

PART I

THE STRUCTURE OF THE MENTAL HEALTH SERVICES

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THE HISTORY OF THE UNITED STATES OF AMERICA

The history of the United States of America is a story of growth and expansion. It begins with the first European settlers in the early 17th century, who established colonies along the eastern coast. Over time, these colonies grew into a powerful nation, facing numerous challenges and triumphs. The American Revolution (1775-1783) was a pivotal moment, leading to the birth of the United States as an independent nation. The subsequent years saw the westward expansion of the country, the Civil War (1861-1865), and the rise of the industrial revolution. The 20th century brought significant social and political changes, including the Civil Rights Movement and the Vietnam War. Today, the United States remains a global superpower, facing new challenges in the 21st century.

Chapter 1

AN HISTORICAL REVIEW OF MENTAL HEALTH LEGISLATION

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A. EARLY HISTORY

1.01 Introduction

The early history of the law relating to mental disorder in England and Wales can be examined according to the different means by which the insane were confined: the poor laws, the vagrancy laws, the criminal laws and the laws regulating private madhouses and subscription hospitals such as Bethlem. This chapter is not intended to be comprehensive but is included to give a perspective into how contemporary mental health legislation has developed.¹

1.02 The Poor Insane

1.02.1 *The Pauper Lunatic*

The Poor Relief Act 1601 (43 Eliz. c. 2) provided for the naming of unpaid churchwardens and others to be overseers of the

¹ For a more detailed account of the legal and social history see K. Jones (1972) *A History of the Mental Health Services*, Routledge and Kegan Paul, London; C. Unsworth (1983) *Origins of the Mental Health Act 1959*, unpublished, D. Phil. Thesis, Wolfson College, Oxford; A. Scull (1979) *Museums of Madness*, Allen Lane, London.

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poor. The poor, including the lunatic pauper, were the responsibility of the overseer who was empowered to levy rates and arrears in each parish for the relief of its own paupers. The Act authorised justices of the peace to commit persons refusing to work to houses of correction or gaol. Overseers could also arrange for the impotent poor to be placed in workhouses. The mentally disordered were among the people housed in these institutions which carried with them the idea of correction and punishment. The number of lunatics and idiots in workhouses in 1828 was estimated at 9,000.¹

After the passage of the Poor Law Amendment Act 1834, the parish poorhouse was gradually superseded. Section 45 of that Act proscribed the detention of any dangerous lunatic, insane person or idiot in any workhouse for more than fourteen days. This resulted in the admission of the dangerous lunatic to the county asylum with the workhouses retaining the non-dangerous pauper lunatic. Nonetheless, the Poor Law Commissioners considered "as a rule, that the workhouse is not the proper place for lunatic paupers. . . . The detention of any curable lunatic in a workhouse is highly objectionable on the score both of humanity and economy".²

1.02.2 Vagrancy: *The Dangerous Lunatic*

Pauperism was genuine poverty with the pauper respectably applying for relief in his own parish; the pauper who wandered abroad begging was classed as a vagrant, and any beggar who was found other than in his place of settlement was treated with severity. Lunatics first joined the class of vagrants and nomads in the Vagrancy Act 1713 (12 Anne c. 23). That Act provided for lunatics' detention, restraint and maintenance, but not for their treatment. The importance of the Vagrancy Act 1744 (17 Geo. 11 c. 5) rests on the fact that it added the words "and curing". "Persons, who by lunacy, or otherwise, are furiously mad, or are so far disordered in their senses that they may be dangerous to be permitted to go abroad", could be apprehended and detained as dangerous lunatics. By section 20, two or more justices of the peace were authorised by warrant to direct the constables, churchwardens and overseers of the poor of the parish to apprehend them and keep them "safely locked in some secure place . . . [and if necessary] to be there chained . . . for and during such time only as such lunacy or madness shall continue".

¹ K. Jones, *ibid.*, pp. 18, 124; D. H. Tuke (1882) *Chapters in the History of the Insane in the British Isles*, Kegan Paul, London, p. 173.

² Quoted in K. Jones, *ibid.*, pp. 125, 130.

1.03 Criminal Insanity

1.03.1 *Criminal Lunacy: An Overview*

The term "criminal lunatic" included persons who, under the Criminal Lunatics Act 1800 (39 and 40 Geo. 111 c. 94), were acquitted by reason of insanity or found insane on arraignment; the former resulted from insanity at the time of the offence which negated criminal responsibility, while the latter resulted from insanity at the time of the trial which prevented an understanding of the proceedings. The Insane Prisoners Act 1840 (3 and 4 Vict. c. 54) provided for the third category of criminal lunatic—*i.e.* those transferred by warrant of the Home Secretary from prison to the asylum. This applied not only to those serving sentences of imprisonment but to those awaiting trial. In 1938 the Home Office decided to replace the term "criminal lunatic" with "Broadmoor patient"; the Criminal Justice Act 1948 amended the earlier statutes accordingly. The Mental Health Act 1959 did not use any specific term to refer to mentally disordered offenders as a class.¹

1.03.2 *Acquittal By Reason of Insanity*

There is authority of some weight from the time of Lord Coke for considering that it was contrary to the common law to execute an insane criminal.² Generally if a person was obviously insane he would be sent to a gaol or bridewell, thus evading the gallows or plantations which awaited many of those who were not so disordered. Statutory provision recognising exemption from criminal responsibility was first made in the Act of 1800, "for the safe custody of insane persons charged with offences". The Act provided for the special verdict of "not guilty by reason of insanity" for those who were insane at the time of the commission of the offence; however it contained no definition of insanity. A return of the special verdict meant that the accused person would be detained in custody during His Majesty's Pleasure. The essence of the special verdict remains today what it was in 1800: it is an acquittal (absolving the person of criminal responsibility) in name alone, because the defendant is made subject to an indefinite period of confinement.³ The House of Lords has made clear that the purpose of the legislation ever since its origin in 1800 is not therapeutic but preventive—*i.e.* "to protect society against recurrence of the dangerous conduct".⁴

¹ The legal history of the mentally disordered offender is well documented and will be dealt with here only in outline. See N. Walker (vol. 1, 1968; and vol. 2 co-authored with S. McCabe, 1973) *Crime and Insanity in England*, University Press, Edinburgh.

² See the *Report of the Committee as to the Existing Law, Practice and Procedure Relating to Criminal Trials in which the Plea of Insanity as a Defence is Raised* (1923; Atkin), Cmnd. 2005, pp. 16–17, 19; *Report of the Royal Commission on Capital Punishment* (1953; Gowers), Cmnd. 8932, para. 278.

³ See Gostin (1981) Justifications for the Insanity Defence in Great Britain and the United States, *Bull. Am. Acad. Psychiat. & Law*, vol. 9, p. 100.

