

X. v. The United Kingdom:

Mental Health Activism and the Limits of Human Rights, 1971-1983

1. Introduction

On 5 November 1981, the European Court of Human Rights published a landmark decision condemning the United Kingdom of human rights violations for its treatment of people with mental disabilities. Titled *X. v. the United Kingdom*, the ruling forced Parliament to rewrite its mental health legislation under Britain's obligations as a member of the Council of Europe and as a signatory to the European Convention on Human Rights. Hailed as a great advance for the rights of mental patients, the Mental Health Act of 1983 created Britain's modern mental health regime and, despite changes introduced with the Mental Health Act of 2007, remains the basis for mental health legislation especially regarding patients' rights, patient consent, and the forced institutionalization of the mentally disabled.

Having had reform forced upon it by the European Court, however, Parliament played a largely passive role in these events. Instead, while *X. v. the United Kingdom* was the direct catalyst for change, the case itself and the reforms it brought about must be placed in the context of a longer history of activist struggle. In this paper, I will show how the reforms of the early 1980s were a culmination of a decade-long battle waged throughout the 1970s by mental health activists and led by the mental health advocacy group, MIND. While radical critiques of psychiatric discourse and practice were not new to the 1970s, MIND's pioneering activism combined these fundamental criticisms, largely drawn from the antipsychiatry of the 1960s, with a shifting, actionable, and pragmatic rights-based politics based on legal advocacy and representation, lobbying and political advising, and public campaigning and protests.

Despite MIND's roots as a public charity, activists within MIND drastically reorganized it after 1970 into a legal pressure group. They rejected dominant psychiatric discourses and practices based on stigmatization, invasive medical control, and forced institutionalization. Instead, they envisioned a dramatic transformation towards a community-based approach based on patient's consent, local and short-term treatment, and an emphasis on radical equality for all regardless of mental condition. At the same time, activists challenged the very foundations of psychiatric thought disavowing its ability to make reliable diagnoses and instead presenting it as a system of social control. While remaining committed to these aims and convictions, MIND continued to shift its tactics and its language as new opportunities for reform arose.

In this thesis, I will argue that, while MIND's chief aims remained the recognition of the fundamental equality of all regardless of mental condition, MIND and its activists made strategic and pragmatic use of different legal structures and rights languages to obtain its desired reforms. I will chart the development of MIND's activism by focusing on three key moments: the initiation of the MIND campaign in 1971, the publication of a major reform program entitled *A Human Condition* in 1975, and the *X. v. the United Kingdom* ruling in 1981. Using a combination of MIND publications, European Court records, government records, and periodicals, I will show how MIND initially committed to national reform through Parliament and thus cloaked its radical antipsychiatry in the language of civil rights and liberties. After publishing *A Human Condition*, MIND's activists became disillusioned with the potential for change through British institutions and altered its strategy by adopting the language of international human rights as opportunities arose through the European Court of Human Rights.

In doing so, mental health activism embraced an international perspective and language that transcended the national limits of civil liberties politics. Through the use of the European

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human rights system, MIND was able to force Parliament to adopt many of its measures in the Mental Health Act of 1983. Yet while these reforms did much to increase protections for patients' rights and consent, the adoption of the system and language of a legalistic international human rights regime forced MIND to compromise on its radical critiques of psychiatry as a discipline. In the end, mental health activists had to accept reforms to the existing system rather than a fundamental overhaul. As such, this thesis concludes with a discussion of the limits of human rights and considerations for future research.

Although many legal and medical scholars recognize the importance of *X v. the United Kingdom* in shaping British mental health legislation today, historians up to now have written little on the case or the larger mental health activism movement.¹ Many of the works are a few decades old and of a general nature covering changes in psychiatric theory and practice over long periods of time. As a result, historians have missed the importance of mental health activists even though their activities constituted a fundamental challenge to a number of twentieth-century modernist assumptions.

Central to MIND's activism were attempts to redefine both mental illness and the individual, liberal subject. With intellectual roots in eugenics and theories of degeneration, twentieth-century conceptions of mental illness were heavily imbued with social stigma. This remained long after postwar medical experts officially began treating mental illness as a medical issue rather than a racial, moral, and social problem. In this shift towards a medicalization of mental disorder, however, medical experts took upon themselves almost complete control and

¹ For perspective from legal and medical scholars, see Philip Bean, *Mental Disorder and Legal Control* (Cambridge: Cambridge University Press, 1986); Phil Fennell, *Treatment Without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* (London: Routledge, 1996); Jonathan Toms, *Mental Hygiene and Psychiatry in Modern Britain* (Houndmills, UK: Palgrave Macmillan, 2013).

authority over mental patients denying even the most basic ideas of patient consent and patients' rights. With the Mental Health Act of 1959, this received official legal backing thereby creating a mesh of legal and medical power over institutionalized mental patients and the mentally disabled in general.

Against a society that still associated mental disorder with danger, deviancy, and criminality, the mental health activists in MIND asserted the common humanity of mental patients and, in so doing, challenged medical authority and expertise. At the same time, these activists were challenging preconceived notions of 'humanity' which left out the mentally disabled. While legal and medical experts were content depicting the mentally disabled as helpless victims in need of medical expertise, mental health activists asserted the fundamental equality of patients and the equal rights of the disabled. Since the state and dominant discourses routinely denied the most basic civil and political rights of the mentally disabled, MIND's fight for these rights challenged a particular vision of the autonomous, stable, and rational liberal subject. In its place, MIND and mental health activists hoped to broaden conceptions of humanity to include all regardless of mental condition or capacity. As such, this project explores the 'human' in 'human rights' and how reformulations of 'humanity' can both include and exclude.

Relatedly, this project speaks to the historiography of human rights which has seen explosive growth in the past two decades.² Sam Moyn and others have pointed to the 1970s as the

² For some examples of this literature, see Samuel Moyn, *The Last Utopia: Human Rights in History* (Cambridge, MA: The Belknap Press of Harvard University Press, 2010); Lynn Hunt, *Inventing Human Rights: A History* (New York: W. W. Norton & Company, 2007); Kenneth Cmiel, "The Recent History of Human Rights," *The American Historical Review* 109, no. 1 (2004): 117–35, doi:10.1086/530153; Micheline Ishay, *The History of Human Rights: From Ancient Times to the Globalization Era* (Berkeley: University of California Press, 2004); Carole Fink, *Defending the Rights of Others: The Great Powers, the Jews, and International Minority Protection, 1878-1938* (Cambridge: Cambridge University Press, 2004); Mark Bradley, *The World Reimagined: Americans and Human Rights in the Twentieth Century* (New York: Cambridge University Press, 2016); Elizabeth Borgwardt, *A New Deal for the World: America's Vision for Human Rights* (Cambridge, MA: The Belknap Press of Harvard University Press, 2007); Roland Burke, *Decolonization and the Evolution of International Human Rights* (Philadelphia:

decade in which human rights emerged in political and legal discourse and institutions.³ The development of the *X. v. the United Kingdom* case fits into this chronological narrative. Nonetheless, I emphasize that the turn to human rights was one of convenience or expediency. The language of supranational rights and the legal structures of the European Court offered opportunities in the mid to late 1970s when attempts at national reform failed, but the underlying principles of activists remain largely the same. If anything though, human rights ended up limiting mental health activists' ambitious reform agenda; the assumptions inherent to a human rights framework, and indeed rights-based claims generally, foreclosed possibilities for challenges to many deeper structural and discursive issues. This does not mean that MIND's reforms did not improve the lives of patients, but it does push back against the triumphalism of certain human rights scholarship.

I should also emphasize the particularities of the European human rights system in this thesis. The historiography of human rights regularly glosses over the unique aspects of the European human rights regime in favor of narratives focused on the United Nations or NGOs. While the Universal Declaration of Human Rights is notoriously unenforceable and the jurisdiction of international human rights law generally manages to avoid unwilling superpowers in favor of relatively weak postcolonial and post-Communist states, European human rights law is both enforceable and binding on all member states of the Council of Europe. In the long wake of Brexit and formal repudiation of the European project, my thesis shines light on one example when the European human rights regime made limited reforms possible.

University of Pennsylvania Press, 2010); A. W. Brian Simpson, *Human Rights and the End of Empire: Britain and the Genesis of the European Convention* (Oxford: Oxford University Press, 2001); Marco Duranti, *The Conservative Human Rights Revolution: European Identity, Transnational Politics, and the Origins of the European Convention* (Oxford: Oxford University Press, 2017).

³ Moyn, *The Last Utopia*, 1–8.

Such cases have given rise to a certain triumphalism or exceptionalism regarding European human rights, yet my thesis shows at the same time how human rights, by their very nature, can be limiting. Indeed, I hope in my project to avoid both the utopias of a triumphal European legalism and a parochial Eurosceptic nationalism. At the same time, while I attempt to recognize the fundamental importance and agency of transnational activists, I also place them in existing social totalities and structures. Additionally, I must add that the lack of leadership or strong input from mental patients or the mentally disabled themselves always placed a serious limit on MIND's reformist agenda despite its radicalism. That being said, reform of mental health law was necessary and desirable in the minds of mental health activists, but law was not the only aspect of the mental health regime in need of change. Activists targeted discourses and practices as much as law; while the European Court of Human Rights could redress human rights abuses, it could not change medical stigmatization of the mentally disabled or really ensure the equality of all regardless of mental condition.

