



**HAL**  
open science

# Changes between the 1959 and 1983 Mental Health Acts (England & Wales), with particular reference to consent to treatment for electroconvulsive therapy

Claire Hilton

► **To cite this version:**

Claire Hilton. Changes between the 1959 and 1983 Mental Health Acts (England & Wales), with particular reference to consent to treatment for electroconvulsive therapy. *History of Psychiatry*, 2007, 18 (2), pp.217-229. 10.1177/0957154X06073636 . hal-00570874

**HAL Id: hal-00570874**

**<https://hal.science/hal-00570874>**

Submitted on 1 Mar 2011

**HAL** is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.



---

## Changes between the 1959 and 1983 Mental Health Acts (England & Wales), with particular reference to consent to treatment for electroconvulsive therapy

CLAIRE HILTON\*

*Central and North West London Mental Health NHS Trust*

*Consent to treatment was not mentioned in the Mental Health Act 1959, assuming that a detained patient could be treated against his/her will. However, consent was a crucial new feature in the 1983 Act. This paper traces and evaluates the issues, debates, people and organizations in England and Wales who advocated and enabled this important change to come about, using examples from the clinical practice of electroconvulsive therapy.*

**Keywords:** *consent to treatment; ECT; electroconvulsive therapy; England; Mental Health Act; MIND; Royal College of Psychiatrists; Wales*

### Introduction

Developing mental health legislation is a slow process. The Government is currently introducing new mental health legislation: a draft Mental Health Bill was published in September 2004 (Department of Health, 2004a: 2), and this remains under review (Dyer, 2006). The revision of the Mental Health Act 1983 has so far taken 8 years, mirroring the prolonged process of revision in the 1970s between the 1959 and 1983 Acts.

By the early 1970s various aspects of the Mental Health Act 1959 were being questioned. There were several possible triggers to this. Care and treatment of people detained in mental illness and mental handicap hospitals had been highlighted by several reports of abuse, such as at Ely Hospital (1969),

---

\* *Address for correspondence:* Mental Health Services for Older Adults, Northwick Park Hospital, Watford Road, Harrow, HA1 3UJ, UK. Email: [claire.hilton@nhs.net](mailto:claire.hilton@nhs.net)

Farleigh Hospital (1971) and Whitingham Hospital (1972) (Fennell, 1996: 172), and also by Barbara Robb in *Sans Everything* (1967). The focus was moving away from the legal principles of detention towards how people were cared for within the hospital. In addition, treatment was already in a period of transition, towards 'community care' with the development of more effective pharmacotherapy, and also controversial physical treatments such as psychosurgery.<sup>1</sup> Both the civil rights movement involvement with the care of detained patients in the USA (Fennell, 1996: 170; Krouner, 1973; Salzman, 1977) and concerns over abuses of psychiatry in the former Soviet Union (Jones, 1993: 198) were of public interest. In England, with the writings of Ronald D. Laing among others (Sedgewick, 1982) and the new civil rights and legalistic focus of the National Association for Mental Health (MIND),<sup>2</sup> there was further impetus to review the care of the severely mentally ill. With the 1983 Act under review, in the not to distant future its origins are likely to be of more interest to historians and the individual patients whose lives it influenced rather than to mental health care professionals. Perhaps it is now time to look at how that Act emerged, in particular on the issue of consent to treatment, prominent in the 1983 Act but unmentioned in the 1959 Act.

### **Consent to treatment and electroconvulsive therapy**

The concept of consent is closely linked to concepts of rights and autonomy. The rights of the individual within society emerged in the Enlightenment, and the philosopher Immanuel Kant (1724–1804) developed the ideas that people have rights and duties which ought to be respected (Lepping, 2003). Other landmarks in the development of autonomy of the individual include: the French Revolution; the Universal Declaration of Human Rights (1948), which includes the right to liberty, and to be free from cruel, degrading or inhuman treatment; the Nuremberg Code (1949); and the Human Rights Act (1998) (Lepping, 2003). Such developments form the bedrock upon which consent to treatment legislation has developed. In terms of mental illness, although the notion of informed consent was recognized as early as 1700, it was not until the advent of the voluntary boarder status in the Lunacy Act 1890 and the voluntary patient in the Mental Treatment Act 1930 that the issue of capacity and consent for psychiatric treatments was first raised in non-detained patients (Raymont, 2002). In detained patients this issue was not raised until the 1970s with the review of the Mental Health Act 1959.