⁴ *R. v. Sullivan* [1983] 2 All E.R. 673, 678, H.L.

The criteria for determining criminal responsibility now rests upon the M’Naghten Rules which were formulated by the judges in 1843 in answer to questions submitted by the House of Lords following the acquittal for murder of Daniel M’Naghten on the grounds of insanity.¹ The M’Naghten Rules have been criticised almost since their inception largely because they are pre-eminently concerned with the ability of the accused person to reason.² (As to the M’Naghten Rules, see para. 13.04 *post.*)

The Trial of Lunatics Act 1883 changed the form of the special verdict to what was referred to as “guilty but insane”. The change was criticised by the Atkin Committee³ in 1923, by the Gowers Commission⁴ in 1953 and by the Criminal Law Revision Committee in 1963. The Criminal Procedure (Insanity) Act 1964 restored the form of the special verdict to “not guilty by reason of insanity”. (As to the contemporary use of the insanity defence, see paras. 13.03–13.05 *post.*)

1.03.3 *Insanity on Arraignment*

The concept that the courts would not try a person who was obviously insane at the time of the trial was also well established in the common law.⁵ The Act of 1800 dealt not only with the insanity defence but also with a person found insane on arraignment by a jury impanelled for the purpose, or—at a later stage of the trial—appeared insane to the jury which was trying him. Like the special verdict, a successful plea of insanity on arraignment required the court to make an order for the accused person to be kept in custody during His Majesty’s Pleasure. The Act also did not define insanity for this purpose. The most authoritative early definition came in the case of *R. v. Pritchard*.⁶ was the accused “of sufficient intellect to comprehend the course of the proceedings in the trial so as to make a proper defence—to know that he might challenge any of [the jury] to whom he may object, and to comprehend the details of the evidence”.

The Criminal Procedure (Insanity) Act 1964 currently provides for a finding of unfitnes to plead and requires a mandatory hospital order

¹ (1843) 10 Cl. and F. 200; 8 E.R. 718.

² *Report of the Royal Commission on Capital Punishment* (1953; Gowers) Cmnd. 8932; *The Report of the Committee on Mentally Abnormal Offenders* (1975; Lord Butler), Cmnd. 6244, paras. 18.5–18.14. But see Devlin (1954) *Criminal Responsibility and Punishment: Functions of Judge and Jury*, *Crim. L. Rev.*, 661, 677–86; Livermore and Meehl (1967) *The Virtues of M’Naghten*, *Minn. L. Rev.* vol. 51, p. 789.

³ *Report of the Committee as to the Existing Law, Practice and Procedure relating to Criminal Trials in which the Plea of Insanity as a Defence is Raised* (1923) Cmnd. 2005, pp. 11–12.

⁴ *Report of the Royal Commission on Capital Punishment* (1953) Cmnd. 8932, para. 459.

⁵ N. Walker (vol. 1, 1968) *Crime and Insanity in England*, University Press, Edinburgh, Chap. 14.

⁶ (1836) 7 Carr. and Payne 303.

with restrictions. As to the current use of the plea of unfitness to stand trial see paras. 14.05–14.13 *post*.

1.04 County Asylums for Paupers and Criminals

The Act of 1800 did not direct where the criminally insane were to be confined, nor had it expressly provided any method of discharge. The Select Committee on the State of Criminal and Pauper Lunatics 1807¹ recommended the construction of county asylums where pauper and criminal lunatics could be treated as insane persons and not primarily as paupers or criminals. This recommendation was implemented in the County Asylums Act in the following year; the asylums subsequently established were the predecessors of the contemporary mental hospital, some of which occupy the original premises. The Special Criminal Lunatic Asylum (Broadmoor) was opened in 1863, and eventually most criminal lunatics were concentrated in Broadmoor.

Justices were authorised and directed under the County Asylums Act 1808 to issue warrants upon application of the overseer for the “conveyance of any lunatic, insane person or dangerous idiot . . . to such asylum, there to be safely kept”. Further, patients were to be admitted as “dangerous to be at large” under the Vagrancy Act 1744 on a warrant from two justices or as criminal lunatics under the 1800 Act. Following amending legislation from 1811–19, the County Asylums Act 1828 (9 Geo. IV c. 40) consolidated the law. In 1845 the construction of county and borough asylums was made mandatory (8 & 9 Vict. c. 126).

1.05 The Non Pauper Insane

1.05.1 *The Private Madhouse*

At this time there were two types of lunacy law. The first related to the county asylum which housed three classes of patient: dangerous lunatics detained under the 1744 Act; criminal lunatics detained during “His Majesty’s Pleasure” under the 1800 Act; and pauper lunatics who were transferred from poorhouses or “houses of industry” by the overseer. The second related to the private madhouse, which came to be known as “licensed houses”. Private madhouses were operated for profit where people of means were detained; occasionally they received pauper lunatics sent by the parish overseer because their presence in the workhouse was disturbing to the other inmates. Private patients were without any form of statutory protection, and it was exceedingly difficult for them to obtain their discharge. Private madhouses often received patients at the instance of their relatives;

¹ Session no. 39, reproduced in the British Parliamentary Papers (1968; vol. 1) *Health: Mental*, University Press, Shannon, Ireland, pp. 3–7.

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since the relative paid for the person's reception and care, there was little incentive for the proprietor to discharge the person from confinement.

1.05.2 *The Early Habeas Corpus Cases*

Two early cases of *habeas corpus* were directed against the keepers of private madhouses. In *R. v. Turlington*,¹ Mrs Deborah D'Vebre was confined at the instance of her husband. The court enquired into the truth as to whether she was insane by requiring a previous inspection of her "by proper persons, physicians and relations". An order was made, therefore, for certain persons to have free access to her. The doctor found her to be "very sensible and very cool and dispassionate". She was brought before the court and appeared "absolutely free from the least appearance of insanity"; she was permitted to leave with her attorney.

In *R. v. Clarke*² the court would not direct the body of Mrs Anne Hunt to be brought up on *habeas corpus* where it considered her to be actually insane. The court made the decision on an affidavit from an appointed physician that Mrs Hunt was a lunatic; she had in fact been sent to the private madhouse at the recommendation of the same doctor.

These cases suggest that the reach of the courts on a writ of *habeas corpus* in relation to detention on grounds of mental disorder would go to the truth or merits of the case. This cannot be regarded as a true indication of the attitude of contemporary courts for, at the time, there was no specific statutory protection for patients admitted to private madhouses. Yet, the writ of *habeas corpus* was not often employed, such was the secrecy with which the proprietors of private madhouses surrounded their activities; patients' names were changed, they were forbidden to send correspondence or to receive visitors, and the conditions were sometimes such as to contribute to a person's mental disability.³ (As to the modern use of the writ of *habeas corpus*, see para. 17.07 *post*.)

