

# *The Origins of the Mental Health Act 1983: Doctors in the House*

ROBERT BLUGLASS (Chairman, PPC Working Party on the Mental Health Act),  
Professor of Forensic Psychiatry, University of Birmingham

The role played by the House of Commons in the legislative process has been steadily changing since the Reform Acts of the nineteenth century. Previously, most of the Commons' legislative work consisted in passing private measures initiated and introduced by individual Members of Parliament concerned with, and knowledgeable about, local issues which required change. The growth of an increasingly vocal and educated mass electorate, the pressures of mass-membership political parties, and the increasing specialization of an industrial society, all increased the need for wider legislation, particularly for public social measures, and its initiation passed from the hands of individual members to the Government. Parliament as a law-making body moved towards a more formal constitutional and legal role. Its twentieth century task is more often the *legitimation* of legislative changes originating elsewhere.

Drewry<sup>1</sup> usefully describes the legislative process as involving four interlocking and overlapping functions: (1) inspiration; (2) deliberation and formulation; (3) legitimation; and (4) application—with capacity for feedback, or learning by experience. Parliament has some involvement in *deliberation* and *formulation*, but is mainly involved in the *legitimation* process.

The inspiration initiating Government legislation may derive from a wide variety of possible sources; special reports or commissions, the pressure of interest groups, the cause of political advantage, national crisis, a decision by the courts and many others. In general, the inspiration is outside the Houses of Parliament themselves, although Select and Standing Committees may make an important contribution.

Involvement in the reform of mental health legislation provided an opportunity to trace the course of one important new statute from its origins to the confirmation of the Royal Assent.

The existing mental health legislation was derived from the initial laws of the eighteenth century, the Vagrancy Acts of 1713 and 1744 which provided for the detention of dangerous individuals and the Madhouses Acts of 1744 which provided for minimum standards of care in privately run houses for the insane.

The County Asylums Act 1808 removed the care of patients from private institutions by authorizing the provision of public asylums, laying the foundations for our present mental health service. During the subsequent 83 years from 1808 to 1891 over 20 further Acts of Parliament were passed dealing with the care of the mentally disordered. There were also four consolidations of the law, the

last being the Lunacy Act 1890. During the next 65 years to 1955 there were a further seven Acts, but no major overhaul or restatement of the law and no further consolidation since 1890. There were, however, two Royal Commissions, and the Acts passed during this period resulted in fundamental changes in attitudes and practice, so that by the mid-fifties 75 per cent of all admissions to mental hospitals were without the formality of certification and psychiatric care became more widely available, paralleling the improvements in treatment methods.

The National Health Service Act 1946, which established the NHS, placed the responsibility for the administration of psychiatric hospitals with the Minister of Health, but still retained many of the restrictions on admission and discharge that had been formulated in the early part of the century.

The status of psychiatry as a developing branch of medicine had been elevated by the progress made during the Second World War and there was a general optimism about the advances that were likely to be made in the near future. The creation of the National Health Service also brought psychiatric hospitals and their staff closer to hospitals providing general medical and surgical services, and this encouraged a change in attitude to regard psychiatric disorder in the same way as physical illness and to remove the isolation and segregation of psychiatric patients and staff.

During a period when the welfare state was evolving, the time was ripe to commence a major investigation into the law and administrative machinery governing the certification, care, treatment and management of mentally ill and mentally defective persons in England and Wales. The Royal Commission on the Law relating to Mental Illness and Mental Deficiency was established in October 1953 by the Minister of Health. It sat under the chairmanship of Lord Percy of Newcastle from 1954–1957, when it published a detailed and wide-ranging report.<sup>2</sup> All the previous legislation built up over many years was to be repealed and the keystone of the new legislation was to be the right of mentally ill patients to be cared for informally, in so far as this is possible. Compulsory procedures would be an adjunct to a voluntary system, rather than the reverse, which characterized the previous legislation. Mental disorder was redefined in modern terms, hospitals were to be desegregated and the circumstances justifying compulsion were reviewed. New procedures for the compulsory detention of patients were recommended which did not involve a legal element, a magistrate or judge, to confirm that detention was justified; as had been the case previously. This 'legalistic' approach

was thought to be appropriate when society was to be protected from the 'lunatic', but now that the primary concern was the welfare and treatment of the individual patient, the decision to detain could safely be left in the hands of doctors, social workers and the hospital managers.

Most of the Percy Commission's recommendations were incorporated in the Mental Health Act 1959<sup>3</sup> which took effect from 1 November 1960. It became widely regarded as an enlightened and liberal piece of legislation which improved the acceptability of psychiatric care and reduced, without entirely eliminating, the stigma attached to it. The legislation was imitated by many other countries and influenced important changes in psychiatric care and practice.