2. MIND and the Emergence of Mental Health Activism

On 16 February 1971, Britain's leading mental health charity and advisory group, the National Association for Mental Health (NAMH), launched a national campaign promoting patients' rights and better conditions in mental health care. Symbolically changing its name to MIND, the twenty-five-year-old organization was relaunching itself and shifting focus from charitable work to pressure-group tactics. In the spring of 1971, MIND made its intentions clear by publishing "The MIND Manifesto" in its quarterly journal, *Mental Health*.⁴ Under the direction of MIND's campaign director, David Ennals, Labour MP for Dover and brother of Amnesty International

⁴ Anonymous, "The MIND Manifesto," *Mental Health* 30, Spring (1971): 2-8.

Secretary Martin Ennals, MIND stated that its intentions were “to draw attention to the needs of the mentally sick and handicapped who are given too low a priority in our daily life.”⁵ Long ignored and disrespected by society, the mentally disabled needed to be recognized and cared for.

Central to this campaign would be promoting the basic and fundamental equality of all people regardless of their mental health or mental capacity. To this end, the report argued that “no boundaries mark out mental illness from mental health. [...] The mentally ill are not a separate race, divorced from our world and our experience: they are ‘we’ and we are ‘they’.”⁶ This assertion of common humanity was not just empty rhetoric. It was a plea to a society that still viewed the mentally disabled as unhinged, sexually deviant, largely criminal, and dangerous.

At the time, stories often appeared in major newspapers about deranged killers and social outcasts formerly incarcerated in mental asylums. Such stories were often met with indignant calls for stronger sentencing and harsher restrictions on institutional discharge and patient life generally. To give just one example, the 1 December 1969 edition of *The Times* reported on “a former mental patient” who killed a police officer at Wimbledon Commons in August 1969.⁷ Focusing on his mental condition as a source of criminality, the report criticized the Home Secretary for allowing former mental patients to live unsupervised after discharge. In addition, the report highlighted the patient’s alleged deviancy by singling out his admitted homosexuality and his possession of sadomasochistic materials as supposed warning signs of criminal and mentally disturbed behavior. Underlying this report was the belief that the mentally disabled should not be allowed unsupervised and independent lives; they were simply too dangerous to exist in open society.

⁵ Ibid., 2.

⁶ Ibid., 3.

⁷ Anonymous, “Inquiry Call on Killer’s Free Life,” *The Times*, December 1, 1969, The Times Digital Archive.

Combating such notions was central to the MIND campaign. This assertion of common humanity and fundamental equality served as a basis for a wider claim to the protection and promotion of patients' rights. Earlier issues of *Mental Health* indicate that NAMH was already developing a language of rights before the campaign.⁸ Nonetheless, this language came to fruition in "The Mind Manifesto" which explicitly makes rights-based arguments grounded upon the belief that rights are universal and therefore applicable to the mentally disabled.⁹ Indeed, the Manifesto includes a robust rights language which emphasizes social and economic rights. Admittedly, civil and political rights were not on the table at this time. Yet these would come soon; by the mid-1970s, MIND was leading the fight for equal suffrage, equal access to courts, and protections for the rights to free expression and association on behalf of mental patients.¹⁰

With these ideals and aims in mind, MIND in 1971 was motivated and prepared to fight for patients' rights. Yet this was a major change from NAMH's founding priorities and beliefs. With the merging of three predecessor organizations, NAMH was originally founded in 1946.¹¹ Rather than playing a role as a legal advocate or a pressure group, NAMH began as a charitable volunteer organization that advised the government on policy, disseminated mental health information to doctors and the public, and provided residential services for the mentally disabled. With its roots in early twentieth-century psychiatry, NAMH started out as part of the wider mental hygiene movement.¹² Heavily influenced by psychoanalysis, the movement focused on the role of the

⁸ Tony Marshall, "Voice for the Silent Minority," *Mental Health* 29, Autumn (1970): 40–42.

⁹ Anonymous, "The MIND Manifesto," 4–5.

¹⁰ Larry Gostin, *Electoral Registration of Patients in Mental Hospitals: MIND's Observations on the DHSS Consultative Paper* (London: MIND, 1977); Larry Gostin, *A Human Condition: The Mental Health Act from 1959 to 1975 Observations, Analysis and Proposals for Reform* (London: MIND, 1975).

¹¹ For NAMH's history, see Jonathan Toms, "Mind the Gap: MIND, the Mental Hygiene Movement and the Trapdoor in Measurements of Intellect," *Journal of Intellectual Disability Research* 54, no. 1 (2010): 18, doi:10.1111/j.1365-2788.2009.01234.

¹² *Ibid.*, 16–27.

unconscious in mental disorder and promoted the talking cure. Psychiatrists presented mental disorders as resulting from abnormal personalities rooted in the unconscious and formed in reaction to social factors.¹³ Social conditions and one's surroundings therefore played a central role in the cause and cure of mental illness.¹⁴

This highly stigmatizing movement was closely tied to early-twentieth-century ideas of social inefficiency, degeneration theory, and faith in progress.¹⁵ To use the language of the time, 'primitive' peoples, 'backwards' and 'regressive' intellects, criminals, sex offenders, and depressives all fell under the label of 'degeneracy' and allegedly suffered from similar problems rooted in both biology and abnormal social responses.¹⁶ By necessity, mental hygienists sought to tackle social and mental health 'problems' together. This was essential not only for patients but for society itself since mental hygienists explicitly connected social and racial progress with the development of individuals in communities. Coupled with beliefs in hereditarianism, eugenics, and the degenerative effects of the mentally disabled on society, mental hygienists encouraged segregation of the mentally disabled and the 'socially inefficient' throughout the interwar years.¹⁷ Indeed, psychiatry only began moving away from these theories in the 1930s and the Second World War due to increased negative exposure to Nazi race science.¹⁸

This move away from scientific racism allowed for a more medical view of mental disorder to emerge which separated mental disorder from criminality and social inefficiency. This increased

¹³ Ibid., 20.

¹⁴ Ibid., 21.

¹⁵ Barbara Taylor, *The Last Asylum: A Memoir of Madness in Our Times* (Chicago: The University of Chicago Press, 2015), 113.

¹⁶ Daniel Pick, *Faces of Degeneration: A European Disorder c. 1848-1918* (Cambridge: Cambridge University Press, 1989); George Stocking, *Victorian Anthropology* (New York: Free Press, 1987).

¹⁷ Toms, "Mind the Gap," 22; Taylor, *The Last Asylum*, 108.

¹⁸ Erik Linstrum, *Ruling Minds: Psychology in the British Empire* (Cambridge, MA: Harvard University Press, 2016), 109–15.

trust in the opinions and abilities of doctors led to the reform of British mental health legislation with the Mental Health Act of 1959. Remembered as a great piece of liberal, reformist legislation, the Mental Health Act was the first piece of British legislation to view mental disorder as a definable and treatable illness rather than a social problem.¹⁹ Indeed, it was the first piece of legislation to attempt a medical definition of mental disorder.

Nonetheless, underlying this optimism about medical experts was the belief that doctors could only cure their patients if given total control of treatment regimens.²⁰ Consent was ignored because legislators and medical experts agreed that doctors alone understood the science and medical technology sufficiently well to ‘cure’ mental disorder. This trust in medical expertise was bolstered by a coinciding revolution in pharmacology. With the development of psychoactive drugs, medical and legislative experts expressed new hopes of finding revolutionary treatment options and cures through innovative drug research.²¹

This trust in medical expertise provoked a backlash in the 1960s with the emergence of the antipsychiatry movement. Throughout the decade, academics from across the western world emerged often tied to the counterculture and radical politics. The most well-known include Michel Foucault and Gilles Deleuze in France, Thomas Szasz and Erving Goffman in the United States, Franco Basaglia in Italy, and R. D. Laing in Britain.²² The antipsychiatry movement made a larger critique of the evils of ‘total institutions’ and analyzed both the subtle and conspicuous ways in

¹⁹ Bean, *Mental Disorder and Legal Control*, 1–2.

²⁰ *Ibid.*, 1.

²¹ Andrew Scull, *Madness in Civilization: A Cultural History of Insanity from the Bible to Freud, from the Madhouse to Modern Medicine* (London: Thames & Hudson, 2016), chap. 12.

²² Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, NY: Anchor Books, 1961); Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard (New York: Vintage Books, 1965); Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Hoeber-Harper, 1961); R. D. Laing, *The Divided Self* (New York: Pantheon Books, 1969). For a discussion of Basaglia, see Andrew Scull, *Madness in Civilization*, 374.

which doctors and medical experts exercised power over their patients. Some of these figures were psychiatrists who critiqued psychological theories and attempted to redefine mental illness. One such figure was R. D. Laing who wrote about the social causes of schizophrenia and, as part of a larger countercultural critique, attacked society, rather than mental patients, as sick. Others such as Foucault were historians and philosophers who criticized psychiatry as a discourse of political and social repression for the empowerment of medical and legal experts and the status quo.

The antipsychiatry movement heavily influenced MIND and mental health activists in the 1970s. Critically, it challenged the mid-century faith in medical experts; this was a critique that mental health activists would take up eagerly. Antipsychiatry's influence on MIND is clear in its chief reform manual, *A Human Condition*, which cites leading antipsychiatry texts such as Foucault's *Madness and Civilization*, Goffman's *Asylums*, and Theodore Lidz's "The family, language, and the transmission of schizophrenia."²³ As my next section will show, MIND drew on these figures in its sharp critiques of 'institutionalism' (a term borrowed directly from Goffman).

Nonetheless, due to some fundamental differences, the antipsychiatry movement cannot completely explain why NAMH transformed into MIND and adopted the new pressure group tactics as were present in "The MIND Manifesto." While it was necessary in many ways for the emergence of mental health activism in the 1970s, it was not sufficient. Crucially, activists needed a workable and pragmatic politics which could produce results. Some antipsychiatry figures did work for public reform: in the case of Italy, Franco Basaglia's efforts led to the complete deinstitutionalization of the country in 1978 with the closing of all mental hospitals and the transition to local community treatment. For the most part, however, antipsychiatry figures were

²³ Gostin, *A Human Condition*, 111–14.

academics often connected to radical politics and the counterculture and frequently suspicious of reform and working within the system. For mental health activism to emerge, a political language and program was still needed.