The public interest in the cases of *Turlington* and *Clarke* was considerable and was to lead to the Act for Regulating Private Madhouses 1774 (14 Geo. III c. 49). The 1774 Act was the first statute to provide for a system of licensing by Commissioners elected by the Royal College of Physicians. A keeper who refused to admit the Commissioners forfeited his license, but there was no authority to withdraw a licence on the

¹ (1761) 2 Burr. 1115; *English Reports*, vol. 97, p. 741.

² (1762) 3 Burr. 1383; *English Reports*, vol. 97, p. 875.

³ K. Jones (1972) *A History of the Mental Health Services*, Routledge and Kegan Paul, London, pp. 11, 29-31, 154. See also Gostin (1982) *Human Rights, Judicial Review and the Mentally Disordered Offender*, *Crim. L. Rev.* 779.

grounds of ill-treatment or neglect of patients; Commissioners could only display their reports in the Censor's Room of the Royal College.

1.05.3 *The Metropolitan Commissioners*

The House of Commons Select Committee on the Better Regulations of Madhouses in England 1815¹ was dismayed with the condition of the madhouse: "there are not in the country a set of Beings more immediately requiring the protection of the legislature. . . ." The Select Committee cited the following abuses: overcrowding, shortage of keepers, the "union of patients who are outrageous with those who are quiet and inoffensive", the want of medical assistance, detention of the sane and the insufficiency of certificates for reception into the madhouses.

The Select Committee on Pauper Lunatics and on Lunatic Asylums 1827² reported that the abuses cited by the 1815 Select Committee were still applicable in the licensed houses in the metropolis. The 1827 Select Committee considered that the medical commissioners had proved ineffective and recommended that they be replaced. Under the Madhouse Act 1828 (9 Geo. IV c. 41) all commissioners were to be appointed by the Home Secretary; they were given the power to release any person who was in their estimation improperly confined. The Act also provided for a more detailed form of certification of patients, designed to reduce the possibility of wrongful confinement.

1.05.4 *The Lunatics Act 1845*

The Lunatics Act 1845 (8 & 9 Vict. c. 100) appointed new Commissioners in Lunacy now accountable to the Lord Chancellor. The inspection, licensing and reporting functions of the former Metropolitan Commissioners were continued by the Lunacy Commissioners. However the right of inspection was extended to cover all insane persons in any kind of institution including gaols and workhouses. (Previously only the Poor Law Commissioners had the power to inspect the workhouses.) A more detailed form of certification was devised which increased the safeguards against wrongful detention for both pauper and private patients.

1.06 The Advent of Legalism

1.06.1 *Introduction*

Social historians have sometimes characterised the process of reform of mental health legislation as a pendulum swinging between

¹ Session no. 227, reproduced in the British Parliamentary Papers. (1968, Vol. 1) *Health: Mental*, University Press, Shannon, Ireland, p. 296.

² Session no. 557, reproduced in the British Parliamentary Papers. (1968, Vol. 2) *Health: Mental*, University Press, Shannon, Ireland, pp. 3-9.

two opposing schools of thought—legalism and professional discretion.¹ Neither term is susceptible to neat definition. Traditional “legalism” appears to embody a set of principles whereby the use of compulsion in mental health should be carefully limited by statutory criteria and procedures; often the term is used to signify the importance of a judicial determination of the need for compulsory admission. The medical or social approach to mental health legislation emphasises the need to facilitate access to prevention, care and after-care services, without legal encumbrance or formality; here, greater reliance is placed on diagnosis and the exercise of professional discretion. The Lunacy Act, 1890 was a statute, perhaps more than any other, which was based upon the principle of “legalism”.

1.06.2 *The Lunacy Act 1890*

The Lunacy Act 1890 was seen in conventional social historical assessments as creating legal obstacles to early and effective treatment for mentally disordered people. The procedures for compulsory admission under the Act broadly embodied the principle that, except in cases of short-term emergency detention, the decision to commit to an institution on grounds of mental disorder should involve a lay (judicial) authority operating on the basis of medical recommendations. The orders for commitment, usually by a justice of the peace, were conceived as a judicial, not merely an administrative, safeguard as confirmed in *Hodson v. Pare*². Thus, medical opinion was not to be conclusive and had to be sufficient to convince a lay authority; however, there was evidence that magistrates simply “rubber stamped” medical opinion.³ The 1890 Act reconstituted the Commissioners in Lunacy. The Commissioners were later replaced by the Board of Control appointed under the Mental Deficiency Act 1913 and reorganised under the Mental Treatment Act 1930. The Board had responsibilities in connection with the scrutiny of admission documents, the continuation of orders and the visiting of patients. The Board also had the power to discharge detained patients. (As to the powers of the modern Mental Health Act Commission see paras. 22.02–22.14 *post*.)

1.06.3 *The Mental Treatment Act 1930*

The critical legislative turning point against the legalism of lunacy legislation can be located in the *Report of the Royal Commission*

¹ See Gostin (1983) *The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry*, in P. Bean, ed., *Mental Illness: Changes and Trends*, Wiley, Chichester, pp. 27–54; Gostin (1983) *Contemporary Social Historical Perspectives on Mental Health Reform*, *J. Law & Society*, vol. 10, pp. 47–70.

² [1899] 1 Q.B. 455.

³ *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* (1957; Lord Percy) Cmnd. 169, HMSO, London, paras. 267, 745–47.

on *Lunacy and Mental Disorder*.¹ Its report contained the beginnings of the principles which were to form contemporary mental health legislation: no clear line of demarcation should exist between mental and physical illness; voluntary admission should be introduced into legislation and encouraged in practice; the law should abolish all distinctions between private and pauper patients; care in the community and after-care should be encouraged.

Many of these principles found their way into the Mental Treatment Act 1930, including a specific provision for **voluntary admission** to hospital based upon an application from the person seeking admission or his guardian; **temporary admission** could be arranged for those unable to express themselves as willing or unwilling to enter hospital. The concept of temporary admission was important because it dispensed with the prior safeguard of judicial intervention. The Act also authorised local authorities to make after-care arrangements, and changed to more modern terminology.

1.07 Mental Deficiency Legislation

1.07.1 *The Idiots Act 1886*

Specialised "idiot asylums" were founded by voluntary societies in the latter half of the 19th century and found official recognition (relating to registration, inspection and admission) in the Idiots Act 1886. Most mentally handicapped people, however, were dealt with not by reason of their social disability but on their presumed association with poverty, insanity or delinquency, and only a small percentage were in institutions specifically established to meet their needs. The remainder were in workhouses, lunatic asylums and prisons.² Under the 1886 Act "idiots" and "imbeciles" were separate and distinct from "lunatics". Yet, the 1890 Act overlooked this distinction and defined "lunatic" to include an "idiot or person of unsound mind" (s. 34).