However, the Act was not without its critics. It had, for instance, disbanded the Board of Control, an independent inspectorate which, since 1913, had been responsible for visiting hospitals and overseeing the conditions provided for patients. Following 1959 there were a series of major scandals leading to 14 official inquiries into allegations of ill-treatment or malpractice, and there were numerous minor investigations. There were allegations of misuse of certain sections of the Act and concern about poor facilities, inadequate resources and lack of security. Scotland, which had its own legislation (the Mental Health (Scotland) Act 1960),<sup>4</sup> retained a Scottish Mental Welfare Commission and did not experience similar problems.

Despite the undoubted benefits of the 1959 Act, the growth of the civil rights movement in the 1960s led to a new period of criticism and disenchantment with medical paternalism and what was seen as an excessive reliance on psychiatric judgement. In so far as the mentally disordered are concerned, the reaction against restrictive barriers to psychiatric care and the movement towards the community rather than the institution, began in the United States where the courts were used as a forum for the mentally ill and mentally retarded to obtain recognition of their civil rights. A long series of decisions began with *Rouse v Cameron* in 1966. The District of Columbia Circuit Court of Appeals held that mental patients committed by criminal courts had the right to adequate treatment. In the absence of criminal responsibility, those sent to hospital because they had been found not guilty by reason of insanity were not subject to punishment and incarceration. Confinement in a high security hospital implied a need for therapeutic care and treatment and such confinement without adequate treatment would be tantamount to incarceration, transforming the hospital into a prison. Two years later, in Massachusetts, a similar right to treatment was established for those found unfit to stand trial. Further decisions focused on the mentally retarded establishing rights not to be exploited for cheap labour, a right to a free public educational programme, to special education, the right to privacy, the right to refuse treatment on the basis of religious beliefs, and others. By 1969 there were a series of cases restricting the

involuntary commitment of the mentally disordered, 14 states listing 'dangerousness' as the sole criterion, while 18 others permitted the need for care or treatment in addition. Some provisions were designed only for short-term care, others mandated periodical review. The court decisions led to new legislation in connection with many of these matters. New legislation also established a further range of civil and personal rights, for example, the right to communicate privately outside an institution (via correspondence or telephone), the right to keep personal clothing and effects, to religious freedom, to be (if possible) employed, to manage or dispose of property, to execute statutory instruments such as wills, to enter contractual relationships, to make purchases, to education, to habeas corpus, to independent psychiatric examination, to retain licences, to marry and not to be subject to unnecessary mechanical restraints. There were further rights to legal representation, to confidentiality and to give informed consent to treatment.<sup>5</sup>

In England and Wales, in the early seventies, changing practices in psychiatry and rapidly changing attitudes of society led to a growing realization that the Mental Health Act should be kept under some degree of scrutiny. In July 1972 the Royal College of Psychiatrists established a committee to carry out a detailed review of the Act to consider which parts would benefit from change. Meanwhile, in the United States, the American lawyer, Mr Larry Gostin, who had become closely involved in the revision of mental health legislation in the United States, had decided to study the English and Welsh legislation and had arranged to spend a period of time in this country with Professor Margot Jeffries. Before moving to London he was employed as a research worker with the administrative authorities of the state of North Carolina, which was investigating the care of individuals in mental hospitals and other institutions. It was agreed that he would allow himself to be admitted to hospital as a patient to observe conditions from the inside. He did not, however, know how his admission would occur. In due course he was wrongfully arrested, accused of rape and he was confined in a secure and backward mental hospital for some months. He was given electroconvulsive therapy without consent and experienced a period of intense introspection and reflection on the plight of the mentally ill and the mentally well in such circumstances and their rights. He was in due course released and by the time that he arrived in the United Kingdom he was preoccupied with this subject and determined to work towards changes and improvements. Although the situation in England could not be compared with that in North Carolina, he, nevertheless, identified many areas which seemed to him unjust and outdated. His experiences led to his appointment as Legal Director of the National Association of Mental Health (MIND) and to an evaluation of the present state of the law, the way it was applied and to the identification of individual instances of misuse and possible abuse. Gostin published two reports under the auspices of MIND, entitled *A Human Condition*,

in 1975 and 1977.<sup>6</sup> They suggested that the 1959 Act was over-restrictive, gave patients too few opportunities to appeal against detention and was too heavily controlled by the medical profession.

The Royal College of Psychiatrists completed a detailed review of the Mental Health Act 1959 and its conclusions were published in 1974 in *News and Notes* (supplement to the *British Journal of Psychiatry*)<sup>7</sup>, supporting the general principles upon which the Act was based, reaffirming the view that doctors were in the best position (as a result of their training and experience) to determine the need to commitment and treatment, and asserting the need to establish an independent body to replace the lost Board of Control.