The importance of consent was well established in medical practice by the early 1970s (Medical Defence Union, 1971). However, a method for medical practitioners to ensure valid consent, i.e., that the patient could actually understand the nature and purpose and likely effect of treatment, was not outlined. Even by the time of the Mental Health Act 1983, this was not included in the text (Bluglass, 1983: 84). The process of ensuring that the person has capacity to consent – that they are able to understand information

about the proposed treatment, are able to remember the information long enough to weigh up the benefits and risks in order to make a decision, and to communicate that decision – evolved later. It has been recognized for decades that, although consent to treatment criteria apply to all medical and surgical interventions, in the context of mental illness there may be specific difficulties when the patient is unable to fulfil the criteria to make such decisions because of the very mental illness which requires treatment (Medical Defence Union, 1971: 7–8).

Although there are numerous different treatments for mental illness, examples in this essay are drawn from the practice of electroconvulsive therapy (ECT), the passage of a small current of electricity through the brain to induce a convulsion. ECT, despite recognized clinical effectiveness, has remained a controversial although widely used treatment since its introduction in 1938 by Ugo Cerletti and Luigi Bini in Rome. Since the 1950s, it has been standard practice to give a general anaesthetic plus a muscle relaxant before the induction of the convulsion, and thus the patient is unconscious before the convulsion is induced. An epileptic convulsion modified by the effects of the muscle relaxant occurs. The convulsion lasts about 30 seconds, the whole procedure a few minutes. For half a century, ECT has been recognized to give therapeutic benefit in the treatment of severe depressive illness.

In clinical practice, however, emotive debates persist around consent issues, particularly in relation to ECT. Postal surveys of psychiatrists about the legal framework they use for deciding whether to use ECT in 1980 and 2006 bear remarkable similarities, suggesting the issues and concerns remain unresolved (Anon., 1981;<sup>3</sup> Law-Min and Stephens, 2006).

### **The Mental Health Act 1959 and consent to treatment**

The 1959 Act was based almost entirely on the recommendations of the Royal Commission on the law relating to mental illness and mental deficiency chaired by Lord Percy ('The Percy Commission') which gave its report in 1957 (*Royal Commission*, 1957). Sweeping away much of the legalistic framework of the old Acts of 1890 and 1930, the 1959 Act was guided by the philosophy that, whenever possible, care should be provided without the use of compulsion (Gostin, 1983: ix). However, in terms of treatment, it was assumed that detained patients admitted for treatment could be treated against their will. Although unwritten, it was considered good practice to discuss treatment in these circumstances with the patients' relatives, or to seek a second opinion from a colleague. It is unclear from the literature precisely when these good practice recommendations were put into effect, and quite how controversial or widely implemented they were. They were certainly still being debated in 1977, and some psychiatrists contributing to the debate described considerable paternalistic practice (Guirgis, 1977; Sedman, 1977; Spencer, 1977). However, mental illness has always been

constructed or framed by society at the time in which it was experienced. In the 1960s and 70s, debates on the nature of mental illness itself were confronting the medical profession. The social aetiologies proposed by Laing, for example, contrasted with the biological basis of mental illness derived from neuroscience research (Shorter, 1997: 270–7). The 1960s were also more generally associated with anti-authoritarian attitudes. Clearly, the view of the medical profession, despite a practical expertise on treating mental illness acquired over a century or more, largely from asylum-based work, was not going to be exclusive; the expectations of the patient, their family, society and the law were inevitably involved.

In 1973, Sir Keith Joseph, Secretary of State at the Department of Health and Social Security (DHSS), was asked in Parliament about consent. He stated that he had been advised that, for detained patients, consent to treatment was not necessary, but it was normal practice to obtain the patient's agreement if he or she was capable of understanding the proposed treatment (*Hansard*, 1973; Medical Defence Union, 1971: 7–8). In the same year, the Davis Committee on Hospital Complaints was convened in response to a series of enquiries into mental hospitals. This Committee considered the issue of voluntary patients refusing treatment and then being detained under the Mental Health Act in order to enforce treatment. It stated that detained patients could not legally refuse treatment (Gostin, 1975: 120), but proposed that a second medical opinion should be obtained before treatment could be imposed (Fennell, 1996: 172). It recognized that the 1959 law was coercive in terms of treatment and needed reform.