1.07.2 *Segregation of "Defectives" from Society*

In 1908 the Royal Commission on the Care and Control of the Feeble-Minded³ concluded that heredity was an important factor, that "defectives were often highly prolific, and that other social problems, notably delinquency, alcoholism and illegitimacy, were aggravated by the freedom of such people within the community." They recommended segregation to protect them from the worst elements of society and from their own instinctual responses. Remarkably, this was seen as a

¹ (1926; MacMillan) Cmd. 2700, HMSO, London.

² See generally the *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* (1957; Lord Percy) Cmnd. 169 HMSO, London, chap. 3 and paras. 207-13, 227-29; Gostin (1982) *Mental Handicap Policy in Great Britain*, *Mental Handicap* vol. 10, p. 39.

³ Cd. 4202, HMSO, London.

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liberal proposal because it rejected "genetic purification", an idea being put forward by the influential Eugenics Society.

The Mental Deficiency Act 1913 was concerned to extend special legislation to the more mildly handicapped under the heading of "feeble-minded" and to make provision for "moral defectives". New compulsory provisions were directed to the need for more permanent institutionalisation or supervision of repetitive petty offenders and women who were repeatedly admitted to maternity wards of workhouses; these people were classified as "mental defectives" but were of the higher grades. The 1913 Act sought to reach previously "non-certifiable" cases and therefore to shift the "mental defective" population from prisons, workhouses and asylums to special mental deficiency institutions where more vigorous social segregation could have eugenic effects.

1.07.3 *Legal machinery for care and detention of "Mental Defectives"*

The Mental Deficiency Act 1913 provided a structure for the protection of "mental defectives" by introducing statutory guardianship and licence from the institution. The parent or guardian of an idiot or imbecile of any age could place the patient in an institution or under guardianship; two medical certificates were required but no judicial order. The Lunacy Act 1890 and the Mental Deficiency Act 1913 provided between them comprehensive legal and administrative machinery for the care and detention of mental defectives.

1.07.4 *Transfer of responsibility for supervision and protection of "defectives" from local authorities to the health service*

The Mental Deficiency Act 1913 placed on local government responsibility for the supervision and protection of defectives, both in institutions and in the community; however local authorities had no statutory responsibility to provide occupation and training. This new responsibility was added by the Mental Deficiency Act 1927. The National Health Service Act 1946 removed mental deficiency institutions from the responsibility of local government. There was no formal recognition in the Act that the institutions had performed both medical and social welfare functions and responsibility for them was not apportioned. All became "hospitals" under the auspices of regional hospital boards.

1.07.5 *The Medicalisation of Subnormality*

The Percy Commission, and the Mental Health Act 1959, joined mentally ill and mentally handicapped people under the broad definition of mental disorder. Mental subnormality was dealt with, together with mental illness, as a medical condition: compulsory admission would be

based upon medical recommendations, the “patient” would be admitted to “hospital” and responsibility for the “patient’s medical treatment” would be delegated to a “responsible medical officer”.¹ (As to mental impairment under the Mental Health Act 1983, see para. 1.11.2 below).

B. PRINCIPLES OF CONTEMPORARY LEGISLATION

1.08 The Royal Commission Leading to the Mental Health Act 1959

The Lunacy and Mental Treatment Acts 1890–1930, and the Mental Deficiency Acts 1913–1938 were the subject of the *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* (1957) (the Percy Commission)². The principles accepted by that Commission are still fundamental to our understanding of contemporary mental health legislation. The essential principles are described below; the paragraph numbers referred to are those in the Report of the Commission.

1.08.1 *The Assimilation of Psychiatry with General Medicine*

The approach of the Percy Commission was effectively to make access to treatment and care a matter for professional (primarily medical) discretion. Review of medical decision-making was to be limited to a small minority of cases; the system of review was to be *de facto* and exercised by an administrative tribunal with a medical component. The Report was part of a social revolution; for the first time since 1774 there were to be no judicial controls prior to compulsory admission.³

The Percy Commission reaffirmed the principle that mentally disordered and physically ill patients should be treated in the same way (paras. 132–35). Once this principle was accepted several conclusions necessarily followed, which were fundamentally to affect mental health legislation from 1959 to the present day; these principles are outlined in the ensuing paragraphs.

1.08.2 *Care Without Compulsion*

The early history of voluntary admission to hospital without certification is outlined in the Percy Report (paras. 216–29): “so strong

¹ See Gostin (1978) *Mental Handicap: A Case for Exclusion from the Mental Health Act 1959*, *Apex: J. Brit. Inst. Ment. Hand.*, vol. 6, p. 28.

² Cmnd. 169, HMSO, London.

³ There was, however, an earlier tradition of certification of **non-pauper** patients without judicial oversight. The Lunatics Act 1845 provided for the detention of private patients without a judicial order. See paras. 1.05.1 and 1.05.2 above.

was the feeling [under the Lunacy Laws] that certification and detention was the proper course for people who were actually “insane”, and so strong the fear of improper admission . . . that precautions were taken to ensure that no one was admitted as a voluntary boarder unless he was rational enough to take personal responsibility for his own admission” (at para. 216). The 1926 Royal Commission recommended that voluntary admission should be restricted to patients with “true volition”; voluntary admission under the 1930 Act required an application indicating consent of the patient or his guardian. (See para. **1.06.3** above) The Percy Commission recommended that, wherever possible, admission to hospital of a mentally disordered person should be on the same basis as admission of a physically ill person to a general hospital—*i.e.* on an informal basis, without the need for a valid consent to admission or the necessity of a declaration of intention to leave (paras. 6, 7, 21–23). See further para. **10.01 post**.

1.08.3 *Equivalence in Status*

One of the governing principles of the Percy Commission’s report was that the position of informal patients should be equivalent in all respects to that of non-psychiatric patients (para. 292 *et. seq.*). Admission to hospital on an informal basis, whether for physical illness or mental disorder, should not result in the diminution of a patient’s civil rights or status. The Commission also recommended that there should be no distinctions in status based upon whether a mentally disordered person was admitted informally or through compulsory powers. Within hospital all patients should be treated and classified according to medical, not legal, considerations. “The patients are simply patients suffering from various forms of mental disorder” (paras. 384–6).