Views were also being formulated from other sources. In 1975 the Labour Government published a White Paper, *Better Services for the Mentally Ill*<sup>8</sup> which discussed a programme of proposed improvements in the mental health services, and in October 1975 the *Report of the Committee on Mentally Abnormal Offenders*<sup>9</sup> (Chairman—Lord Butler of Saffron Walden) included comments and recommendations on the part of the Mental Health Act (Part V) dealing with mentally disordered offenders, with other comments relating to those with personality disorders, said to suffer from psychopathic disorder, and the validity of this legal classification. The British Association of Social Workers, the Chairman of Mental Health Review Tribunals and other bodies also began to express views and the pressure to review mental health legislation in a more formal way began to mount.

In January 1975 the Department of Health and Social Security, under Mr David Ennals, with the Home Office, the Lord Chancellor's Department and the Welsh Office established an inter-departmental committee to consider the suggestions for amending the Act that had been made in recent years by various professional and other bodies and by individuals. This included, in particular, the comprehensive reviews carried out by the Royal College of Psychiatrists and by MIND, as expressed in Gostin's reports. The Act had already been subject to a number of amendments during the preceding years and the new review concentrated on detention in hospital or for guardianship and the sections concerning the protection of staff and patients. The sections relating to the management of property and affairs of patients were to be considered by the Lord Chancellor's Department, electoral registration was to be considered by the Speakers' Conference, and Tribunal Rules by the Lord Chancellor.

The Government published a Green Paper, a consultative document, in 1976 outlining alternative proposals for change about which further views were requested, and indicating their own response to some specific suggestions. The document provided observations, suggestions and reactions rather than specific policies at this stage and left many matters for further discussion. The various bodies and

individuals responded in some 300 published detailed reports, and on 25 October 1976 a day conference was called at the United Services Club under Mr David Ennals' chairmanship to discuss the Green Paper, *A Review of the Mental Health Act 1959* (1976).<sup>10</sup> It was a very large conference attended by every conceivable sectional interest representing all the concerned professions, charities and patient-interest groups. The College team of about six people was led by the President, Professor W. Linford Rees. The conference consisted of short set-piece statements by each representative group, with some response from the Minister, but with little opportunity for discussion in a gathering of between one and two hundred individuals. There was a general feeling of dissatisfaction, but no doubt the Department would feel (and might claim) that it had 'consulted widely'.

There followed from the College, the doctors' point of view, a quiescent and frustrating period where little appeared to be happening, but, in fact, the Department of Health, whose Secretary of State was previously campaign director of the MIND organization, was apparently closetted in lengthy discussions with the representatives of that body who heavily influenced the next stage of progress towards eventual legislation. To this was added the second volume of Larry Gostin's report, *A Human Condition*,<sup>6</sup> which discussed offender patients, and a document from the British Association of Social Workers, *Mental Health Crisis Services—A New Philosophy*. Sex offences against patients were now being considered by the Criminal Law Revision Committee in the context of the review of the Sexual Offences Act 1956, which reported in April 1984.

Eventually, in September 1978, the Labour Government published a White Paper (*Review of the Mental Health Act 1959*)<sup>11</sup> with its proposals for an amending Bill to be put before the House 'as soon as Parliamentary time could be found'. Some proposals again invited comment.

Many of the proposals in the White Paper were predictable as a result of the previous discussions, and the expressed general philosophy behind the proposals was the need to strengthen the rights and safeguard the liberties of the mentally disordered whilst retaining a proper regard for the rights and safety of the general public and staff. The hand of the MIND organization was evident in this document and there were a number of highly controversial suggestions. One referred to a proposal to control consent to treatment by a detained patient by requiring a multidisciplinary panel, involving laymen, to confirm that a treatment that was 'irreversible, hazardous or not yet proven' could be given. The Government rejected the notion of creating an independent Commission as inappropriate to the general approach to psychiatric care.

Again there were detailed responses. The College established a Special Committee to review the White Paper and a report was published.<sup>12</sup> The medical profession was united against the controversial consent to treatment proposals, recommended other changes and again made out the case

for a form of independent monitoring body.

Discussions continued within the profession. The doctors perceived a well orchestrated campaign to limit their professional responsibility and to protect the patient against the tendency for doctors to 'impose their views on unwilling patients'. An army of patient's advocates to be based in hospitals to carry out this task had been proposed, based upon experience of such a system in the United States. In New Jersey, for instance, a large number of lawyers are employed to act in this capacity.

The White Paper was debated in the House of Commons in 1978 when a fairly enthusiastic response was given to the new proposals. Dr Gerard Vaughan, a psychiatrist, led for the Opposition as spokesman on health. However, the intentions of the Government were overtaken by events. An election was called in February 1979 and the Conservatives took office. Soon afterwards they indicated that the new Government intended to introduce new legislation during their period in power.