### **The National Association for Mental Health**

The National Association for Mental Health (MIND) was undoubtedly a key player in the changes in mental health legislation in the 1970s. Founded in 1946, it initially sought to provide education on mental illness, and to provide care facilities for people with a wide range of psychiatric disorders. It was a traditional voluntary organization based on a partnership between professionals, relatives and volunteers, aiming to improve services and public understanding within current structures. With a limited budget mainly from central government, its work was based on local associations, and discrete pressure behind the scenes was preferred to public campaigns.<sup>4</sup> All this changed in 1974 with the appointment of Tony Smythe as Director. He brought in experience in the field of human rights, having been Director of the National Council for Civil Liberties; he had also worked in the field of civil liberties in the USA (Jones, 1993: 200). His appointment, and a greater emphasis on the development of an advisory service dealing with welfare and legal rights, led to the establishment of the legal and welfare rights service in 1975 (MIND, 2005). Larry Gostin, an American lawyer who had recently been a Fulbright Fellow at Balliol College, Oxford, and had worked at the

Social Research Unit, University of London, was appointed first legal officer. He subsequently received the Rosemary Delbridge Memorial Award from the National Consumer Council for the person ‘who has most influenced Parliament and government to act for the welfare of society’. Later he became internationally recognized for his work in law and public health, and is currently professor of law at Georgetown University, USA.<sup>5</sup> With both Gostin and Smythe having worked in civil liberties the USA, where the rights of detained mentally ill people was already an issue, their previous experience appeared likely to influence their work in Britain. For example, concepts such as the US principles of ‘least restrictive alternative’ and ‘due process’ (a legal principle which ensures that the government cannot deprive an individual of life, liberty or property without respecting all of the individual’s legal rights) became incorporated into arguments on mental health legislation in Britain (Jones, 1993: 200). A psychiatrist and observer of the events unfolding from within both MIND and the Royal College of Psychiatrists commented:

Smythe and Gostin turned [things] upside down; they also recruited into the staff a number of aggressive anti-psychiatrists who had political connections with the Far Left. The traditional co-operative methods were replaced by confrontation.

Before Gostin, MIND had never had a legal rights officer, but he established a dominant position within the organisation. Smythe, who was a weak character, took a back seat. Gostin was brilliant at manipulating the media so that whenever a mental health issue came up, their first call was always to him.<sup>6</sup>

While legal director for MIND (1975–82),<sup>7</sup> Gostin wrote *A Human Condition*, MIND’s proposals for reforming the Mental Health Act 1959 (1975). Volume 1 dealt with admission and discharge procedures, review tribunals and in-patient rights including consent to treatment. Volume 2 related to mentally abnormal offenders and the Butler Committee Report (1975). Gostin challenged the assumption that compulsory detention also allowed for compulsory treatment, based on the Percy Commission’s statement that ‘there should be no distinction of “status” based on whether a patient is admitted informally or through the use of compulsory powers’ (Gostin, 1975, Vol. 1: 122). He proposed that all treatment to be given to a hospital ‘resident’ who cannot or does not give consent should be reviewed by an independent body, the Committee on the Rights and Responsibilities of Staff and Residents of Psychiatric Hospitals (CORR) (p. 116). CORR would consider concerns of advocates, residents, staff, parents and guardians concerning ‘suspect’ treatments, and its decisions would be based on the principles of the resident’s individual treatment plan, on protecting the dignity of the individual and being the least restrictive to them (p. 117). In particular, ‘Treatment which involves surgery, electro-convulsive therapy or the use of experimental drugs

or procedures shall not be given without approval by CORR'. In addition, for a patient who could not consent, 'express and informed written consent of his legal guardian must be obtained' (p. 152).

The term 'resident' (Latin *sedeo* = sit) is interesting. Using this unbiased term rather than the more medical 'patient' (Latin *patiens* = suffering) tended to negate the illness part of the person's condition, almost implying that the individual's condition was a social phenomenon. Indeed, this would have been compatible with MIND's preferred term of 'mental distress' rather than 'mental disorder'.<sup>8</sup> Gostin, however, maintained that this less stigmatizing terminology 'was intended as a mark of respect ... We wanted to convey the idea that they were people first, with rights, and not patients who were subservient to the medical profession'.<sup>9</sup> Gostin was not just an academic lawyer: he took cases to the European Court of Human Rights,<sup>10</sup> which may also have spurred change.