As the MIND Manifesto reveals, MIND ultimately opted for a rights-based approach. Besides the influence of antipsychiatry, this shift in MIND's tactics and language was made possible by three factors. One dramatic catalyst to psychiatric reform in Britain was the highly-publicized revelation in the 1960s of systematic abuse in mental hospitals including one at Brooklands Hospital involving children.²⁴ The resonance from these cases led to calls for inquiry and reform and, according to Jonathan Toms, directly inspired MIND to take greater action. In reaction to public calls for greater oversight and reform, the NAMH actually devised the MIND campaign originally as a fundraising strategy. As opposed to the headiness of antipsychiatry, the NAMH originally turned to rights-based language in part because it was suitable to public campaigning and simple appeals to equality and fairness.²⁵

This transition was in the late 1960s was key, but the final great catalyst for change came in 1971 when Tony Smythe joined MIND. Smythe was a political radical with a long career in British activism reaching back to the 1950s.²⁶ For an organization like the NAMH looking to transition from charitable work to direct activism, Smythe's activist career was ideal. At an early age he became a committed anarcho-pacifist and went to prison for three months in 1958 as a conscientious objector for refusing military service. In the following years, he played a major role in pacifist activism and, in 1960, he joined War Resisters' International. In the same year, he

²⁴ Toms, "Mind the Gap."

²⁵ Mind (The Mental Health Charity): Archives, SAMIN/A/3/2-3, Wellcome Library, London.

²⁶ See Smythe's obituary for a published compilation of his activist life in Michael Randle, "Tony Smythe," *The Guardian*, March 29, 2004, <https://www.theguardian.com/news/2004/mar/29/guardianobituaries.humanrights>.

became an original signatory of the Committee of 100, an offshoot of the Campaign for Nuclear Disarmament, which promoted direct action and civil disobedience in protest against weapons of mass destruction. In 1966, Smythe became the director of the National Council for Civil Liberties (NCCL) where he became accustomed to large-scale campaigning and fundraising. Since its founding in 1934, the NCCL had been Britain's leading civil liberties NGO similar to the American Civil Liberties Union with which it had close informal ties.²⁷ In this position, Smythe transformed the NCCL by supporting drives which increased the NCCL's membership fivefold.

Significantly, it was in this role that Smythe became heavily influenced by human rights discourse. During Smythe's tenure as head of the NCCL, the United Nations named 1968 as the Year of Human Rights. Revealing his shrewd nature as a successful campaigner, Smythe used the event as publicity to promote the NCCL and expand membership.²⁸ Throughout the 1960s and 1970s, he frequently corresponded with UN-affiliated organizations especially the International League for the Rights of Man (ILRM). The ILRM, or International League for Human Rights as it later renamed itself, was one of the few explicit promoters before the 1970s of human rights as encapsulated in the Universal Declaration of Human Rights of 1948. It was also one of the first and only international human rights NGOs with a presence at the UN General Assembly. Roger Baldwin, chairman of the ILRM and one of the founders of the ACLU, frequently corresponded with Smythe going back to at least 1967.²⁹ In addition to Smythe's interest in and connections with human rights organizations, he explicitly expressed interest in human rights causes. For instance,

²⁷ Anonymous, "Liberty Timeline," *Liberty*, February 12, 2014, <https://www.liberty-human-rights.org.uk/who-we-are/history/liberty-timeline>.

²⁸ Tony Smythe to Roger Baldwin, October 18, 1967, Box 16, Folder: General Correspondence: England: International League for Rights of Man, International League for Human Rights Records: 1948-1990, Rare Books and Manuscripts Division, The New York Public Library, New York.

²⁹ Tony Smythe to Roger Baldwin, June 9, 1967, Box 16, Folder: General Correspondence: England: International League for Rights of Man, International League for Human Rights Records: 1948-1990, Rare Books and Manuscripts Division, The New York Public Library, New York.

in a 1975 letter to Roberta Cohen, Executive Director of the ILRM, Smythe expressed interest in studying human rights abuses in Britain saying he was “trying to get together a high-powered group here to look at the protection (or lack of it) of human rights in Britain.”³⁰ Smythe’s interest in human rights demonstrates that he was firmly attuned to the newly flourishing human rights movement of the 1970s as described by authors such as Moyn.³¹

Having expanded the membership of the NCCL, Smythe left in 1971 to join MIND. It was at this point that the shift from charity to legal pressure group intensified especially after Smythe became director in 1973. As one scholar has written, “MIND became primarily a civil rights organization, abandoning most of its training programmes and embarking on an American-style campaign for reform through legal advocacy.”³² MIND began de-emphasizing or even ramping down its charitable activities. Instead, it shifted its priorities to directly criticizing the mental health system itself and working to reform the existing Mental Health Act of 1959 for its complete neglect of patients’ rights. Dissatisfaction with this legislation was already hinted at in “The MIND Manifesto” of 1971.³³ Yet it was not until 1974 under Smythe’s direction that MIND began work on a report which summarized all of the faults of the existing legislation and made significant recommendations for its replacement.

On 5 June 1974, an anonymous working party within MIND issued an in-house draft report which took the Mental Health Act 1959 head on by emphasizing its utter neglect of patient consent and patients’ rights in general.³⁴ Despite being anonymously written, the report would soon fall

³⁰ Tony Smythe to Roberta Cohen, January 30, 1975, Box 101, Folder: Great Britain, International League for Human Rights Records: 1948-1990, Rare Books and Manuscripts Division, The New York Public Library, New York.

³¹ Moyn, *The Last Utopia*.

³² Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London: Athlone Press, 1993), 200.

³³ Anonymous, “The MIND Manifesto,” 8.

³⁴ Anonymous, “The Mental Health Act 1959,” 5 June 1974, Box 101, Folder: Great Britain

into the hands of MIND's newly-hired Legal Director, Larry Gostin. Soon after arriving at MIND in 1975, Gostin expanded it, made more specific reference to the shortcomings of the existing Mental Health Act, and promoted legislative and structural solutions based on MIND's long-held belief in fundamental equality.³⁵ By the end of the year, Gostin and MIND had published his reworked report as *A Human Condition* inaugurating events that would lead to radical reforms in British legislation.

3. *A Human Condition*: Setting the Stage, Shaping the Debate

One of the most significant events in the history of British mental health reform was the publication in 1975 of *A Human Condition* by Larry Gostin, Legal and Welfare Rights Officer for MIND. *A Human Condition* contained all of MIND's proposals for changes to mental health legislation. It was the culmination of four years' work as a pressure group in addition to decades of study of the effects of the Mental Health Act of 1959. It formed the basis for MIND's campaign against the Mental Health Act of 1959 and marked the highpoint of MIND's attempts to reform mental health through national legislation. In addition, its publication gave its author, Larry Gostin, widespread recognition in Britain and marked his ascendance to the leadership of mental health activism. Although never officially the leader of MIND, Gostin played the most significant role in fighting for the rights of mental patients and in pushing for reform of mental health legislation. In publishing *A Human Condition*, he became a national figure frequently quoted and represented in periodicals and government debates. Yet as the chief legal advisor in *X. v. United Kingdom*, he

³⁵ After finishing the initial draft, the anonymous working party felt overwhelmed at the research needed to complete the project. As a result, Smythe hired Gostin as a full time legal advisor. Smythe explains this in Gostin, *A Human Condition*, 10.

also played a decisive role in the European Court case that forced the British government to rewrite its mental health legislation.

A Human Condition's influence was wide-ranging and brought mental health reform onto the national stage. Scholars have cited the book as the beginning of serious reform that led to the modern mental health regime of the last three decades.³⁶ Indeed, the chief pieces of legislation which reformed the Mental Health Act of 1959 – the Mental Health (Amendment) Bill of 1982 and the Mental Health Act of 1983 – were consciously based on Gostin's recommendations. Two-thirds of the Amendment Bill, for instance, were directly inspired by and taken from *A Human Condition*.³⁷ In a follow-up volume to the original publication, the chairman of MIND correctly summarized its impact in simple terms: "It initiated the debate on mental health legislation."³⁸ In the end, these reforms would only emerge in legislation due to pressure from the European Court of Human Rights in 1981. Nonetheless, the content of the reforms derived largely from Gostin's recommendations and his criticisms of the Mental Health Act 1959.

However, despite the connections shared between *A Human Condition* and *X. v. the United Kingdom*, *A Human Condition* limited itself to national concerns and a British outlook. Scholars have characterized *A Human Condition* as a human rights document in itself because it used a language of rights. For instance, Kathleen Jones has argued that *A Human Condition* "deals with the general case for extended human rights for all mental patients."³⁹ Nonetheless, activists still assumed that reform would come through pressure on Parliament using a language of natural

³⁶ John Gunn, "Reform Of Mental Health Legislation," *British Medical Journal (Clinical Research Edition)* 283, no. 6305 (December 5, 1981): 1487–88; Erasmus Barlow et al., "Mental Health Bill," *The Times*, April 20, 1982, The Times Digital Archive.

³⁷ Barlow et al., "Mental Health Bill"; Pat Healy, "Act Increases Rights of Mental Patients," *The Times*, October 29, 1982, The Times Digital Archive.

³⁸ Charles Clark, forward to *A Human Condition: The Law Relating to Mentally Abnormal Offenders: Observations, Analysis and Proposals for Reform* (London: MIND, 1977).