1.08.4 *No “Designation” of Hospitals*

The old county asylum hospitals were put under the administration of Regional Hospital Boards established under the National Health Service Act 1946. These hospitals, however, were distinguished from other hospitals by being “designated” as “mental hospitals” or “mental deficiency institutions” for the purposes, respectively, of the Lunacy Laws or Mental Deficiency Acts (para. 14). The Percy Commission recommended that there should be no designation of hospitals (paras. 14, 18, 142–5, 291, 378–80). Hospitals should be governed by general health legislation, and become fully a part of the NHS. There would be no rigid legal barrier against admission of a patient to any hospital which could provide suitable treatment for him. (See further para. **3.02 post**)

1.08.5 *The Mental Health Act 1959*

All the principles set out above were incorporated in the Mental Health Act 1959, and have been retained in subsequent legislation.

1.09 The Process of Reform of the 1959 Act

The Mental Health Act 1959, often heralded as a major example of enlightened social welfare legislation, was widely influential in North America, Europe and the Commonwealth. The clear trend it introduced was towards informality and medical discretion, and away from judically ordered civil commitment. Only a few voices were raised, notably by Barbara Wootton and Cyril Greenland,¹ as to whether the Act placed too great a discretion with the medical profession and whether the safeguards were sufficient.

1.09.1 *Public Enquiries*

The impetus for reform of the Act came partly from public enquiries, particularly the St. Augustine's Report,² which not only criticised conditions but also the use of unlawful restraint and treatment without consent. The general findings of the enquiries were supported by research which indicated that safeguards were not always working well—for example, there was excessive use, and regional variations, in respect of emergency admissions³ and police powers;⁴ applications and medical recommendations were sometimes completed inaccurately;⁵ tribunal procedures were not providing a sufficiently strong safeguard against unlawful detention.⁶

1.09.2 *Proposals for reform*

In 1975 the Report of the Butler Committee on Mentally Abnormal Offenders⁷ and the MIND Report *A Human Condition*⁸ were both published. These publications essentially set out the framework for the debate which was to follow.

¹ C. Greenland (1970) *Mental Illness and Civil Liberty*, Bell, London.

² *Report of a Committee of Enquiry, St. Augustine's Hospital* (1976), S.E. Thames R.H.A.

³ See, e.g., Barton and Haider (1965) Misuse of Section 29, *The Lancet*, i, 912; Enoch and Barker (1965) Why is Section 29 Misused? *The Lancet*, i, 760; Gostin (1975; vol. 1) *A Human Condition*, MIND, London, pp. 28–31.

⁴ Gostin, *ibid.*, pp. 31–33. There were Parliamentary debates on this issue but the 1982 Act made no change, *H. C. Debs.* (Oct. 18, 1982) vol. 29, cols. 90–103.

⁵ P. Bean (1980) *Compulsory Admissions to Mental Hospitals*, Wiley, Chichester.

⁶ Peay (1981) Mental Health Review Tribunals—Just or Efficacious Safeguards? *Law & Hum. Behav.* Vol. 5, pp. 161–186; Fennell (1977) The Mental Health Review Tribunal, *Brit. J. Law & Soc.* 186–219; Gostin, *op. cit.*, chaps. 4–7.

⁷ Cmnd. 6244, HMSO, London.

⁸ See also L. Gostin (April 29, 1982) *H. C. Debs.*, Special Standing Committee 4th Sitting, cols. 143–65.

The early work on patients' rights was begun by David Ennals who, as Campaign Director in 1972, changed the name of the National Association for Mental Health to MIND. Mr Ennals was to become the Secretary of State for Social Services responsible for a Consultative Document in 1976¹ and a White Paper in 1978² on the 1959 Act. Tony Smythe came from the National Council of Civil Liberties to MIND as Director in 1974.

Following the publication of the 1976 Consultative Document two more contributions to the debate came in the form of the second volume of *A Human Condition*³ and the British Association of Social Workers' document *Mental Health Crisis Services—A New Philosophy*.⁴ In 1978 a consultative paper was published on Mental Health Review Tribunal procedures.⁵ The House of Commons debated the White Paper proposals in 1979,⁶ but before the Labour government could introduce amending legislation it was defeated in the General Election of that year.⁷

1.10 The European Convention of Human Rights

In 1974/75 a series of cases was brought by MIND before the European Commission of Human Rights; the lead case became *X v. the United Kingdom*⁸ The European Commission of Human Rights found that, because restricted patients did not have access to a binding judicial review, the U.K. was in violation of Article 5(4) of the Convention; the Commission's decision was upheld by the European Court.⁹ A government amendment to the Mental Health (Amendment) Bill complied with the Court's judgment.¹⁰

A second generation of cases was brought to the Commission by MIND in 1977/78. These cases were pending before the Commission

¹ DHSS (1976) *A Review of the Mental Health Act 1959*.

² DHSS *et al.* (1978) *Review of the Mental Health Act 1959*, Cmnd. 7320, HMSO, London.

³ (1977) MIND, London.

⁴ (1977; Chairman: Olsen) BASW, Birmingham.

⁵ DHSS, Lord Chancellor *et al.* (1978) *The Procedures of the Mental Health Review Tribunals: A Discussion Paper by the Committee on Mental Health Review Tribunal Procedures*.

⁶ *H. C. Debs.*, Feb. 22, 1979.

⁷ For a review of the debate up to the general election see Symposium: The British Government White Paper on the Mental Health Act 1959, *Int'l J. L. & Psychiat.*, vol. 2, pp. 127-214.

⁸ Report adopted on July 16, 1980.

⁹ Judgment given Nov. 5, 1981. See further Gostin, (1982) Human Rights, Judicial Review and the Mentally Disordered Offender, *Crim. L. Review*, p. 779 and para. 15.11 *post*.

¹⁰ Lord Belstead, Under-Secretary of State Home Office (Jan. 25, 1982) *H. L. Debs.*, vol. 426, cols. 759-64; Lord Elton, Under-Secretary of State DHSS (Feb. 1, 1982) *H. L. Debs.*, vol. 426, cols. 1175-78.

during the Parliamentary debates and most probably prompted reforms easing the impediment on access of patients to the courts;¹ extension of public funding for representation before tribunals;² and changes in the Mental Health Review Tribunal Rules,³ particularly in relation to the speeding up of proceedings.⁴ Lord Renton inaccurately predicted the outcome of some of these cases but his sentiments reflect the tenor of the debates: It looks as though these cases will be as successful as *X v. the United Kingdom*. "We do not want this kind of proceeding to go on indefinitely—we come out of it badly every time—and it is so obvious on this occasion that we could save ourselves trouble and, indeed, some degree of ignominy."⁵

1.11 The Mental Health (Amendment) Act 1982

In November 1981 the Conservative government introduced the Mental Health (Amendment) Bill, and published an explanatory White Paper.⁶ The Bill began in the House of Lords in order to save Parliamentary time. The fact that the Bill was not party-political resulted in it being dealt with when it came to the House of Commons by the unusual means of a Special Standing Committee, which took written and oral evidence from relevant government departments and voluntary and professional organisations.