### **The Royal College of Psychiatrists, Mental Health Act reform and consent to treatment**

While MIND claimed to be the representative voice of the mentally ill and their advocates, the Royal College of Psychiatrists was the voice of the psychiatric establishment. The College, however, was not the only professional group involved in the debates on reform of the legislation. Nursing, psychology and social work professional bodies were also participants, as well as the Royal Society for Mentally Handicapped Adults and Children (MENCAP), but they were more active during the later stages of debate (Bluglass, 1983: 6; Jones, 1993: 204).

Unfortunately, there is a dearth of archives for many of the College's sub-committees. However, references made to these committees in College Council minutes do survive, and they give glimpses of major concerns and debates expressed by practising psychiatrists in the 1970s. Tensions between MIND and the College are apparent.<sup>11</sup> Although Gostin emphasized that it was not the psychiatrists' decision to give ECT which was under question but the detained patients' competency to make a decision, in essence it appeared that his increasingly influential ideas would remove decisions for giving treatment from the medical profession to an independent multi-disciplinary committee.<sup>12</sup> Gostin's views were interpreted as a challenge to the professional integrity of psychiatrists (Anon., 1979). Debates on treatment were common in the USA at that time (Morrissey, Burton and Steadman, 1979); for example, an Alabama state judge had ruled that ECT could not be given even to consenting patients without the agreements of four psychiatrists and one neurologist with at least two attorneys monitoring the proceedings (Anon., 1979). However, in Britain, during the previous one-and-a-half centuries mental illness had become both more medicalized and subject to treatment by physicians claiming special expertise in this subject, and more legalized.

As far back as 1828, the Madhouse Act placed requirements on the frequency of doctors' attendances on patients in madhouses (Scull, 1993: 231). Practice in the care of the mentally ill had been influenced by legal requirements at least since 1819, with the establishment of a lay Board of Inspection for madhouses (Scull, 1993: 202–3). Since the Mental Treatment Act 1930, there had been a consistent move towards treating psychiatric patients, as far as possible, in the same way as those who were physically ill (Bluglass, 1983: 6; Jones, 1991: 97). Even with challenges by the anti-psychiatry movement since the 1960s, autonomy in medical treatment decision-making by psychiatrists had largely been retained. Now psychiatrists' decisions were being further challenged, and they did not appear prepared for it. Medicine had prided itself on its status as an autonomous, self-regulating profession for centuries.

Concerns over the adequacy of the 1959 Act were being explored by a Royal College of Psychiatrists Working Party by 1972,<sup>13</sup> preceding the Parliamentary questions to the Secretary of State, the Davis Committee and the publication of Gostin's work. The trigger for the establishment of this Working Party is not clear. Unfortunately their minutes no longer exist in the College archives. However, their draft report was circulated to College Council in July 1974.<sup>14</sup> It was also documented that 'MIND is shortly to publish its review of MHA ... College's review is to be published without delay'.<sup>15</sup> Clearly, the desire to appear responsive and innovative in considering legal and ethical matters was of major importance to the College.

The College's 'Review of the Mental Health Act 1959' was published in October and November 1974. A large part of this was about consent to treatment. Concerns were raised and some solutions proposed.

The Working Party are firmly of the view that compulsory powers should include power to treat patients compulsorily for any sort of mental disorder, but has doubts as to how certain types of treatment should be applied on sole authority of the Responsible Medical Officer<sup>16</sup> against the patient's will or when he is incapable of giving consent.

Some further suggestions were made such as consulting the next of kin.<sup>17</sup> In addition, the College advocated that if a second medical opinion was obtained, it should be advisory rather than binding, the patient's own consultant psychiatrist – the responsible medical officer – taking the final decision about treatment (Royal College of Psychiatrists, 1974). The provision of the 1959 Act was clearly regarded as adequate in these circumstances. As will be seen, the development of the 1983 Act manifested a major departure from this standpoint.