In 1980 informal discussions began in the Department of Health, now headed by Mr Patrick Jenkin (with Dr Vaughan as Minister of Health). This time the College representatives were invited to discuss the areas exposed in Mr Ennals' White Paper about which they were particularly concerned. The conversations were kept on a low key and were not publicized.

It was clear that the basis for new legislation was now being formulated by the officials of the Department, based partly upon the previous White Paper and supplemented by further discussions and negotiations. As we proceeded we regularly reported back to the officers of the College and received further briefing. At this stage the civil servants were playing a key part in the progress of the legislation.

Important advances were made at these meetings, in particular, we began to formulate a new basis for consent to treatment control based upon a Mental Health Commission as an independent body which could provide independent medical second opinions when defined treatments were proposed for a detained patient who could not give informed consent. An indication that such a formula might prove acceptable to the new Government propelled the College Committee into a new period of hectic activity. An academic lawyer, with a special interest in Mental Health law, was invited to assist us (Mrs Brenda Hoggett, Reader in Law at Manchester University and author of an excellent mental health text). She provided very important guidance in our discussions towards offering the Department a carefully considered set of proposals based upon the original ideas. After eight drafts our recommendations were approved by Council and published.<sup>13</sup> Other details were also explored and debated with the DHSS officials.

During this time further publications on consent came from MIND<sup>14</sup> and others,<sup>15</sup> and it was evident that the discussions occurring within many groups in the United Kingdom were also taking place in other countries. Many of the

States of the USA and Provinces of Canada produced new and often professionally restricting legislation. In the Netherlands it was almost impossible now to give electroconvulsive therapy and in California a patient could not be detained for more than 72 hours without the need to appear before a court.

The Government's Bill was now awaited. The procedure at this time is clouded by a certain amount of ritual secrecy. Before a White Paper or Bill representing Government policy can be published it must be approved by the Cabinet—or by a Cabinet Committee, but officially, Cabinet Committees do not exist; the Government could not otherwise preserve the fiction of collective Cabinet responsibility,<sup>16</sup> but it may be assumed that the proposed legislation, which had been worked out by a group of three civil servants with advice from specialist colleagues over some two years, would now be considered by a Cabinet Committee, perhaps a Committee which is chaired by the Home Secretary and includes Ministers from the Departments of Health and Social Security, Environment, Employment and from Wales and Scotland. The parliamentary draftsmen would have preliminary instructions on the scope and content of a Bill and in this case a White Paper was being prepared.

In the Queen's Speech at the opening of Parliament in November 1981 it was announced that the Government would be introducing amending legislation and on 11 November 1981 a Mental Health (Amendment) Bill was published,<sup>17</sup> together with a White Paper (*Reform of Mental Health Legislation*)<sup>18</sup>, which in this case was an explanatory document. Initial reactions were published in *The Times* two days later by the two main adversaries, MIND and the College. The College convened a Public Policy Committee Working Party on the Amendment Act which began to monitor progress.

The new Bill incorporated much that was not in dispute from the previous Government's White Paper, and also introduced the notion of a Mental Health Act Commission which the College had repeatedly proposed and which had previously been rejected. The Commission would have a variety of inspectorate and protective functions and would be multidisciplinary. The medical members, supplemented by other doctors appointed by the Secretary of State, would provide second opinions when the informed consent of a detained patient to a proposed treatment was in doubt. On the face of it this seemed an important victory, but qualifications and doubts were later to emerge.

We have up to this point, therefore, discussed the *inspiration* behind this legislation and the period of *deliberation* and *formulation*. The next stage is the involvement of Parliament in the legislative process.

Most Government Bills are taken in the House of Commons. Parliament enacts about 100 Acts each session and the majority are initiated in the Lower House. The Mental Health (Amendment) Bill was, however, started in



the House of Lords. There was much pressure for Parliamentary time in the Commons and it was considered that this Bill, which cut across party lines, was largely politically uncontroversial and could be given more time in the Upper House.

The First Reading was simply a formal introduction concerned with the Bill's publication and without debate. The Second Reading was taken on the floor of the House and at this stage was a debate on the principles incorporated in the Bill when interested parties declare their hand.

It was now clear to the College that close attention must be paid to the passage of the Bill in order to attempt to influence or persuade all those concerned and, hopefully, to have the College's views represented in debate. We canvassed a number of Peers, particularly medically qualified Members of the Lords, and were able to obtain the sympathy of Lord Hunter of Newington, previously Vice Chancellor of the University of Birmingham and Lord Richardson, previously President of the General Medical Council, both physicians. Regular discussions ensued and assistance was given in due course with speeches and with drafting amendments.