³⁹ Jones, *Asylums and After*, 202.

rights, and *A Human Condition* played an essential role in this vision. It was meant as a guide for legislative reform and not as a document of supranational human rights. It focuses on the plight of British mental patients and abuses arising within the British mental health system.

This is not to say that MIND and its activists were narrowly focused on Britain alone; many of them had international ties and perspectives. Gostin himself was an American lawyer who came to study at Oxford in the early 1970s and then stayed until the 1980s.⁴⁰ Many of the report's critiques of psychiatric practices could and were used to criticize other western mental health regimes especially in the United States. In addition, as will be shown, the language of *A Human Condition* was generally universalistic and based on the assumption that mental patients should be treated equally as a common part of humanity.

Indeed, *A Human Condition* is suffused with a language of rights and a fundamental belief in the common humanity of people regardless of mental condition. Underlying it is a basic assumption that rights are meant for everyone regardless of their mental capacity. This rights-talk was based on a simple and intuitive assertion of fairness and equality before the law. In so far as Gostin explicitly referenced any concrete philosophical justification, he generally called upon a theory of natural rights: all humans are endowed with certain natural rights and it is wrong to take any of these rights away from any particular group.⁴¹ Gostin and MIND's innovation was to include the mentally disabled as worthy of these rights just like anyone else.

From the very beginning of *A Human Condition*, the text uses this rights-based language and highlights MIND's role in promoting awareness of mental patients' rights. In the Preface,

⁴⁰ Anonymous, "Profile Lawrence Gostin — Georgetown Law," 2017, <https://www.law.georgetown.edu/faculty/gostin-lawrence-o.cfm#>.

⁴¹ Gostin, *A Human Condition*, 82.

MIND Director Tony Smythe speaks of mental patients as minorities worthy of rights rather than as sick individuals. He further laments the refusal of society and the government to recognize mental patients as a class in need of the same protections as any other:

In offering a comprehensive plan for reform we are conscious that the rights of vulnerable minorities can only be maintained by the utmost vigilance while the rights of mental patients have yet to receive the attention they deserve.⁴²

Despite disappointment over the lack of awareness of the denial of mental patients' rights, the report also expresses reasons for optimism. Drawing on his experience at the NCCL and MIND, Smythe cites "a rising tide of requests for information, help and advice from patients and social workers alike" as evidence of a growing mental health activist movement.⁴³

Even aside from mental health advocates, Smythe was referring to a growing proliferation of rights talk in political activism. Indeed, he points to the emergence of organizations from a variety of sectors that justified their campaigns and interests in terms of rights and promoted rights as a serious political tool. This sentiment was meant to contrast with activist campaigns of the 1960s which, by and large, did not use rights language to justify its demands especially when those demands came from the radical left.⁴⁴ Smythe's recognition of a greater usage of rights language in the 1970s shows that MIND was aware of the proliferation of rights-based appeals beginning in the 1970s as seen with the emergence of Soviet dissidents and groups such as Amnesty International.⁴⁵

The success and influence of *A Human Condition*, however, was ultimately based on the fact that this rights talk was coupled with a clear program of reform and a package of fundamental

⁴² Ibid., 9.

⁴³ Ibid.

⁴⁴ Moyn, *The Last Utopia*, chap. 3.

⁴⁵ Bradley, *The World Reimagined: Americans and Human Rights in the Twentieth Century*.

solutions that were nonetheless workable within the parliamentary system. As Smythe notes, the hiring of Gostin as a legal advisor indicated that MIND was seeking to use the courts to pressure change to legislation. This tactic was meant to go hand-in-hand with more direct tactics of lobbying and raising awareness of patients' rights to those in power:

Our main aim is to extract the general issues arising from individual experiences and through test cases in the courts and direct representation to official bodies to bring them to the attention of legislators, professionals with statutory powers and administrators.⁴⁶

As he well knew, legislation could not, on its own, bring a fair settlement for mental patients. But changing the law would nonetheless play an essential role in securing the “protective framework of rights” which would ensure a certain standard for patient care upon which further reforms could be fought for.⁴⁷

Following the Preface, the text itself focuses on and critiques three broad areas in mental health: the hospital admissions process, the discharge process, and patients' rights. Gostin begins by noting a sharp divergence between many in the medical profession and the government. While many medical experts in the 1970s were becoming warier of formal institutionalization of mental patients and more supportive of local community care, government officials were slashing funding, closing institutions, and supporting the old asylums. Ever since 1961 when Enoch Powell, the Conservative Minister for Health, delivered his Water Tower speech criticizing asylums, British officials had been officially devoted to a policy of transitioning from prison-like, Victorian asylums to new, local community care facilities.⁴⁸

⁴⁶ Gostin, *A Human Condition*, 10.

⁴⁷ *Ibid.*

⁴⁸ Taylor, *The Last Asylum*, 116.

Patients who lived through the experience of community care would later attest, however, that ‘community care’ acted as a political buzzword to justify cuts to mental health and institutions.⁴⁹ Gostin confirms this when he writes about how Harold Wilson’s Labour government had just announced in 1975 a fifty percent reduction in community care places for the mentally disabled.⁵⁰ For reformers like MIND, ‘community care’ was more than a slogan. At the heart of this new regime would be “reintegration into the community” rather than “confinement in traditional institutions.”⁵¹ Even with a shift in official rhetoric, institutionalization and dwindling funds were the norm at the time of Gostin’s writing.

This brought Gostin to his first area of focus: the institutional admissions process. Under the existing Mental Health Act 1959, there existed two large categories of institutional patients: voluntary and involuntary. For the most part, MIND and mental health activists were concerned with the latter. Nonetheless, as Gostin admitted, involuntary cases had been in the minority for decades. In 1971, 84% of new patients were admitted to a mental hospital voluntarily.⁵² Ever since the passing of the Mental Treatment Act of 1930, the law allowed patients to admit themselves to a mental hospital or asylum on a voluntary basis. This represented a major shift in thinking about the mentally disabled. As was alluded to in the above discussion of mental hygiene, leading experts had associated mental illness with degeneracy and criminal deviance in the early twentieth century. Allowing voluntary admission indicated a shift in how experts began to view mental illness as a strictly medical issue divorced from social deviancy. Of course, in practice, mental illness would

⁴⁹ Ibid., chap. 14.

⁵⁰ Gostin, *A Human Condition*, 14.

⁵¹ Ibid., 13.

⁵² Ibid., 15.

continue to be associated with deviance and crime, but, in the official medical view, the mentally disabled were considered a medical, rather than a social, ‘problem.’

According to the law, voluntary patients willingly chose admission and at all times retained the right to deny treatment and leave on their own will. In the abstract, the existence of this regime reassured lawmakers of the benevolence of the mental health system. In practice, these voluntary patients were denied rights and were in some cases not voluntary at all. First, there was the issue of political and civil rights. Just like involuntary patients, institutional detention denied voluntary patients their most basic rights:

The 1959 Act, however, makes little distinction between the rights of patients admitted by informal procedures and those admitted by compulsory procedures. Informal patients are under the same legal restrictions as formal patients in matters such as court access, voting, obtaining a driving licence, sending and receiving postal packages, and receiving pocket money.⁵³

All patients, including those admitted on a voluntary basis, could have their letters and packages censored and monitored. There was no expectation of a right to privacy or adequate access to and engagement with the outside world through voting, the legal process, or employment.

Although the system of voluntary admissions was presented as benevolent, it ultimately masked a harsher reality. Doctors could work in subtler ways to exercise their authority over patients. While voluntary patients reserved the right to refuse treatment, most patients did not understand their treatment regimens since doctors did not have to provide their patients with relevant information. As a result, doctors, who generally disliked when their prescription authority was defied, faced little opposition and no oversight in matters of prescription regimens. In the face of patients who understood little about their disorder and the necessary treatment to handle it,

⁵³ *Ibid.*, 15–16.

doctors had tremendous authority. Furthermore, doctors exercised large power over the quality of a patient's stay in hospital. Doctors could revoke patient privileges and ultimately change their status to involuntary without oversight. Even when not invoked, the possibility of invoking this power gave doctors substantial psychological authority over voluntary patients.

Indeed, involuntary admission stripped patients of their rights and gave psychiatrists complete control over patients' regimens. Due to the absence of the concept of patient consent in the Mental Health Act 1959, doctors essentially acted with impunity when dealing with patients admitted to hospital involuntarily. As a result, while Gostin and MIND were justifiably concerned about the abuses rife in the voluntary sector of patient care, their main concerns were for involuntary patients. Utilizing rights-based arguments, MIND focused on major concerns such as the right to humane detention, the right to a fair discharge process, and the right to have control over one's treatment regimen.

Involuntarily admitted patients existed at the whim of their psychiatrists in mental hospitals. In terms of treatment regimens, the situation of mental patients in the 1970s was especially dire in this regard because a number of violent and invasive treatment options were available including experimental psychopharmacological treatments, psychosurgery and lobotomization, sterilization, sex hormone therapy, and electroconvulsive therapy or 'shock treatment.'⁵⁴ This was in addition to less physically invasive treatments, such as psychotherapy and the talking cure, which could nonetheless be intensely upsetting in an environment where patients were forced to participate. To have no control over one's own treatment regimen thus

⁵⁴ Ibid., 116 and chap. 10.

entailed a loss of power and control of one's own body and mind and a corresponding empowerment of probing medical experts.