Specific concern over ECT followed the 1976 report on St Augustine's Hospital, Canterbury, which highlighted misuses of the treatment. It was alleged, for example, that ECT was given as a punishment, under force, was used excessively, and was inappropriately used as a tool (supposedly) to differentiate depression and dementia (South East Thames Regional

Health Authority, 1976: 63–71, 162, 163). The Committee of Enquiry at St Augustine's specifically requested the College to 'give urgent consideration to these problems and offer clear guidance' (p. 71). The issues raised were of a sufficiently sensitive medico-legal nature that the College sought advice from the Medical Defence Union and Medical Protection Society on how to proceed.<sup>18</sup> Guidelines for the use of ECT were published by the College in 1977 (Royal College of Psychiatrists, 1977), although the section on medico-legal aspects is somewhat vague. For example, in keeping with other documents of the time, it does not clearly specify criteria, or refer to other sources, for capacity to consent.

The College was clearly aware of considerable public interest in ECT which may have been triggered by the release of the highly acclaimed film *One Flew over the Cuckoo's Nest* in 1975 which dramatically portrayed psychiatric treatment being given without consent to detained psychiatric patients in the USA. But ECT was also in the British press. For example, in 1979 there were disconcerting reports that ECT was being given 'unmodified' (i.e., without anaesthetic or muscle relaxant) at Broadmoor Hospital (Roper, 1979),<sup>19</sup> despite previous College recommendations (Royal College of Psychiatrists, 1977), and reiteration in the College Minutes that this should only happen if medically indicated or it may 'not be clinically advisable to wait for an anaesthetist (... a contingency unlikely to arise in the United Kingdom)'.<sup>20</sup> Tensions with MIND are hinted at, reference being made, for example, to a letter in *The Times* by Tony Smythe which may have 'made misleading statements about the College and ECT'<sup>21</sup> (Revill, 1980). When the medical advisor to MIND, Dr Anthony Clare, was asked to state his views at College Council, they were far less radical than had been anticipated.<sup>22</sup> But the College still proceeded with caution: their new paper on 'Medico-legal aspects of ECT' was not to be issued without consulting their lawyers.<sup>23</sup>

In summary, the College's first publication reviewing the Mental Health Act 1959 was published in 1974 (Royal College of Psychiatrists, 1974), MIND's report in 1975 (Gostin, 1975), and the DHSS produced a consultative document on the same subject in 1976 (Jones, 1993: 203). The field of consent to treatment and ECT remained an emotionally charged medico-legal debate.

### **The Mental Health (Amendment) Bill**

Consent to treatment was undoubtedly the most controversial legislative issue in the proposed Bill. The College took the stance of protecting professional standards and medical autonomy, but questioned if 'better' patients' rights were synonymous with better, more effective treatment (Hamilton, 1983). MIND was anti-medical profession and libertarian, based on a very strong belief in law as the safeguard of liberties and the legal profession as the guardians of the law (Jones, 1993: 204). MIND, the DHSS and the Royal

College of Psychiatrists held a series of meetings to ‘thrash out a compromise’ on consent issues, and ‘the Government made a sincere and highly professional attempt to reconcile the disparate views of MIND and the College’ (Bingley, 1983). The DHSS committee took the view that the public would not be satisfied with the College’s advisory second opinion proposal, but were concerned about difficulties in obtaining independent second opinions (Fennell, 1996: 176). Gostin’s proposition of a multidisciplinary review body was also discussed, but if *individual* independent second opinions were going to be difficult to obtain, an independent multidisciplinary *team* would be unworkable. Finally, a compromise was accepted of a second opinion with a multidisciplinary component, and the second opinion would be binding. In summary, for detained patients unable to consent, an independent medical second opinion would be obtained through the newly created Mental Health Act Commission, the independent psychiatrist consulting with non-medical health care professionals who knew the patient. The precise details of this process would vary between different forms of treatment, depending, for example, upon the duration of treatment for pharmacotherapy or the perceived degree of irreversibility of other treatments.<sup>24</sup> ECT, for instance, was permitted to be given to detained patients either with their consent or following the second opinion procedure. Thus the assumption in the 1959 Act that the compulsory detention of a psychiatric patient also provided authority for treatment was overturned.