The principles of the Percy Commission (see para. 1.08 above) were not challenged in the Mental Health (Amendment) Act 1982.⁷ The Act was almost exclusively concerned with compulsorily detained patients. Only some 10% of patients are admitted compulsorily but the Under-Secretary of State said the Bill should not be judged solely upon the number of people it affects: "It touches upon principles of profound

¹ *Ashingdane v. the United Kingdom*, Report of the Commission adopted on 12 May 1983. *Kynaston v. the United Kingdom*, app. no. 9480/81. See *H. L. Debs.* (Jan. 25, 1982) vol. 426, cols. 801–07; *H. L. Debs.* (Feb. 1, 1982) vol. 426, cols. 1124–28; Lord Wallace (Opposition spokesman) (Feb. 23, 1982) *H. L. Debs.*, vol. 427, col. 918 ("the Government, in their role as avid pupil awaiting instruction from the headmaster in Strasbourg"). For amendment designed to rectify injustices in Strasbourg cases, see *H. C. Debs.* (June 24, 1982) Special Standing Committee 19th Sitting, col. 722. As to s. 139 of the 1983 Act see paras. 21.25–21.33 *post*.

² *Collins v. the United Kingdom*, app. no. 9729/82 (withdrawn due to change in the law). See Lord Hoosen (Feb. 23, 1982) *H. L. Debs.*, vol. 427, col. 891. See further para. 18.21 *post*.

³ See S.I. 1983 No. 942, r. 13 (speedy and just determinations).

⁴ *Barclay-Maguire v. United Kingdom*, app. no. 9117/80. Decision as to admissibility, Dec. 9, 1981. see further para. 18.23.1 *post*.

⁵ *H. L. Debs.*, (Jan. 25, 1982), vol. 426, col. 806.

⁶ DHSS et. al. (1981) *Reform of Mental Health Legislation*, Cmnd. 8405, HMSO, London.

⁷ See Lord Elton (introducing the Bill) (Dec. 1, 1981) *H. L. Debs.*, vol. 425, col. 933 ("I doubt whether anyone would challenge those [the Percy Commission's] principles today"); N. Fowler (introducing the Bill) (March 22, 1982) *H. C. Debs.*, vol. 20, col. 688 ("The Bill does not seek in any way to overturn the principles of the 1959 Act").

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importance affecting the liberties and rights of those of our fellow citizens who are, perhaps, least able to look out for themselves".¹

The 1982 Act will be seen as a moderate swing back towards a more legal approach to mental health.² Its three primary areas of change may be characterised as: providing a right to services, setting limits on the exercise of compulsory powers, and maintaining the civil and social status of patients.

1.11.1 *The Right to Services*

The Parliamentary debates showed a consistent concern about the quality and availability of mental health services;³ community services are important because they can either prevent the need for compulsory hospital care or can shorten its duration. Section 51 of the Amendment Act (now s. 117) lays a duty on authorities to provide after-care services for certain detained patients. (See further para. 4.08 *post*). The after-care amendment was carried without government support,⁴ ostensibly because the duty to provide after-care services already existed.⁵

1.11.2 *Setting Limits on the Exercise of Compulsory Powers*

Undoubtedly the major trend set in the Amendment Act is towards more precise definitions, criteria and procedures, and more frequent opportunities for review, in respect of the use of compulsory powers of detention and treatment. The major reforms were:

(i) *Mental impairment*—The term mental impairment replaced "subnormality". The principal result is that mentally impaired people cannot be compulsorily admitted to hospital for treatment or under a hospital order unless their condition is "associated with abnormally aggressive or seriously irresponsible conduct". (See further para. 9.03 *post*). This reform was not in the Bill as orig-

¹ Lord Elton, *ibid.*, at col. 934.

² See Lord Elton (March 4, 1982) *H. L. Debs.*, vol. 427, col. 1434 (The Bill provides "... a clear legal framework which gives detained patients more rights than they have ever had before in this country"). See also para. 1.06.1 above.

³ See, e.g., G. Dunwoody (Opposition spokesman) (March 22, 1982) *H. C. Debs.*, vol. 20, cols. 696-700; T. Davis (Opposition spokesman in Committee) (June 24, 1982) *H. C. Debs.*, Special Standing Committee 20th Sitting, cols. 752-57.

⁴ Baroness Masham of Ilton (March 4, 1982) *H. L. Debs.*, vol. 427, cols. 1401-03, 1416-17.

⁵ Lord Elton (Feb. 23, 1982) *H. L. Debs.*, vol. 427, cols. 913-15; Lord Elton (March 4, 1982) *H. L. Debs.*, vol. 427, col. 1413 ("... this is a House of Revision; it should not issue bad law to another place"). The duty probably already did exist. See paras. 4.06-4.07 *post*. However, the purpose of the Masham amendment was to give local authorities "a very clear instruction from Parliament" expressly within the primary mental health statute. Lord Redcliffe-Maud (March 4, 1982) *H. L. Debs.*, vol. 427, col. 1406.

inally published;¹ it was due to the expressions of concern of professionals and voluntary organisations, notably Royal Mencap, that mental handicap should not be included in the Act alongside mental illness.²

(ii) *Treatability*—The Percy Commission (para. 356) considered that there was insufficient justification for special compulsory powers in relation to adult psychopaths except where their conduct constitutes a criminal offence. The 1959 Act implemented this proposal except it sub-divided the Commission's definition of psychopathic disorder into two forms of disorder: subnormality and psychopathic disorder. The 1959 Act created age limits for the admission of patients classified as suffering from either of these two "minor" disorders; such persons could not be compulsorily admitted for treatment after reaching the age of 21 or, once admitted, could not be detained beyond the age of 25. The 1982 Act abolished the age limits and substituted a "treatability" criterion. Thus, a patient classified as suffering from psychopathic disorder or mental impairment cannot be admitted to hospital unless "treatment is likely to alleviate or prevent a deterioration of his condition". (See further para. 11.06.1 *post*).

(iii) *Mental Health Review Tribunals*—Patients admitted for observation (now assessment) are permitted to apply to tribunals for the first time; the periods of detention for admission for treatment or a hospital order are reduced by half, giving patients more frequent opportunity to apply to tribunals; and there are automatic references to tribunals for those who do not apply within certain periods of time. The latter reform was due to observations by MIND that the majority of eligible patients did not apply to tribunals, in part, because they were too withdrawn or did not have sufficient knowledge of their rights. A provision to inform detained patients of their rights was added during the Report Stage of the House of Lords.³ The government twice defeated amendments to provide public funding for representation before tribunals, but only by narrow margins.⁴ A case brought by MIND was pending before the European Commission of Human Rights (see para. 1.10 above) and there was other outside pressure

¹ The reform was introduced at Committee stage by Lord Elton (Jan. 19, 1982) *H. L. Debs.*, vol. 426, cols. 531–33.