Beyond the chilling prospect of relegating control of one's body to psychiatric authorities, patients faced numerous assertions of institutional control over their daily life. First, patients suffered numerous restrictions on their freedom of speech, association, and movement. Patients had no right to privacy; social workers and doctors were allowed to search their things at all times and all mail in and out of a mental hospital could be censored and retained.⁵⁵ Gostin presented these actions not only as clear infringements of rights, but also as damaging to the mental health of patients. In one section, Gostin argues that mental patients' difficulties conforming to and taking part in society were being amplified by an institutional system that "discourages normal social intercourse with the wider world."⁵⁶

In addition to issues related to freedom of speech and association, Gostin emphasizes the infringements upon patients' rights to free movement and political expression. Patients were not allowed to have driver's licenses. Once brought into care, patients could be moved to any area of the country and, in some cases, even abroad based upon their doctor's wishes.⁵⁷ Once again, medical experts acted with impunity and without oversight: "The patient is without recourse to any independent body, and has no right to state his case."⁵⁸ Even if kept within their parliamentary district, patients could suddenly find themselves unable to vote in elections regardless of their specific mental condition if they could not verify a separate place of residence outside a mental asylum.

⁵⁵ *Ibid.*, chap. 9.

⁵⁶ *Ibid.*, 111.

⁵⁷ *Ibid.*, 103.

⁵⁸ *Ibid.*

The denial of the right to vote was especially confusing because of how it broke down along institutional lines: mentally disabled patients kept in a general hospital were allowed to vote by 1977, but a patient with the same condition in a mental asylum would not be allowed to vote. These restrictions were so contradictory and haphazardly constructed because they were based on fear of mental patients and the effect they had on local communities. Many cities with mental asylums complained that mental patients would not vote ‘correctly.’⁵⁹ During the late 1970s, ensuring the right to vote for mental patients would become one of MIND’s central campaigns, but at this earlier time, Gostin was already condemning it as a severe breach of patients’ rights.

Mental patients also faced severe difficulties in accessing the court system. Patients were disqualified from serving on juries as they were not considered the peers of the able-minded. Under the Mental Health Act of 1959, patients were explicitly barred from bringing criminal cases and lawsuits against their doctors and psychiatrists for their treatment in hospital.⁶⁰ If patients reserved the right to charge their doctors, legislators and medical experts worried that doctors would be constrained in their options. Furthermore, mental patients were not allowed to bring any case to a high court without going through a third party. In framing the issue as a violation of basic natural rights, Gostin was calling upon a well-established language of natural rights in a novel and innovative way by applying them to the mentally disabled who, often by definition in liberal democracies, were not considered rational enough for political participation.

The Mental Health Act included several procedures for involuntarily admitting patients. Under sections 25 and 26, mental hospitals were allowed to forcibly detain patients if admitted by

⁵⁹ Gostin, *Electoral Registration of Patients in Mental Hospitals: MIND’s Observations on the DHSS Consultative Paper*.

⁶⁰ Gostin, *A Human Condition*, 101.

a social worker or the nearest relative with the recommendation of two medical experts. Requiring a second opinion provided legitimacy and reassurance in the admissions process, but medical recommendations were highly problematic. As Gostin revealed, doctors gave their medical recommendations quickly and they often believed that it was safer to admit patients suspected of mental illness rather than release them risking condemnation if the patients harmed themselves or others.

Furthermore, authorities retained a number of ‘emergency powers’ which could be called upon to detain patients without regular oversight. Under section 29, hospitals were given emergency admission powers by which patients could be forcibly admitted with the recommendation of only one doctor. This was a significantly easier procedure and was used in the majority of short-term admissions.⁶¹ As a result, the use of emergency admissions procedures was one of the significant contributing factors to the large number of wrongfully admitted patients in the mental health system. One 1966 study of compulsory admissions procedures calculated that 61% of compulsory admissions were unjustified.⁶²

Also included in the act were certain police powers for detaining those suspected of mental illness without any formal suspicion of wrongdoing or the consent of the patient, their nearest relative, a social worker, or even a doctor. Under the much-criticized section 136, police retained the power without warrant to move mentally disordered persons in public to a ‘place of safety’ such as a police station or a hospital for 72 hours. Similarly, under section 135, police could obtain warrants to detain ‘mentally disordered persons’ for 72 hours even if they were not in public. Police frequently abused these sections; about 1 in 50 mental patients in London were

⁶¹ Ibid., 28–31.

⁶² Ibid.

compulsorily admitted under section 136 alone.⁶³ In many cases, the patients had no history of mental illness and displayed no violent behavior. One particular case that later went to court, *Carter v. Commissioner of Police of the Metropolis*, showed how an individual with no history of mental illness and displaying no signs of danger or disorder nonetheless could be forcibly removed from her residence and kept involuntarily in a mental hospital.⁶⁴ Against all of these police powers, Gostin and MIND asserted the rights of mental patients and argued that these powers constituted a violation of *habeas corpus*.

Broadly speaking, two types of forcible detention existed under the Mental Health Act: limited and unlimited detention. Under section 25, patients of any age or mental disorder could be held for a period of 28 days for observation without treatment. After 28 days, a patient had to be released or detained indefinitely under section 26. On the other hand, section 26 permitted authorities to hold patients in hospital indefinitely depending on their type of mental disorder. The specific type of mental disorder thus had strong legal consequences.

As a result, the creation of legal-psychiatric categories is a central concern of the Act. Indeed, the Mental Health Act of 1959 was surprisingly the first piece of British legislation to even define a mental disorder.⁶⁵ Broken down even further, mental disorder consisted of four categories each with their own special legal consequences: ‘mental illness,’ ‘subnormality,’ ‘severe subnormality,’ and ‘psychopathic disorder.’ These definitions were heavily self-referential, vague, and internally unintelligible. The latter three categories are defined in the legislation in comparison with mental illness, yet mental illness itself is never defined. Where definitions of mental disorder

⁶³ *Ibid.*, 31.

⁶⁴ Gostin, *A Human Condition*, 31

⁶⁵ Mental Health Act 1959, s. 4(1).

are explicit, they are always defined in terms of incomplete development and difference from preconceived notions of normality which are also never defined. As is clear from its normative title, the category of severe subnormality, which is defined before any others in the Act, is characterized by inferiority, incompleteness, and inability in relation to undefined norms:

‘Severe subnormality’ means a state of arrested or incomplete development of mind which includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation or will be so incapable when of age to do so.⁶⁶

The legislation then defines subnormality as a lesser degree of ‘severe subnormality’ in which a patient is of a state of mind which "requires or is susceptible to medical treatment or other special care or training of the patient."⁶⁷

Finally, the category of ‘psychopathic disorder’ is defined the most arbitrarily and strangely. While the other categories appear generally medical, ‘psychopathy’ is distinguished by a social element namely the inherently aggressive nature of the patient:

‘Psychopathic disorder’ means a persistent disorder or disability of mind which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and which requires or is susceptible to medical treatment.⁶⁸

Nonetheless, of these four, mental illness and severe subnormality were considered the most serious. This had important legal consequences because anyone defined as mentally ill or severely subnormal could be detained indefinitely at any age under section 26. Meanwhile, patients diagnosed as subnormal or psychopathic could not be detained indefinitely. The exception was if the patient was under 21; in this case, patients considered subnormal or psychopathic could be held in hospital without consent until the age of 25. Doctors could reclassify patients at any time.

⁶⁶ Mental Health Act 1959, s. 4(2).

⁶⁷ Mental Health Act 1959, s. 4(3).

⁶⁸ Mental Health Act 1959, s. 4(4).

Theoretically, this meant that a patient indefinitely detained for severe subnormality had to be released if reclassified as psychopathic or subnormal. In practice, this changed with the Mental Health (Amendment) Act of 1975 which gave doctors the authority to continue the indefinite detention of psychopaths and ‘subnormal’ patients if they were considered dangerous.

The Mental Health Act’s insistence on clear categories of mental illness is consistent with and indicative of its medicalizing worldview which privileged the authority of medical expertise over the lives of patients. Attacking this faith in medical expertise was at the heart of MIND’s mission. In doing so, Gostin criticized both faith in medical expertise as well as institutions in general. Drawing upon antipsychiatry, Gostin flatly argues that “psychiatrists cannot make reliable diagnoses under normal clinical conditions.”⁶⁹ Citing a number of institutional studies, such as the Rosenhan experiment, he explicitly casts doubt on the ability of psychiatrists to make any verifiable diagnoses.⁷⁰ Arguing for the socially constructed nature of mental disorder, Gostin pointed to three types of error amongst psychiatrists: they disagree amongst each other about how to diagnose a patient, they make different diagnoses of the same patient on different occasions, and they make assumptions about patients’ health based on stereotypes of patients’ gender, race, or culture. Gostin expands on this last point and points out that doctors frequently pathologize women for breaking gender roles and racial and cultural minorities for their particular practices. Rather than scientific rigor or empirical validity, Gostin depicts psychiatry as a discipline based on assumptions and stereotypes.⁷¹

⁶⁹ Gostin, *A Human Condition*, 37

⁷⁰ Gostin, *A Human Condition*, 39

⁷¹ Gostin, *A Human Condition*, 35

Gostin rolled this criticism of medical expertise into a larger critique of what mental health activists called ‘institutionalism.’ Drawing upon Erving Goffman and Michel Foucault, Gostin and MIND defined this term as a “learned helplessness” leading to “loss of motivation, withdrawal, apathy, submissiveness and an inability to make decisions.”⁷² Ultimately, patients became unable to integrate back into society after long periods of conforming to institutional life. While mental health activists did not deny that many patients experienced real mental troubles regardless of how these were perceived or processed by doctors, their emphasis on the dangers of institutionalism amounted to a sustained attack on the entire existing mental health establishment. Mental institutions themselves were harming their patients. This argument formed the basis for MIND’s ultimate goal of instituting community care and revealed MIND’s holistic view of reform encompassing patients’ health, rights, and consent as well as a fundamental critique of assumptions at the heart of western medicine and law.