The more sophisticated and experienced a pressure group or lobbyist is, the more effective they or he will be in influencing changes. Peers and MPs cannot be expert at everything and they often ask for briefings from voluntary societies and others active in a particular field. Some lobbyists even get themselves accredited as Research Assistants to MPs which gives them access to the Commons Library and a pass to allow them into the building.<sup>16</sup> Rolf Hermelin, representing MENCAP, the mental handicap charity and its Director of Parliamentary Affairs, is very experienced at these tactics. As an honorary research assistant to one MP he can go in and out of the House freely. He has said 'one meets MPs at all occasions, not just in the Chamber, not just in the Committee Room, but in the corridors and in the cafeterias and bars, and one builds up a circle of MPs and Peers who one finds out are helpful and supportive to our causes. The MPs rely very much on us... and we are probably greater experts than the MP himself in tabling amendments. We actually construct the amendment and word it to do what we want to do and what the MP wants to do. It is a process of close co-operation once you find the right MPs, particularly in committee...'

As a group of professionals, doctors are relatively naïve and inexperienced at the game that Parliament plays and we had to learn first how to operate in the same way as other lobbyists. In the House of Lords, Mr Hermelin worked with Lord Renton (President of MENCAP); Lady Faithfull (once Director of Social Services for Oxfordshire) represented the views of BASW, and MIND worked with several groups but mainly the Alliance led by Lord Hooson (Liberal), Lord Winstanley (a Liberal medical peer) and others, while we had the help of Lords Hunter and Richardson throughout. The College kept in regular, almost daily contact, with the DHSS

officials with whom a close relationship was established, ensuring that the medical viewpoint might reach Ministerial ears.

The debate on the Second Reading was initiated by Lord Elton, then Parliamentary Under-Secretary for Health and Social Security in the House of Lords. He handled the Bill throughout its stages in the Lords with great expertise, wit and skill. Matters affecting the Home Office were handled equally skilfully by Lord Belstead, then Junior Minister at the Home Office. The Ministers are, of course, supported in the House by a bevy of officials who are expert on the legislation and responsible for it, who sit in a sort of horsebox close to them—able to provide instant answers and explanations in response to unexpected questions. Others are less well provided for and rely upon their research assistants or the services of lobbyists who can rarely be so efficient as the Government machine.

Although the Second Reading Debate is one about principles, hares can be started and the Government alerted to any problems it might have to face later. In this case Lord Renton for MENCAP insisted that Mental Handicap (previously subnormality) should not be mentioned in the Act associated with mental illness, a totally different form of condition. Lord Renton, once a Junior Minister in the Home Office, when in the Commons, carried with him considerable influence and the Government was persuaded during further difficult meetings in the DHSS in the Christmas 1981 recess to try and find an answer to his objections, despite the opposition to this move from the psychiatrists. The College lobbied the Minister and sent messages via officials, but MENCAP was more influential. The Minister and his advisers eventually found an ingenious solution; to create a new category called 'mental impairment' for the purposes of the Act, thus leaving mental handicap out of it.

The Committee stage in the Lords involved the whole House and was generally well attended. It took place during February 1982 when the Bill was considered clause by clause. This was a time of intense activity behind the scenes, discussions with Peers and officials and the urgent drafting of Amendments. The House often sat from 3.30 pm to 11.00 pm. Attitudes were tested out in friendly discussions between Peers and lobbyists late at night in the Bars, or between the lobbyists themselves, now forming a cordial club of interested parties.

At the Report stage concessions made by the Government during Committee were developed or honoured and further amendments made. Some concessions were left to later stages in the Commons. The Bill received its final approval at the Third Reading stage which was completed on 4 March 1982 after nearly 29 hours of debate. One hundred and ninety-eight amendments were proposed at various stages and 119, more than half, were agreed. The Bill had, therefore, emerged from the Lords in a very different form from that in which it arrived four months earlier.

In the next few weeks we all had to turn our attention to

the Commons and find MPs willing to take an interest in our cause. I even approached one Member on a train when I found myself standing next to him as we approached the station. It was he who explained it was only worthwhile contacting a Member with a known interest in a specialist field. Others would not appear to have the same credibility and his field was finance. Others known previously to be specialists were found to be committed elsewhere.

The Bill moved to the Commons in April 1982 for its First, then Second Reading, when a number of Members spoke who never expressed themselves again on this subject. The Secretary of State, now Mr Norman Fowler, introduced the Bill and was supported by a new Minister of Health, Mr Kenneth Clarke, a Queen's Counsel who had replaced Dr Vaughan in a reshuffle. This was possibly advantageous as there were fears that Dr Vaughan, as a doctor and a psychiatrist, might have difficulties promoting a Mental Health Bill, where he might be thought to be representing the views of doctors and attract unreasonable hostility.