² See Lord Renton (Dec. 1, 1981) *H. L. Debs.*, vols. 425, cols. 970–73. See also para. 1.07.5 above.

³ Lord Elton (Feb. 23, 1982) *H. L. Debs.*, vol. 427, cols. 847–48. See Lord Wallace (Jan. 19, 1982) *H. L. Debs.*, vol. 426, col. 543 ("There is no point whatever in an individual enjoying particular rights unless he knows how and through whom they can be exercised"). See further para. 6.07 *post*.

⁴ Lord Elton (Jan. 25, 1982) *H. L. Debs.*, vol. 426, cols. 790–92; Lord Elton (Feb. 23, 1982) *H. L. Debs.*, vol. 427, cols. 894–95. (Government defeated amendment at Committee stage by 82 votes to 77 and at Report stage by 60 votes to 58.)

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on the government.¹ The Lord Chancellor subsequently brought forward the necessary regulations under the Legal Aid Act 1974 (s. 2A(3)).² (See further para. 18.21 *post.*)

(iv) *Clarification on Consent to Treatment*—The imposition of treatment without consent, said Lord Hoosen in the Parliamentary debates, is “the most delicate situation known in a civilised world”.³ The 1982 Act was the first legislative provision in England and Wales which specifically empowered doctors, in certain situations, to treat patients without consent. This provision, more than any other, divided those who advised successive governments—notably MIND⁴ and the Royal College of Psychiatrists⁵—and those who participated in the Parliamentary debates.⁶ The central disagreements concerned, firstly, whether it is right to withdraw the well-established common law right of a **competent** patient to consent to treatment;⁷ second, whether the review of the decision to impose treatment without consent would be only medical or multidisciplinary.⁸ A compromise was reached whereby a multidisciplinary decision would be taken to certify the patient’s consent for the most serious treatments (*e.g.* psychosurgery), and a medical decision (subject to prior multi-disciplinary consultation) would be taken to certify the patient’s consent for other specified treatments (*i.e.* medication given for 3 months or more or ECT). (See further paras. 20.17–20.28 *post.*) The basic principles relating to consent to treatment adopted by successive governments varied considerably from the 1976 Consultative Document and throughout the Parliamentary process. Two significant changes—periodic reviews of treatment,⁹ and inclusion of informal patients within the safeguards relating to the most serious treatments¹⁰—were adopted as late as Third Reading in the House of Commons.

¹ See, *e.g.*, *Thirteenth Annual Reports of the Law Society and of the Lord Chancellor’s Advisory Committee* (1981), paras. 55–56.

² See Memorandum on Behalf of the Lord Chancellor (April 22, 1982) *H. C. Debs.*, Special Standing Committee, 2nd sitting, cols. 3–5.

³ (Jan. 25, 1982) *H. L. Debs.*, vol. 426, col. 826.

⁴ See Gostin (1981) Observations on Consent to Treatment and Review of Clinical Judgment in Psychiatry: A Discussion Paper, *J. Roy’l Soc. Med.*, vol. 74, p.742; Gostin (April 29, 1982) *H. C. Debs.*, Special Standing Committee, 4th sitting, cols. 143–44, 151–66.

⁵ See K. Rawnsley and R. Bluglass (April 27, 1982) *H. C. Debs.*, Special Standing Committee, 3rd sitting, cols. 75–84; Clare (1981) Consent to Treatment, *J. Roy’l Soc. Med.*, vol. 74, p. 787.

⁶ See, *e.g.*, Lord Hoosen (Dec. 1, 1981) *H. L. Debs.*, vol. 425, cols. 992–95.

⁷ See, *e.g.*, M. Thomas (June 29, 1982) *H. C. Debs.*, Special Standing Committee, 22nd sitting, col. 835 (“... psychiatric patients are no less entitled than any other British citizen to say ‘No, thank you’ to medical treatment if they are competent to do so. . .”).

⁸ See, *e.g.*, C. Irving (March 22, 1982) *H. C. Debs.*, col. 712 (“According to English law, issues of competency and consent have always been a judicial or quasi-judicial decision”).

⁹ K. Clarke (Under-Secretary of State) (Oct. 18, 1982) *H. C. Debs.*, vol. 29, col. 56.

¹⁰ T. Davis (Oct. 18, 1982) *H. C. Debs.*, vol. 29, col. 77.

(v) *Mental Health Act Commission*—The Act established a special health authority to oversee the exercise of powers to detain and treat patients under the Act. (See further paras. 22.02–22.14 *post.*) Historically this can be seen as an extension of the principles behind the old Lunacy Commissioners and Board of Control. (See paras. 1.05.3, 1.05.4, 1.06.2 above) It also reflected a deepening of concern with the need to protect detained patients and to investigate their complaints adequately. The idea for a Commission was not accepted by the Labour government;¹ it was proposed by the Boynton Committee² and the Royal College of Psychiatrists.³ A rational explanation for its acceptance by the Conservative government was because it was perhaps the only way in which second opinions for consent to treatment could be given which would have been acceptable to the College.

(vi) *Guardianship*—The guardianship powers under the 1959 Act were seldom used, in part, because guardians were given the virtually unlimited powers of a father over a child under the age of fourteen years. The 1982 Act limited the authority of a guardian so that he can exercise only specified powers, and it prevents the use of guardianship in respect of children under the age of sixteen. (See further paras. 11.07–11.09 *post.*) These changes were made in response to claims that guardianship could often be a less restrictive alternative to hospital care; greater use would be made of the provisions if the powers exercisable by the guardian were realistically more limited.⁴

(vii) *The Home Secretary's Powers*—The Bill, as originally published,⁵ did not take account of the European Court of Human Rights' judgment in *X v. the United Kingdom*. (See para. 1.10 above) A government amendment was subsequently introduced by Lord Belstead to bring the law into conformity with the European Convention,⁶ and the Act now gives restricted patients the right to a binding tribunal review. (See further paras. 15.11, 18.12–18.14 *post.*)

(viii) *The Appointment and Function of Social Workers*—Significant changes were made in respect of the appointment and

¹ DHSS *et al.* (1978) *Review of the Mental Health Act 1959*. Cmnd. 7320, HMSO, London, paras. 6.31–6.35.

² *Report of the Review of Rampton Hospital* (1980), Cmnd. 8073, HMSO, London, para. 4.7.

³ R. Bluglass (July 1981) *Towards a New Mental Health Act: Mental Health Commissions for England and Wales*, *Bull. Roy'l Coll. Psychiatrs.*, pp. 130–32.

⁴ See DHSS *et al.*, (1978) *Review of the Mental Health Act 1959* Cmnd. 7320, HMSO, London, paras. 4.1–4.8; British Association of Social Workers, (1977) *Mental Health Crisis Services—A New Philosophy*, BASW, Birmingham.