The Bill was published by the Government in 1981 (*Mental Health (Amendment) Bill 1981*) and enacted on 28 October 1982. According to Beedie and Bluglass<sup>25</sup> (1982) in the *British Medical Journal*, psychiatrists viewed the change as cumbersome and unworkable. Jumping on this bandwagon, a subsequent letter in the *BMJ* from Gostin and Davis at MIND joined with their psychiatry colleagues to criticize the Bill. They claimed:

The Bill as currently drafted is a triumph of the Lunacy Laws ... it does not satisfy mental health professionals because of its heavy legalistic quality ... it will not provide patients with any meaningful safeguard ... because professional self-regulation will not be seen to be open, rigorous and dispassionate ... if enacted, these provisions will fail to maintain the confidence of the public. (Gostin and Davis, 1982)

None of the major contenders in the debate appeared to approve of the outcome. What is truly remarkable, however, is that so much of the development of the 1983 Act was achieved by the inspiration of an American lawyer with remarkable skills of political and public persuasion.

### **The Mental Health Act 1983 and subsequent developments**

The 1959 and 1982 Acts were consolidated in the *Mental Health Act 1983*. MIND congratulated itself on this new Act: ‘two-thirds of the new provisions

of the 1983 Act are based on proposals originally made in *A Human Condition* but in respect to consent to treatment 'MIND still has some reservations about this particular part of the new Act' (Bingley, 1983).

The process of change had taken a decade from the establishment in 1972 of the Royal College of Psychiatrists Working Party on the 1959 Act. Consent to treatment had been the most controversial issue – a battle between mental health care professionals, represented largely by the Royal College of Psychiatrists, and MIND defending civil liberties and as an advocate for the mentally ill. Of course others were involved including nursing and social work professional bodies, concerned individuals reporting malpractice, such as at St Augustine's, and the DHSS. Whether public confidence in psychiatric treatment was undermined by the 1983 Act, as predicted by Gostin, would be another study in its own right.

However, almost as important as the legislation itself, was the fact that the relationship between the psychiatric profession and MIND was seriously damaged. For many years, MIND has been viewed by psychiatrists as being anti-psychiatry, rather than negotiating mental health care in the patients' best interests. In Gostin's opinion, the Royal College of Psychiatrists, rather than MIND, has changed to a stance of being 'more on the patients' rights side'.<sup>26</sup> It would be difficult to validate this statement, but taking into account the considerable paternalistic style practised in the 1970s, as already mentioned, (Guirgis, 1977; Sedman, 1977; Spencer, 1977),<sup>27</sup> psychiatric practice itself appears to have changed in the context of a changing social milieu.

In 2006, with further changes in the new Mental Health Bill on the horizon, issues of capacity and consent remain a priority. In particular, a multidisciplinary panel to authorize treatment similar to Gostin's (1975) previously rejected radical proposal, remains under consideration. The current Bill provides for a multidisciplinary Mental Health Tribunal to approve written care plans for all compulsory treatment for detained patients (Department of Health, 2004a: 3) and 'to authorise ECT where a patient lacks capacity' (Department of Health, 2004b: 47). Perhaps Larry Gostin was ahead of his time: in 1975 he really thought that his proposals relating to consent to treatment would work;<sup>28</sup> 30 years later a similar prototype for multidisciplinary consent is still under debate and could even become law.

### **Acknowledgements**

Thanks to Dr Michael Neve, Wellcome Trust Centre for the History of Medicine at UCL, for his discussions on this paper, and to the anonymous reviewer of the paper whom I understand is both a historian and was practising psychiatry in England at the time of the events described. Professor Lawrence Gostin also kindly read the manuscript and offered comments.