The final major issue covered by Gostin in *A Human Condition* is the procedure by which patients are discharged from hospital. Per the Mental Health Act, mental patients supposedly had recourse to quasi-judicial panels called Mental Health Review Tribunals (MHRT). In the end, though, the real power for discharge came down to the Home Secretary rather than the MHRTs. Although MHRTs had authority to recommend discharge, the Home Secretary exercised the power at all times to release and recall patients at will.⁷³

Nonetheless, the MHRTs were the only recourse available to certain involuntary patients. These MHRTs were open solely to involuntary patients who would apply if they believed their mental condition did not warrant involuntary, indefinite detention. Under the NHS Act of 1946,

⁷² Gostin, *A Human Condition*, 13

⁷³ Mental Health Act 1959, s. 66.

fifteen Mental Health Authorities existed throughout England and Wales each with their own MHRT. These fifteen tribunals were therefore responsible for the tens of thousands of involuntary patients who might at any time apply to have their cases heard. Each tribunal had three members: a medical expert, a legal expert, and a lay advisor who usually came from a strong local organization like a trade union or a school. The Lord Chancellor appointed each member from a pool of about 500 candidates; in May, 1975, 89 legal members, 242 medical members, 192 lay members were available for selection.⁷⁴

Despite the vital roles they played in determining the very existence and lives of mental patients, the work was part-time. Given that most members would be coming from the upper-middle class professions, such as lawyers and doctors, the pay was generally bad ranging from £10.50 per day for lay members to about £40 per day for medical and legal experts.⁷⁵ As a result, the Tribunals were notoriously variable in their quality and interest in taking up cases seriously. As Gostin reported, "It is a common observation that tribunal members, because they hold part-time positions which are not regarded as particularly prestigious, are variable in quality. There are marked differences in the way cases are conducted and decided."⁷⁶ One result of this poor quality was significant wait times for cases. Patients generally waited a minimum of two to three months to ever hear back from a Tribunal. Waits exceeding a year were common enough to be unsurprising in some regions.⁷⁷ Under section 123 of the Mental Health Act, MHRTs exercised only one authority: the ability to recommend complete discharge. This was one of the more seriously lacking aspects of the Tribunals. Patients who objected to their treatment or the conditions of their stay

⁷⁴ Gostin, *A Human Condition*, 58

⁷⁵ Gostin, *A Human Condition*, 58

⁷⁶ Gostin, *A Human Condition*, 58

⁷⁷ Gostin, *A Human Condition*, 74-75

had no recourse at all through the MHRTs or any other system. MHRTs were not even allowed to conditionally or provisionally discharge patients.

Nonetheless, very few patients ever had the right or possibility to contest their case. Indeed, only a slim minority of involuntary patients would ever even have the chance to appear before an MHRT. As Gostin writes, "A substantial majority of the persons who enter a mental hospital against their will are given no right or opportunity to present their case to an MHRT or any other independent authority."⁷⁸ Involuntary patients on 'short-term' detention were not allowed to submit applications even though they made up a large section of the involuntary population and their stays could in fact stretch on for months if their doctors wished it. The result, as Gostin explains, was that "the patient who is wrongfully admitted under a short-term compulsory order has no effective legal means of regaining his liberty."⁷⁹ This affected a large number of patients since "only 2,279 (8%) of the 27,860 persons who were compulsorily admitted to hospital in 1971 had the right to apply for an MHRT."⁸⁰

Involuntary patients who did have the nominal right to access the MHRTs were nonetheless in little better position. The vast majority of patients who could apply to a Tribunal never did. Some who did would still never get the opportunity. For example, of the roughly 28,000 involuntary patients admitted in 1971, "less than 1,092 (4%) actually applied for a tribunal; and less than 990 (3.5%) actually had their case heard by a tribunal."⁸¹ In sum, 96% of eligible patients never had their case heard before an MHRT. The overall effect of this system meant that the vast majority of patients were serving indefinite sentences in hospitals without ever having their cases

⁷⁸ Gostin, *A Human Condition*, 67

⁷⁹ Gostin, *A Human Condition*, 67

⁸⁰ Gostin, *A Human Condition*, 66

⁸¹ Gostin, *A Human Condition*, 66

reviewed. Even for patients whose conditions warranted treatment, the lack of a compulsory review system once again empowered doctors and medical institutions at the expense of patients.

For his own part, Gostin attributed the low number of applications to faults within psychiatric care. He particularly emphasized the failure of hospital staff to inform patients of their rights and the stultifying effects of institutional authority. Of these two, Gostin preferred the latter and once again wrote strongly about the subtle, ever-present power of psychiatrists over their patients:

The resident is under the strict implied authority of the medical regime. In both formal and informal ways, the institution fosters submission to psychiatric authority. The patient is not likely to question the authority of a person who controls so much of his liberty and life.⁸²

In both indirect and open ways, doctors discouraged patients from applying as this marked a profound challenge to medical expertise and authority. Here again then, Gostin appealed to the deleterious effects of ‘institutionalism’ to explain why patients who had the ability nonetheless never would appeal to the MHRTs.

For patients who did get a trial, discharge rates varied wildly depending on one’s region. Statistics from 1974 show that zero patients in North Western England were discharged after a Tribunal procedure. The region with the highest discharge rate was the Southwest Thames region with 38%. All told, in 1974, English and Welsh regions averaged a 20% discharge rate out of 560 cases.⁸³ While regional variations might be expected, such large disparities point to a lack of consistent quality and commitment from the regional MHRTs.

In addition, the Tribunal meetings themselves were rife with problems and rights violations. Mental hospitals and MHRTs were under no obligation to publish or provide relevant

⁸² Gostin, *A Human Condition*, 68

⁸³ This study is cited in Gostin, *A Human Condition*, 96-99.

information for the trial. As a result, patients lacked information vital for conducting their defense. As hospitals did not have to make their own information about patients available, they could distort and spin patients' medical histories. Gostin argues that this frequently happened as hospitals were incentivized to keep their patients and not risk discharging 'potentially dangerous' individuals.⁸⁴ In addition, reporters were not allowed to report on proceedings so there was little public accountability.

During the actual trial, patients were not allowed to present evidence basic to other judicial procedures. Patients were not allowed to bring in witnesses or see the evidence against them from medical authorities. Hospital staff could also prevent patients from going to the MHRT on the day of the trial if they could provide any medical justification. Hospital staff were rarely challenged in this regard and Gostin reports instances when staff prevented patients from attending because they condescendingly believed it would be upsetting. Furthermore, most patients lacked the funds for any kind of representation even though the issues dealt with were extremely difficult and the law was quite complicated. MIND provided one of the few resources in this regard due to its Legal and Welfare Rights Service providing specially trained lawyers to patients who needed it.

As an alternative, Gostin supported rewriting admission rules and creating the possibility of a mandatory review process for the protection of patients' rights and their ability to give consent. This would be an ongoing review of every patient over the course of their stay in hospital with the first meeting occurring within ten days of admission. In addition, short-term detention would be abolished in favor of formal admissions so that every involuntary patient would have access. Every involuntarily admission would require recommendation from a social worker and two medical

⁸⁴ For a description of Tribunal procedure and his criticisms, see Gostin, *A Human Condition*, chap. 7.

experts and nearest relatives would lose their ability to admit. All of this was designed to create more accountability and counteract the possibility of too much power ending up with one doctor of the families of mental patients.

In one form or another, such proposals would find widespread acceptance in the 1980s. Yet in 1975, Gostin and MIND's criticisms and proposals made a large splash with little headway. After the publication of *A Human Condition*, a series of events demonstrated a growing political consciousness about mental health reform. Much of the early response was negative because of Gostin's sympathy for mental patients who were considered by many to be dangerous. Some critics were quick to criticize MIND and *A Human Condition* for fighting for mental patients' rights at a time when public fear of mental patients was high. As a *Times* correspondent wrote in November 1975:

The public still has very much in mind several recent cases in which former mental patients have committed serious crimes on release, or have been officially dealt with in ways that offend popular ideas of retribution and the protection of society.⁸⁵

Such thinking was by no means new. The assumption that the mentally disabled were criminal and deviant had a long history and, as was referenced above with the 1969 issue of the *Times*, could be found regularly in the major periodicals of the day. As a result, this correspondent from 1975 concluded that it was "an unlucky time for the appearance of the MIND report [*A Human Condition*], which is based on the thesis that the rights of mental patients [...] are insufficiently secured."⁸⁶ For many people of the time, mental illness constituted a public threat and, as such, the rights of mental patients were of less concern than society's immediate safety.

⁸⁵ Anonymous, "The Total Banishment Of Bedlam," *The Times*, November 3, 1975, The Times Digital Archive.

⁸⁶ *Ibid.*

Nonetheless, MIND's proposals still made waves in Parliament and actually led to serious considerations of reform. After *A Human Condition*'s publication, Gostin and MIND made steady progress pressuring the government for major legislative and administrative reforms. A major victory came in 1976 when the Labour government appointed David Ennals, MP for Norwich North, to become Secretary of State for Social Services. Ennals, a Labour MP serving non-consecutively since 1964, had been Director of MIND at the time of the publication of the "MIND Manifesto" in 1971. His appointment signaled the growth of a political consciousness about the possibilities of mental health reform.