Events then took an interesting turn. It was decided to refer the Committee Stage to a new special procedure used only once previously, for the Education Act of 1981. The Special Standing Committees began as an experiment associated with the names of George Cunningham MP, who thought of the idea in 1971, and Norman St John Stevas MP who, as Leader of the House, got it through Cabinet. The Special Standing Committee is a cross between the two kinds of committee with which we are familiar. Firstly, Select Committees which shadow ministries, examining policy, calling evidence and writing reports. On the other hand, there are Standing Committees to which most Bills are sent for detailed examination and possible amendment. A Special Standing Committee commences as a sort of Select Committee presided over by the Chairman of the appropriate Select Committee (in this case Health, in the form of Mrs Renée Short) calling evidence and examining witnesses for up to three half-day sessions. It then metamorphoses into a Standing Committee chaired by an MP from the panel of Chairmen to consider the Bill in detail (in this case Mr R. C. Mitchell MP).

By this stage, further debate and scrutiny of the detail contained in the Bill had taken place in the College and there was mounting anxiety about the controversial consent clauses which had always been the focus of deep concern. Psychiatrists were rapidly concluding that the Government's proposals were too wide-ranging and restrictive, they would involve too much professional time unnecessarily and might even prevent the patient receiving the treatment he needs. The College wrote to *The Times* expressing this view, as did colleagues from the Institute of Psychiatry. Strong feelings were expressed and some psychiatrists announced that they would simply refuse to take responsibility for detained patients if the proposals stayed as they were. A special meeting of the Council of the College was called to

discuss the present stage of progress and it was resolved to campaign against the consent proposals to the limit. Although the College welcomed the Government's acceptance of its original suggestions for consent, they had been elaborated to an impracticable degree. Psychiatrists would spend a great deal of their time obtaining or giving second opinions.

The Special Standing Committee of the Commons consisted (apart from the Chairman) of the Minister (Mr Clarke) and his Under-Secretary of State (Health), Mr Geoffrey Finsberg, and seven Conservative members, including a Government Whip. Mr Terry Davis, Deputy Opposition Health Spokesman led for the Opposition with Mr David Ennals and four Labour backbenchers. In addition, there were two members of minority opposition parties. Government Whips on each side, as is the custom, did not speak.

The Committee first called invited witnesses representing interested organizations. They examined the Minister of State Home Office (Mr Patrick Mayhew), the Permanent Secretary Lord Chancellor's Department, two chairmen of Mental Health Review Tribunals (Sir John Wood and Mr James Cooke), the Director of Broadmoor and Professor Olsen, Professor of Social Work at Birmingham and Chairman of BASW's Committee on the legislation. On the second day the President of the College and myself, as Chairman of the Special Committee on the Act, were examined, followed by a representative from the Royal College of Nursing, Mr Albert Spanswick (Gen Sec COHSE), representatives from NUPE, the British Psychological Society and the National Association of Health Authorities. On the last day, two representatives from MIND, including Mr Gostin, were seen together with a psychiatric patient (who caused some conflict of principle among the members). This was followed by a representative from the National Schizophrenia Fellowship, Mrs Molly Meacher from BASW, representatives from the Association of Directors of Social Services, from the Association of Metropolitan Authorities in England and Wales (in fact also a MIND officer), from the Association of County Councils and from the London Boroughs Association.

All the witnesses first submitted written evidence which was subsequently published in *Hansard*.

The Committee met twice on each Tuesday and Thursday and sat 22 times in all. The proceedings were conducted as they are in the main chamber, although members could speak any number of times. Generally the atmosphere was good-humoured and co-operative. The Members were well prepared and exceptionally knowledgeable and informed. All the clauses were reviewed and many detailed and interesting debates took place. A few weeks after commencement there were indications that the Government was having second thoughts about the consent clauses and it was said that the Minister, who had taken over responsibility for the Bill on moving to the DHSS, did not think much of them himself. A draft of new proposals was then circulated for consideration

by MPs and lobbyists—now getting to know each other well. An interval occurred at the time of President Reagan's visit to Parliament when the Committee had a day off. Many MPs did not wish to take part in the ceremonials so Mr Terry Davis called an informal meeting of MPs and lobbyists in the Committee room on that day, under Mr Tom Benyon's chairmanship, to debate the new consent proposals. Although this was an unofficial meeting, a minute was taken and the meeting played an important part in airing views and influencing future changes. The new proposals were much more acceptable to the medical profession, but were regarded by others, MIND and BASW particularly, as a soft option. They were, however, proceeded with and ultimately accepted, with some qualifications. From the College's point of view they were more acceptable than any of the alternatives that had been proposed.