## Notes

1. Although by the 1970s psychosurgery was already being used less, mainly because of effective pharmacotherapy.
2. Known as MIND in the 1970s, and as Mind today.
3. This was a summary of work done by John Pippard and Les Ellam, and previously published as *Electroconvulsive Treatment in Great Britain. A Report to the Royal College of Psychiatrists* (London: Gaskell, 1981), quoted in Anon. (1981).
4. Comments from anonymous reviewer of this paper.
5. [www.law.georgetown.edu/curriculum/tab\\_faculty.cfm?Status=Faculty&Detail=258](http://www.law.georgetown.edu/curriculum/tab_faculty.cfm?Status=Faculty&Detail=258) (accessed 22 Jan 06).
6. Comments from anonymous reviewer of this paper.
7. Personal communication (e-mail) from Professor Laurence Gostin, 29 Jan. 2006.
8. Comments from anonymous reviewer of this paper.
9. Gostin (pers. comm.; see Note 7).
10. Gostin (pers. comm.; see Note 7).
11. Gostin (pers. comm.; see Note 7) says that the relationship between MIND and the College ‘was cordial, but we did not have the same vision. We sharply disagreed on matters of patients rights’.
12. Similar, multi-disciplinary Mental Health Review Tribunals, usually relating to requests for discharge from hospital, had been established by the 1959 Act
13. Royal College of Psychiatrists Archives, C 32/72, PPC [Public Policy Committee] 17/72 (July 1972).
14. Royal College of Psychiatrists Archives, C 46/74, PPC 26/74 (July 1974).
15. Royal College of Psychiatrists Archives, C53/75, PPC 77/75. The quote is taken from a computerized summary of Minutes (Oct. 1975).
16. Responsible Medical Officer is the physician in charge of care of a detained patient, defined under the 1959 Act.
17. The currently used term ‘nearest relative’ was not introduced until the 1983 Act.
18. Royal College of Psychiatrists Archives, EFCC [Executive and Finance Committee], 14 Jan. 1977, item 5.
19. Royal College of Psychiatrists Archives, C13/80, 15 Feb. 1980, item 5.
20. Royal College of Psychiatrists Archives, C13/80, 15 Feb. 1980, item 5.
21. Royal College of Psychiatrists Archives, C42/80, EFCC 27/80, 11 July 1980.
22. Royal College of Psychiatrists Archives, C27/80, 21 Mar. 1980.
23. Royal College of Psychiatrists Archives, C28/81, EFCC10/81, 19 Mar. 1981.
24. For further information, see: [www.mind.org.uk/Information/Legal/OGMHA.htm#consent](http://www.mind.org.uk/Information/Legal/OGMHA.htm#consent) (accessed 28 Jan. 2006).
25. Gostin (pers. comm.; see Note 7) notes that Robert Bluglass influenced the legislative debate.
26. Gostin (pers. comm.; see Note 7).
27. Oral history interview with Dr Marissa Silverman, Aug. 2004.
28. Gostin (pers. comm.; see Note 7).

## References

- Anon. (1979) ECT, forty years on. *Lancet*, 314 (27 Oct.), 888–9.
- Anon. (1981) Electroconvulsive treatment in Great Britain 1980. *Lancet*, 318 (21 Nov.), 1160–1.