Due to the similarities Gostin had brought out between imprisonment and the indefinite detention of mental patients, the political debate anxiously focused on reforming the MHRTs and opening up possibilities for discharge.⁸⁷ After Ennals' appointment in 1976, the Labour Party published a major green paper outlining the different possibilities for legislative reform of the Mental Health Act. As ideas were being debated in Parliament, government officials, including Lord Butler of the Butler Committee on Mentally Abnormal Offenders, met at Church House, Westminster on February 10, 1977 to specifically debate MIND's proposals as set forth in *A Human Condition*.⁸⁸ Then, in September 1977, Secretary Ennals held a conference in preparation for the publication of an official White Paper on mental health reform which would appear in 1978.⁸⁹ A number of reforms were promised but the main thrust focused on compulsory detention and opening up opportunities for discharge.

⁸⁷ Staff Reporter, "Plans for New Mental Health Law 'Inadequate,'" *The Times*, September 26, 1977, The Times Digital Archive.

⁸⁸ Medical Correspondent, "Law Changes Urged for Mentally Ill Offenders," *The Times*, February 10, 1977, The Times Digital Archive.

⁸⁹ Staff Reporter, "Plans for New Mental Health Law 'Inadequate.'"

Nonetheless, these reforms were somewhat vague and Gostin declared them “inadequate.”⁹⁰ Up to now, Gostin had made little use of human rights language. Though his beliefs certainly shared many of the assumptions of human rights, his focus on domestic reform complicates this interpretation of his thought. Some authors have indeed interpreted *A Human Condition* as a human rights document.⁹¹ Yet rather than ‘human rights,’ Gostin had preferred using ‘natural rights’ to describe the inalienable rights of patients.⁹² Already in *A Human Condition*, however, Gostin was setting his sights higher to the possibilities of using human rights institutions to make serious legislative progress. In one passage on the inability of patients to contest their detention, Gostin specifically pointed to the European Convention on Human Rights as a document which defined the rights of all people: “The absence of a forum in which to contest the deprivation of liberty is inimical to conventional standards of justice, such as those enunciated in the European Convention of Human Rights (1950).”⁹³ This was a limited reference; Gostin was citing the ECHR as a ‘standard of justice’ rather than as a human rights document per se.

Nonetheless, the reference pointed to Gostin’s growing awareness of the possibilities of using human rights institutions and language. This trajectory would only strengthen as Gostin and MIND found themselves frustrated with the pace and scale of change in the mid to late 1970s. Indeed, with major cases opening up at the European Court of Human Rights related to mental patients, a number of new opportunities were emerging on the international stage which would allow for domestic reform. This shift away from Britain and domestic reform towards Europe and human rights was in part just a change in a long-term strategy of achieving reform. Yet in the face of a stalled domestic situation, reconstituting mental health activism in international terms

⁹⁰ Ibid.

⁹¹ Jones, *Asylums and After*.

⁹² Gostin, *A Human Condition*, 82.

⁹³ Gostin, *A Human Condition*, 67

presented not only a new opportunity but a possibility for swift change. With Britain a signatory to the ECHR, a ruling from the European Court would force the changes that MIND wanted to see. With this in mind, MIND began accepting a number of European cases lodged by British mental patients in the mid-1970s. One of these in particular, however, would have lasting significance and bring fundamental reforms to British law and psychiatric practice.

4. *X. v. the United Kingdom* and its Effects

The roots of the *X. v. the United Kingdom* case stretch back to 1965 when an anonymous 31-year-old working-class Sheffield man began suffering from paranoid delusions.⁹⁴ Referred to in all available documents as ‘X,’ he spent several days in 1966 in a mental hospital. At this time, doctors diagnosed him as suffering from paranoid psychosis meaning that he could not be held indefinitely under the Mental Health Act. He soon left and, over the course of the next two years, divorced his first wife and remarried. He experienced few problems until 1968 when he began suspecting his friends and fellow workers of a conspiracy against him. One day, X overheard a conversation by a coworker that he took to be conspiratorial. When X confronted this man on 26 August, he denied any knowledge of a plot and, as a result, X flew into a paranoid rage and bashed the man with a heavy wrench fracturing his upper jaw and damaging his teeth and lips. X was promptly arrested under section 18 of the Offences Against the Person Act 1861.

On 22 October, X pleaded guilty and, after a week of psychiatric review, a medical expert confirmed his earlier diagnosis of paranoid psychosis.⁹⁵ As a result, on 7 November, the court invoked sections 60 and 65 of the Mental Health Act 1959 to detain X indefinitely in Broadmoor

⁹⁴ All relevant details of the case and X’s life can be found in: *X. v. the United Kingdom*, judgment of 5 November 1981, Application 7215/75 and *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*. These titles will be shortened appropriately.

⁹⁵ *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*, 20.

Hospital in Berkshire. Designed in the Victorian era, Broadmoor has been notorious for its antiquated, prison-like design. Nonetheless, over the course of a three-year stay there under the supervision of a Doctor Udwin, X showed strong improvement. Upon a positive recommendation from Udwin, the Home Secretary agreed to release X on 19 May 1971. Until 1974, X lived a normal working-class life and found work in the then-thriving Sheffield steel industry to support his new wife and son. On condition of his release, X met regularly with a probation officer and attended an out-patient clinic. Looking back on this period, the European Court’s official judgment later reported that he had “appeared adequately to adjust to normal life [and] he committed no criminal offence.”⁹⁶

Nonetheless, on 5 April 1974, the police arrested X and recalled him to Broadmoor for indefinite detention. Citing Section 66 (3) of the Mental Health Act, the Home Secretary’s office would later argue that X’s release in 1971 was a conditional discharge and that the Home Secretary retained the right to recall X at any time. As would be revealed much later, the Home Secretary issued this new warrant for arrest upon recommendation of X’s probation officer. The trouble arose from complaints made by X’s wife who reported he had become threatening and delusional and had begun drinking heavily and using foul language. Once the probation officer learned that she was planning on leaving X, he made the recommendation for immediate recall understanding X’s previous history with violent outbursts.⁹⁷

While the recall may have been justified for the safety of X’s wife, the government refused to give any explanation or justification for the recall to X of his legal defense.⁹⁸ Instead, the government consistently argued that the recall was justified entirely under its own authority

⁹⁶ *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*, 20

⁹⁷ *X. v. the United Kingdom*, judgment of 5 November 1981, 9.

⁹⁸ *X. v. the United Kingdom*, judgment of 5 November 1981, 9.

without any pretext needed. Immediately after arriving at Broadmoor, therefore, X instructed his counsel to file for a writ of habeas corpus since he was unable to access the courts directly under the Mental Health Act. On 24 May, the Divisional Court heard X's case but, with no official justification for the arrest from the government, was unable to make a decision. After the Court applied pressure to the Home Office, the government finally explained that X had been recalled upon recommendation from his probation officer yet provided no further information. As X's counsel reported, "Although enquiries have been made, no information has been obtained [...] so that it is difficult for the applicant or his advisers to know whether there was sufficient justification for the course taken by the Home Secretary."⁹⁹

On 18 June, the Divisional Court met again and, at first, X appeared to have the upper hand. The government's justification of 31 May was weak and X was able to bring to the trial three letters from workmates, all reporting him to be a perfectly "normal" person, and two positive medical recommendations from doctors who had dealt with his condition ever since being discharged in 1971.¹⁰⁰ Nonetheless, without publishing any clear justification themselves, the Divisional Court rejected his writ of habeas corpus saying only that the probation officer had full authority to issue a recall. No attempts were made by the Court or the government to justify the deservedness of X's recall only that the government possessed the power under the Mental Health Act to do so. As the European Court would later summarize:

The habeas corpus proceedings did not fully investigate the merits of the Secretary of State's decision but had to accept the legality of it as it was made in accordance with the provisions of the Mental Health Act 1959. These provisions gave the Home Secretary absolute discretion to recall the applicant, whether or not the conditions for release had been observed.¹⁰¹

⁹⁹ *X. v. the United Kingdom*, judgment of 5 November 1981, 10.

¹⁰⁰ *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*, 21-22

¹⁰¹ *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*, 22

Essentially, the courts agreed with the government's argument that it did not require a justifiable cause when detaining former mental patients. While X's case was somewhat unique amongst mental patients given that he had originally faced criminal charges, the recall in 1974 was justified by X's status as an ex-patient rather than an ex-criminal. Empowered by the Mental Health Act, the government had full legal authority to recall any former patients to an asylum at any time. Furthermore, the Divisional Court's ruling established that mental patients had no right to hear their reason for recall or the evidence provided against them.

After the 1974 ruling, X had no further recourse through the British Courts. The decision was final and he returned to Broadmoor for involuntary, indefinite detention. As such, he was subject to the same restrictions on his rights that Gostin had listed in *A Human Condition*. Yet the legal struggle was not over. On 14 July, merely two weeks after losing his case at the Divisional Court, X lodged an application to the European Commission of Human Rights.¹⁰² In its final report submitted on 16 July 1980, the Commission reported that X claimed "that he was not mentally ill, that his recall was unjustified and that he had no effective way to challenge the decision, as it rested entirely with the Home Secretary."¹⁰³

In particular, X and his counsel appealed to Article 3 and Article 5 sections 1, 2, and 4 of the European Convention on Human Rights (ECHR). They argued that his recall to Broadmoor violated the prohibition against cruel punishment in Article 3 which states that "no one shall be

¹⁰² The European Court system is notoriously complex and difficult to understand. Signed in 1950, the European Convention on Human Rights is binding on all members of the Council of Europe and calls for a court with jurisdiction over all Council members. From the opening of the Court in 1959 until reforms carried out by Protocol No. 11 in 1998, there existed a two-tiered system: the European Commission on Human Rights and the European Court of Human Rights. The Commission played a filtering role deciding which cases would proceed to the Court. Individual petition was first made possible in Britain in 1966. For the Commission's final report published in 1980, see *X. against United Kingdom*, Report of the Commission of 16 July 1980, Application 6998/75.