As the Committee proceeded, it was accompanied by frequent meetings with MPs in the corridors or cafeteria, briefing, drafting of amendments and daily contact with the DHSS officials. All this contributed greatly to the shape of the eventual Bill. A further 100 amendments were accepted, often after a division. The Government was sometimes defeated and often made concessions or promises when possible defeat was foreseen or an argument accepted. At intervals the main College lobbyists met with the Committee or the President and Registrar of the College to consider progress and plan strategy. It was a time of planning and plotting, bargaining and consultation. An additional complicating event at this stage was the judgment of the European Court of Human Rights on the English laws concerning restricted patients, which the Government also had to accommodate.<sup>19</sup>

The Committee Stage was completed on 29 June 1982 when the controversial consent clauses were kept to be dealt with together. However, so much consultation had already occurred that their progress was remarkably smooth.

At last a rest was possible as the Summer Vacation arrived and it seemed that most of the work was done.

There was still the Report Stage to come and this was dealt with in the 'overspill' period in October, prior to the new session of Parliament. More amendments were put forward and a few serious developments occurred when unforeseen proposals were carried without any of the previous consultation taking place (in particular the extension of Section 57 to informal patients). Protests were made and a Peer briefed to attempt a reversal in the Lords, but despite a firm effort, this had no support.

Finally, when the Bill arrived back in the Upper House it had been changed a great deal. Now the Lords task was to approve the amendments passed in the Commons. It had a smooth and unruffled passage. The Bill was passed and received the Royal Assent on 28 October 1982,<sup>20</sup> almost a year after it had started its journey. Legitimation was now completed and the new Act was to become operative from 30 September 1983.

This was not the end. The new Act was an Amendment Act amending the 1959 Act and a consolidation measure was soon started to become in due course the Mental Health Act 1983;<sup>21</sup> but this is a technical rather than a policy matter. The next stage for the rest of us involved negotiations and discussion about regulations, forms, implementation, explanatory memoranda and the setting up of the new Mental Health Act Commission—the stage of application and feedback.<sup>22</sup>

I have been involved in this process for more than ten years and for me and my colleagues it has been an education in the Parliamentary process. The resulting Act has met with general approval, sometimes muted, from others with some enthusiasm, and perhaps not surprisingly so because all those involved in one way or another contributed to it and feel some responsibility for it. If the progress of this legislation is typical then it was a remarkable example of finding solutions by consensus, adapting and shaping the Bill constantly as it progressed. The contribution of the officials in the Department were undoubtedly of fundamental importance and the influence of all the lobbyists must be acknowledged as of prime importance. Yet the knowledge and input of the Parliamentarians was no less noticeable, but one important lesson was the necessity of being present and getting to know Peers and MPs to ensure that influence was maintained to the end.

#### REFERENCES

- <sup>1</sup>DREWRY, A. (1981) Chapter in *The Commons Today* (eds. S. A. Walkland and M. Ryle). London: Fontana.
- <sup>2</sup>DHSS (1957) *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954–1957*. Cmnd 169. London: HMSO.
- <sup>3</sup>——— (1959) *Mental Health Act 1959*. London: HMSO.
- <sup>4</sup>SHHD (1960) *Mental Health (Scotland) Act 1960*. London: HMSO.
- <sup>5</sup>MCGARRY, A. L. & KAPLAN, H. A. (1973) Overview: Current trends in mental health law. *American Journal of Psychiatry*, **130**, 621.
- <sup>6</sup>GOSTIN, L. O. (1975, 1977) *A Human Condition, Vols. I and II*. London: National Association of Mental Health.
- <sup>7</sup>ROYAL COLLEGE OF PSYCHIATRISTS (1974) Review of the Mental Health Act 1959. *News and Notes*, supplement to the *British Journal of Psychiatry*, October, 3–8; November, 11–14.
- <sup>8</sup>DHSS (1975) *Better Services for the Mentally Ill*. London: HMSO.
- <sup>9</sup>——— HOME OFFICE, LORD CHANCELLOR'S OFFICE (1975) *Report of the Committee on Mentally Abnormal Offenders*. Cmnd 6244. London: HMSO.
- <sup>10</sup>——— (1976) *A Review of the Mental Health Act 1959*. London: HMSO.
- <sup>11</sup>——— (1978) *Review of the Mental Health Act 1959*. Cmnd 7320. London: HMSO.
- <sup>12</sup>ROYAL COLLEGE OF PSYCHIATRISTS (1979) The White Paper on the Mental Health Act: The College's comments. *Bulletin of the Royal College of Psychiatrists*, April, 58–65.

