follow-up are more established. However, the casualty department and the HM that seeks to intervene upon it still attempt to negotiate the enduring boundary line between psychiatric and general medicine, and to draw out, control and produce information about attempted suicide. The inescapably social, communicative reading of attempted suicide needs more than just referral to and liaison with a psychiatrist. It needs consistent psychiatric scrutiny, and more of an institutional foundation and psychiatric resource base than a memorandum can provide. The efforts of MH(61)94 at securing nationwide rates of 75% referral do have an effect, prompting and solidifying channels of communication and scrutiny between accident departments and psychiatric expertise. However, a lack of extra resources and the sorting role of the casualty department within the NHS undercuts high-intensity psychiatric scrutiny at that site.

Concluding thoughts

There is a strong link between the Mental Health Act 1959 and the Suicide Act 1961. Both are implicated in a process through which different therapeutic regimes are integrated at general hospitals. This makes possible a consistent articulation of a highly psychologised, highly social reading

of self-harm with complex intent. This contrasts starkly with today's clinical concern with self-cutting, which is based upon internal, and sometimes neurochemical triggers. Both acts of Parliament involve the removal or significant retraction of the law around the field of mental disorder (with suicidal behaviour securely, though not inevitably, entrenched as part of this field). This enables a more fluid interaction between mental and general medicine, altering the kinds of clinical objects likely to emerge. The Suicide Act, in removing the legal sanctions around attempted suicide does not necessarily change practices very much in one (empirical) sense; people are not being convicted very much during the 1950s. However, reform arguments have a resonant connection with ambiguous suicidal intent, and decriminalisation alters the terms of the debate through which attempted suicide is conceptualised, prompting formal intervention by the Ministry of Health.

Because of the high level of psychiatric scrutiny required to produce complex, communicative intent around a presenting physical injury, HM(61)91 does not enable a huge number of studies by itself. The lack of extra resources is significant, but perhaps even more significant is the vastly increased potential for the object to flourish in a number of different sites, if increased resources become available. This is another important step for the progress of a clinical object – from an observation ward curiosity to one inscribed in a nationally consistent manner. The epidemic – and the broad, homogenising administrative machinery required for a multi-site epidemic – emerges through wider integration promoted through a retraction of the law in the areas of suicide and mental health more broadly.

Returning to the notions of incidence broached discussing Stengel's attitude to the hospital memorandum, we can see that as the potential for this clinical object becomes more and more widespread and more visible, the behaviour potentially becomes more and more available. Ian Hacking observes:

> Cynics about one thing or another … say the epidemics are made by copycats. But even if there was a lot of copying, there is also a logical aspect to 'epidemics' of this type. In each case … new possibilities for action, actions under new descriptions, come into being or become current … to use one popular phrasing, a culturally sanctioned way of expressing distress.[76]

Hacking shows, in his example of multiple personality disorder, that this logic of epidemics is a powerful and useful way to understand

how behaviours travel and multiply. Something similar happens with attempted suicide. His use of distress as a basic anchoring category also has a history. In the next chapter the growing resonance of terms such as stress and distress is analysed and placed into context. Psychological medicine increasingly turns to these concepts to understand mental disorder; attempted suicide is central in this development.