- Beedie, M. and Bluglass, R. (1982) Consent to psychiatric treatment: practical implications of the Mental Health (Amendment) Bill. *British Medical Journal*, 284, 1613–16.
- Bingley, J. (1983) Foreword. In L. Gostin, *A Practical Guide to Mental Health Law: The Mental Health Act 1983 and Related Legislation* (London: MIND), v–viii.
- Bluglass, R. (1983) *A Guide to the Mental Health Act 1983* (Edinburgh: Churchill Livingstone).
- Butler Committee Report: Report of the Committee on Mentally Abnormal Offenders* (London: HMSO, 1975).
- Department of Health [England & Wales] (2004a) *Improving Mental Health Law – Towards a new Mental Health Act – Summary*. Retrieved (26 Jan. 2006) from: [www.dh.gov.uk/PublicationsAndStatistics](http://www.dh.gov.uk/PublicationsAndStatistics).
- Department of Health [England & Wales] (2004b) *Improving Mental Health – Towards a new Mental Health Act*. Retrieved (26 Jan. 2006) from: [www.dh.gov.uk/PublicationsAndStatistics](http://www.dh.gov.uk/PublicationsAndStatistics).
- Dyer, C. (2006) Mental Health Bill for England and Wales may be postponed. *British Medical Journal*, 332, 444.
- Fennell, P. (1996) *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* (London and New York: Routledge).
- Gostin, L. (1975) *A Human Condition. The Mental Health Act from 1959 to 1975: Observations, Analysis and Proposals for Reform*. Vol. 1 (London: MIND).
- Gostin, L. (1983) *A Practical Guide to Mental Health Law: The Mental Health Act 1983 and Related Legislation* (London: MIND).
- Gostin, L. and Davis, D. R. (1982) Consent to psychiatric treatment. *British Medical Journal*, 284, 1945.
- Guirgis, W. R. (1977) [Letter]. *British Journal of Psychiatry*, 131, 646.
- Hamilton, J. (1983) Observations on the Mental Health Act 1983. *International Journal of Law and Psychiatry*, 6, 371–80.
- Hansard* (1973) HC Debs. Ser 5. 849 (23 Jan.), 77; quoted in Fennell, 1996: 171.
- Human Rights Act 1998*. Retrieved (16 Mar. 2006) from: [www.opsi.gov.uk/acts/acts1998/19980042.htm](http://www.opsi.gov.uk/acts/acts1998/19980042.htm).
- Jones, K. (1991) Law and mental health: sticks or carrots. In G. Berrios and H. Freeman (eds), *150 years of British Psychiatry 1841–1991* (London: Gaskell), 89–102.
- Jones, K. (1993) *Asylums and After: A Revised History of the Mental Health Services from the Early 18th Century to the 1900s* (New Jersey: Athlone Press).
- Krouner, L. (1973) Shock therapy and psychiatric malpractice. *Forensic Science*, 2, 397–439.
- Law-Min, R. and Stephens, J. P. (2006) Capacity, compliance and electroconvulsive therapy (ECT): the practice of ECT among consultant psychiatrists. *Psychiatric Bulletin*, 30, 13–15.
- Lepping, P. (2003) Consent in psychiatry – an ethical review. *Psychiatric Bulletin*, 27, 285–9.
- Medical Defence Union (1971) *Consent to Treatment* (London: MDU).
- Mental Health Act 1959: 7 and 8 Eliz. 2., Ch 72*. (London: HMSO).
- Mental Health Act 1983* (reprinted Norwich: The Stationery Office, 2000); reproduced under the terms of Crown Copyright Policy Guidance issued by HMSO.
- Mental Health (Amendment) Bill 1981* (London: HMSO).
- Morrissey, J. P., Burton, N. M. and Steadman, H. J. (1979) Developing an empirical base for psycho-legal policy analyses of ECT: a New York State survey. *International Journal of Law and Psychiatry*, 2, 99–111.

- Nuremberg Code* (1949) Retrieved (29 Jan. 2006) from: <http://ohsr.od.nih.gov/guidelines/nuremberg.html>.
- Raymont, V. (2002) 'Not in perfect mind' – the complexity of clinical capacity assessment. *Psychiatric Bulletin*, 26, 201–204.
- Revoll, M. G. (1980) Treatment in mental hospitals. *The Times*, (25 June), p. 15, col. F.
- Robb, B. (1967) *Sans Everything: A Case to Answer* (London: Nelson).
- Roper, J. (1979) Complaints of sadism and brutality on Broadmoor patients. *The Times*, (20 Dec.), p. 5, col. A.
- Royal College of Psychiatrists (1974) Review of the Mental Health Act 1959. In 'News and Notes', supplement to the *British Journal of Psychiatry*, 125, (Oct.), 3–8; (Nov.), 11–14.
- Royal College of Psychiatrists (1977) Memorandum on the use of electroconvulsive therapy. *British Journal of Psychiatry*, 131, 261–70.
- Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1954–57): Report* (London: HMSO, 1957).
- Salzman, C. (1977) ECT and ethical practice. *American Journal of Psychiatry*, 134, 1006–9.
- Scull, A. (1993) *The Most Solitary of Afflictions: Madness and Society in Britain 1700–1900* (Newhaven and London: Yale University Press).
- Sedgewick, P. (1982) *Psychopolitics* (London: Pluto Press).
- Sedman, G. (1977) [Letter]. *British Journal of Psychiatry*, 131, 647.
- Shorter, E. (1997) *A History of Psychiatry from the Era of the Asylum to the Age of Prozac* (New York: John Wiley and Sons).
- South East Thames Regional Health Authority (1976) Report of the Inquiry on St Augustine's Hospital (unpublished typescript, consulted at the British Library, London).
- Spencer, S. (1977) [Letter]. *British Journal of Psychiatry*, 131, 645.
- Universal Declaration of Human Rights* (1948). Retrieved (5 Dec. 2005) from: [www.amnesty.org.uk/udhr.shtml](http://www.amnesty.org.uk/udhr.shtml).