- <sup>13</sup>BLUGLASS, R. (1981) Towards a new Mental Health Act: Mental Health Commission for England and Wales. *Bulletin of the Royal College of Psychiatrists*, 5, 130–2.
- <sup>14</sup>GOSTIN, L. O. (1981) Observations on consent to treatment and review of clinical judgement in psychiatry: a discussion paper. *Journal of the Royal Society of Medicine*, 74(10), 742–52.
- <sup>15</sup>CLARE, A. W. (1981) Consent to treatment (Editorial). *Journal of the Royal Society of Medicine*, 74(11), 787–9.
- <sup>16</sup>ROZENBERG, J. (1981) *The Listener*, 19 November.
- <sup>17</sup>DHSS (1981) *Mental Health (Amendment) Bill*. London: HMSO.
- <sup>18</sup>——— (1981) *Reform of Mental Health Legislation*. Cmnd 8405. London: HMSO.
- <sup>19</sup>BLUGLASS, R. (1981) Towards a new Mental Health Act: Sections 60 and 65 and the European Commission for Human Rights. *Bulletin of the Royal College of Psychiatrists*, 5, 151–3.
- <sup>20</sup>DHSS (1982) *Mental Health (Amendment) Act 1982*. London: HMSO.
- <sup>21</sup>——— (1983) *Mental Health Act 1983*. London: HMSO.
- <sup>22</sup>BLUGLASS, R. (1983) *A Guide to the Mental Health Act 1983*. London and Edinburgh: Churchill Livingstone.

## ***The Edinburgh Three-Year Course and M.Phil Degree***

R. E. KENDELL, Professor of Psychiatry, University of Edinburgh

The introduction of the College's Membership Examination in 1971 created a dilemma for the university departments which had previously provided postgraduate teaching for a Diploma in Psychological Medicine. For it was clear that the MRCPsych would soon become a mandatory qualification for anyone wishing to pursue a psychiatric career, at least in this country, and that consequently there would no longer be a useful role for these diplomas. The universities concerned therefore had to choose between letting their diplomas die, or converting them into something other than a basic clinical qualification. The University of Edinburgh, like the Institute of Psychiatry and one or two other departments, decided to replace its DPM with a master's degree (M.Phil) in psychiatry which would be primarily an academic and research qualification, complementing rather than rivalling the College Membership.

The Edinburgh M.Phil came into being in 1972 and has two components: a course of seminars and lectures extending over three years (nine academic terms), and a thesis. The three-year course itself is open to all psychiatric trainees (SHOs, registrars and honorary clinical assistants) on the staff of the Royal Edinburgh Hospital or the six other psychiatric hospitals in SE Scotland within reasonable travelling distance. It consists of a comprehensive programme of lectures and seminars on two afternoons a week (2.00–5.25 pm) for the first five terms and one afternoon a week thereafter. As each term lasts ten weeks the total number of hours of teaching is therefore 420. The first year's teaching is mainly concerned with the basic syndromes and therapies of general psychiatry; the second mainly with research methods and the so-called 'basic sciences' of psychology, neurophysiology, neurochemistry and neuropharmacology; and the third mainly with specialty subjects such as child psychiatry, forensic psychiatry, general hospital psychiatry and the psychiatry of old age. There is also a slow transition from 60-minute lectures in the first year to 90-minute seminars in the third. Dealing with the essentials of clinical psychiatry before the 'basic sciences' is

a deliberate policy which we are convinced is educationally sound, despite the protests of some trainees preoccupied with the College's Preliminary Test.

The bulk of the teaching is by members of the university department of psychiatry but there is a substantial contribution from NHS consultants, from the staff of the MRC Epidemiological Studies in Psychiatry and Brain Metabolism Units, and from other departments of the university. Trainees on the course are all formally registered as part-time, supervised postgraduate students of the university and pay standard university fees (£60 a year in 1972/73 but now £500 a year for home and £2370 a year for overseas students). At the end of their fifth term students have to decide whether or not to enroll formally as candidates for the M.Phil degree. This involves a commitment to writing a thesis on a topic specified at the time and under the supervision of an appropriate member of the academic staff, which consists either of a description of research carried out by the candidate or of a critical review of the literature on that topic. This thesis can be submitted in the ninth term, or at any time during the following fifteen months, i.e. up to four years after first starting the course.

Teaching starts in October each year. There are usually 20–30 trainees in the first year class, 15–25 in the second and 10–20 in the third, a total of 50–70 overall. Over half are from the Royal Edinburgh Hospital itself, including 10–15 clinical assistants from overseas. The remainder come from other psychiatric hospitals in the region. The Health Boards pay their trainees' fees on their behalf and the clinical tutors in the various hospitals arrange for them to be free of clinical commitments on teaching afternoons. The first intake of students was in October 1972, so the first registrations to take the M.Phil were in April 1974. The first candidates actually to obtain the degree did so in June 1976 and since then 34 M.Phils have been awarded, an average of between five and six from each intake. Usually about half the second year students register as candidates for the M.Phil, but on average only half of these actually submit a thesis at