⁵ See DHSS *et al.* (1981) *Reform of Mental Health Legislation*, Cmnd. 8405, HMSO, London, para. 52.

⁶ (Jan. 25, 1982) *H. L. Debs.*, vol. 426, cols. 759–64.

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function of Mental Welfare Officers (from October 1984, Approved Social Workers). The background to the reform and the contemporary provisions are discussed at length in Chapter 7.

1.11.3 *Maintaining the civil and social status of patients*

The Amendment Act sought to extend the principle of the Percy Commission that there should be an equivalence in status between physically and mentally disordered patients. Accordingly, it made clear the right of informal patients to refuse treatment (see para. 20.17 *post*), to send and receive correspondence (see para. 24.30 *post*) and to remain in the United Kingdom (see para. 19.01 *post*). These rights are not now affected simply by virtue of the person's admission to hospital on an informal basis. The Act also strengthened the position of informal patients in relation to electoral registration (see para. 24.02 *post*), and amended section 141 of the 1959 Act (now s.139) which can impede a patient's access to a court. (See para. 21.30 *post*.)

(i) *Voting*—Electoral reform for mental patients was already an issue of public concern before the Parliamentary debates on the 1982 Act: in 1973 the second Speakers' Conference on Electoral Reform recommended that informal mental patients should be placed on the same footing as physically ill patients for voting purposes; in 1976 and 1981 two cases were brought by MIND which enfranchised residents in mental illness or mental handicap hospital so long as they could demonstrate that they did not come within the statutory definition of "patient".¹ The issue was raised in the House of Lords without success,² but the Commons Standing Committee voted by a majority of one to adopt the Speakers' recommendation.³ During the summer recess the government came under considerable pressure to reverse the Committee's amendment, particularly by MPs who held marginal constituencies and where there was a sizeable patient population; there was an assumption that enfranchising patients would have a "swamping" effect and would distort election results. The Amendment Act (s. 62(2) and Sch. 2) contained a compromise (introducing an implicit capacity test for patients) which was the subject of debate at Third Reading.⁴

(ii) *Access to the courts*—The cases which at the time were pending before the European Commission of Human Rights (see

¹ *Wild and Others v. Electoral Registration Officer for Warrington and Another*, County Court of Warrington (June 15, 1976); *Smith and Others v. Electoral Registration Officer of the Clitheroe Constituency*, County Court of Blackburn (Sept. 1981). See Gostin (1976) *A Mental Patient's Right to Vote*, *Poly L. Rev.*, 2, 17; and para. 24.02 *post*.

² Lord Kilmarnock (Jan. 25, 1982) *H. L. Debs.*, col. 426, cols. 810–12.

³ M. Thomas (June 22, 1982) *H. C. Debs.*, Special Standing Committee, 18th sitting, cols. 681–700.

⁴ *H. C. Debs.*, (Oct. 18, 1982) vol. 29, cols. 175–97.

para. 1.10 *above*) ensured that section 141 of the 1959 Act was debated at length before the Bill reached Committee Stage in the Commons.¹ A compromise was reached between members of the Standing Committee and the government, and an amendment was agreed to without recourse to any further Parliamentary debate.² The amendment was clearly designed to rectify the injustices apparent in the Strasbourg cases by, *inter alia*, removing from the Secretary of State and health authorities the protection against proceedings afforded by section 141 (now s. 139).

1.12 The Mental Health Act 1983

The law relating to mentally disordered persons was consolidated in the Mental Health Act 1983. Most of the new provisions were implemented on September 30, 1983 (s. 149(2)). However, remands to hospital for report (s. 35) and for treatment (s. 36) and interim hospital orders (ss. 38, 40(3)) did not come into force until the date appointed by s. 149(3) (*i.e.* October 1, 1984). The provisions for approved social workers (ss. 114, 145(1)) came into force on October 28, 1984 (Sch. 5, para. 4).

Sections 8 and 9 (local authority services), section 128 (sexual intercourse with patients) and certain other ancillary provisions of the 1959 Act remain in force.³ Section 34 (amendment of the Bail Act 1976) and other ancillary provisions of the 1982 Act also remain in force (Sch. 6); section. 62 (electoral registration of patients) has been incorporated into the Representation of the People Act 1983. It is eventually intended to incorporate these remaining provisions of the 1959 and 1982 Acts into other legislation.

1.13 The Care Programme Approach and the Mental Health (Patients in the Community) Act 1995

In 1990 the Department of Health in England issued a joint health and social services circular HC(90)23/LASSL(90)11 requiring health and social services authorities to collaborate in introducing a care programme approach in dealing with people with a mental illness. This involves systematic arrangements for assessing the health and social care needs of patients who could be treated in the community, the allocation of a key worker and the institution of regular reviews for patients already in the community, and arrangements to ensure that agreed health and social services are provided in the community. In 1993, following a number of incidents of homicide and self-harm involv-

¹ See, *e.g.* *H. L. Debs.*, (Jan. 25, 1982) vol. 426, cols. 801-810; *H. L. Debs.*, (Feb. 23, 1982) vol. 427, cols. 917-20; *H. L. Debs.*, (Feb. 1, 1982) vol. 426, cols. 1124-29.

² *H. C. Debs.*, Special Standing Committee, 19th sitting (June 24, 1982) col. 1722.

³ As to the interpretation of unrepealed provisions of the 1959 Act see s. 148, Sch. 5, para. 2 of the 1983 Act.

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ing current and former psychiatric in-patients,¹ the Government set up an internal working party to examine the need for further controls over patients in the community, and this recommended a number of measures designed to increase the controls on psychiatric patients in the community.² Guidance on Discharge was issued in 1994 emphasising the need for an agreed care plan and the allocation of a key worker in every case where discharge is a possibility,³ and also purchaser units were required to include in their contracts with providers provision for a supervision register for patients presenting a significant risk to themselves or others.⁴ The Mental Health (Patients in the Community) Act 1995 introduces a new status of "supervised discharge" in relation to non-restricted patients who have been detained under Mental Health Act powers authorising long term detention (See paras 11.13.4-11.13.16 below).

¹ *Report of the Committee of Inquiry into the Care of Christopher Clunis* HMSO 1994; L. Blom Cooper, H. Hally, E. Murphy *The Falling Shadow: One Patient's Mental Health Care* 1995 Duckworth.

² For a general discussion of the background to these measures see P. Fennell, 'Community Care, Community Compulsion and the Law', in Watkins, M. Hervey, N. Carson, J. and Ritter, S. *Collaborative Community Mental Health Care* 1996 Edward Arnold 97-130.

³ HSG(94)27.

⁴ HSG(94)5.