¹⁰³ *X. against United Kingdom*, Report of the Commission of 16 July 1980, 1

subjected to torture or to inhuman or degrading treatment or punishment.”¹⁰⁴ In addition, they argued that his arrest had violated Article 5 on several grounds because 1) his detention was unjustified under section 1, 2) he was not given any reason or legal cause for his arrest as required by section 2, and 3) he had no recourse to a fair procedure or speedy trial as set forth in section 4. Article 5 in general deals with “the right to liberty and security of person” and section 1 details what conditions must apply for an individual to lose their freedom. Under Section 1, subsection e, the Convention states that “persons of unsound mind” can be lawfully detained. In reply, X and his counsel argued that X was by all accounts of sound mind in 1974 at the time of his recall and that his recall therefore constituted a human rights violation.

Furthermore, X claimed that the government had violated his human rights under section 2 which states, “Everyone who is arrested shall be informed promptly in a language which he understands, of the reasons for his arrest and of any charge against him.”¹⁰⁵ The government had never made their reasons for recall public. Instead, they simply appealed to the authority of X’s probation officer and the powers granted by the Mental Health Act. X’s last submitted rights violation invoked section 4 which states that “everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.”¹⁰⁶ This put the entire MHRT system on trial. X was accusing the Tribunal system of being completely inadequate and constituting a human rights violation for denying patients’ rights to a fair, speedy trial and the possibility of release.

¹⁰⁴ European Convention on Human Rights, Art 3

¹⁰⁵ European Convention on Human Rights, Article 5 (2)

¹⁰⁶ European Convention on Human Rights, Article 5 (4)

Up to this point, little has been said about the role of MIND in X's case because it is simply not clear from the available records when exactly it became involved in the case. As part of its shift to legal advocacy, MIND and Gostin had taken up a number of European Commission cases by 1977. One other particularly promising case was also entitled *X v. the United Kingdom* and involved an Irish mental patient detained at Broadmoor in 1973 who had been kept in isolated, cold, and appalling conditions.¹⁰⁷ Although important, this case largely met little lasting success. Ultimately, the *X v. the United Kingdom* involving the anonymous Sheffield man would have the most lasting significance. Nonetheless, by examining court documents and the oral arguments of X's counsel, it can be inferred confidently that MIND was not involved with the original British case or the original application to the European Commission.

By the time the case actually appeared before the Commission, however, both Larry Gostin and Tony Smythe were present to represent X. MIND, therefore, were quick to grab onto the case since they realized it would potentially have a revolutionary effect on British legislation. If found culpable of even one human rights violation in the case, the British government would be under immense pressure at home and from Europe to make fundamental changes. The case fit perfectly into MIND's new legal advocacy campaign and marked a turn away from seeking change through parliamentary legislation. In addition, embracing the possibilities of the ECHR and the European Court marked a shift in strategy towards human rights which would ultimately be successful.

Indeed, MIND, especially Gostin, played central and eager roles in the case. Gostin provided X's counsel a deep knowledge of British mental health legislation and psychiatry as demonstrated in *A Human Condition*. As is clear from available oral arguments, X's counsel was

¹⁰⁷ *X. v/ the United Kingdom*, Decision of the Commission of 12 May 1977, Application 6840/74.

limited in its knowledge of the mental health system and only saw X's case in a limited, individual basis. As X's original lawyer, TM Napier, would later say at public hearings before the European Court:

Although the case of X was not brought by MIND, I should like to acknowledge the assistance I have received from Mr. Gostin, whose special knowledge has been invaluable in placing the individual application into perspective as it relates to restricted mental patients generally.¹⁰⁸

While perhaps not the original bringers of the case, Gostin and MIND thus played an essential role in the ultimate success and framing of the case.

Despite the severity of the charges, the Commission was slow to take up the case. While X submitted his application on 14 July 1974, the Commission did not even register the case until 2 May 1975. Even then, it was not until 11 March 1976 that the Commission finally deliberated on the case's admissibility. At this time, the Commission ruled the violation of Article 3 to be inadmissible since X could not produce any evidence of degrading and inhuman treatment.¹⁰⁹ At the same time, however, the Commission ruled that the applications under Article 5 were reasonable enough to request responses from X and the government. The government submitted theirs on 11 May and 25 August while X and his counsel submitted on 24 September 1976.¹¹⁰ After reviewing these submissions, the Commission decided in March 1977 that oral hearings were merited. The Commission scheduled the first of these hearings for 11 and 12 May 1977. In the meantime, much had happened in X's life. In December 1975, X went before a Mental Health Review Tribunal after almost 17 months of detention at Broadmoor. Although still displaying

¹⁰⁸ *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*, 103

¹⁰⁹ For the specific ruling, see *X. against United Kingdom*, Report of the Commission of 16 July 1980, Appendix II in *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*, 48-53

¹¹⁰ For a history of proceedings before the Commission, see *X. against United Kingdom*, Report of the Commission of 16 July 1980, Appendix I in *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*

some symptoms of delusional psychosis, this condition, as previously noted, did not justify indefinite detention. Nonetheless, the Tribunal required him to demonstrate that he was not a danger to society. He was successful in this regard and, as a result, convinced the Tribunal members to grant him supervised leave in February 1976. In July of the same year, perhaps under pressure from the Commission case, the Home Secretary approved his formal discharge.¹¹¹

As a result, he was living a somewhat free existence by the time his case finally came to its first hearings at the Commission in May 1977. With Gostin and MIND present, the May hearings represented a major change even though MIND likely played an important advisory role before this point. Another change was the presence of the British government's representatives including a team of top-rate lawyers and the head of Broadmoor Hospital. Despite having already waited for three years to speak at the Commission, however, the May hearings merely marked the beginning of another three-year-long period of hearings, formal submissions, and Commission deliberations ending on 16 July 1980. These included additional submissions by the government on 2 May and 25 September 1978 and X's counsel on 12 and 13 April 1979. Tragically, X would not live to see the end of this series of trials as he died on 17 January 1979 at the early age of 44.¹¹² The cause of death is unclear, but X had lived a troubled life of mental disability, extensive manual labor, and intermittent long-term detention in mental asylums which all likely contributed to his early death. As a result, the Commission moved to drop the case, but, after an intercession by X's sister, it decided to retain the case.

Unfortunately, many important documents, reports, and verbatim records of Commission and European Court proceedings, which would provide a glimpse of the specific content of each

¹¹¹ *X. against United Kingdom*, Report of the Commission of 16 July 1980, 23

¹¹² *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*, 16

hearing and submission, are unavailable. On 24 September 1984, the President of the European Court ordered these not to be published or made public in accordance with X's wish for anonymity.¹¹³ The European Court allowed some of its oral arguments and proceedings to be published, but the Commission was more protective. Nonetheless, the Commission included the content of each side's arguments as well as its own final deliberations in its final 1980 report. Based on this report, X and his counsel stuck to their arguments alleging that his recall was unjustified because he was mentally sound, he was never given a reason or charge for his recall, and there was no recourse to a speedy trial and release process.¹¹⁴ The government's response largely focused on denying X's fundamental claims and asserting its legal authority to act as it had in X's case. In doing so, it often relied on confusing tactics such as challenging the Commission's understanding of the ECHR and putting forth multiple, sometimes contradictory justifications for its actions.

The first point to address was X's claim that Article 5, section 1, subsection e did not justify his recall in 1974 since he was not of "unsound" mind at the time. The government decided to avoid the issue and simply claim that the entire case was a criminal rather than a mental health concern. As such, they appealed to Article 5, section 1, subsection a, which grants governments the right to restrict criminals' rights to liberty, and argued that X had been a criminal since his arrest in 1968. Any release since then was a criminal's parole and, as such, the government argued that X's recall was justified as a parole violation. In so doing, the government consciously called upon a more stable ground for justification because it could not prove that X had really been of

¹¹³ *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*, 243

¹¹⁴ *X. against United Kingdom*, Report of the Commission of 16 July 1980, 11-14

unsound mind. Nonetheless, the government also argued perplexedly that X's recall was justified for mental health reasons as well.

Using strikingly ominous language, the government claimed that it was right for the Home Secretary to have full authority at any time to make assessments of patient health and essentially recall or release patients at will. The government therefore had decided to try and cover all of its bases by asserting the rights to recall both paroled criminals and ex-mental patients. That inmates and patients could be considered together on such similar terms was certainly a vindication of Gostin's rhetoric from *A Human Condition*. This strategy also indicates that the government viewed X as both a criminal and a mental patient. In both cases, the government was confident in its legal authority to recall X as it had.

In its subsequent replies, the government continued to appeal to legal authority and power rather than rights or simple morality in its justifications. When dealing with Article 5, section 2, the government claimed that it was not necessary to tell ex-patients why they were recalled to a hospital. All that was necessary was explaining the "legal authority for the arrest."¹¹⁵ Similar to its earlier argument, the language used here seems almost authoritarian and the government seems to have recognized this dilemma in its concluding remarks on the subject. To combat this, the government reframed the issue as medical rather than legal. Arguing that mental patients present a potentially violent and uncontrollable danger, the government claimed it was the duty of medical doctors, rather than police officers or legal officials, to explain the reason for a patient's recall even if this recall had been carried out for legal reasons by legal officials. In either case, the government essentially denied patients' rights to know why they were being detained in hospital.

¹¹⁵ *X. against United Kingdom*, Report of the Commission of 16 July 1980, 15

Obviously, there is a contradiction here between claiming that mental patients have no right to learn the reason of their detention but medical officials have a duty to explain this reason. Beyond this, however, such reasoning goes back to the faith in medical expertise that Gostin criticized so heavily. Assuming that doctors should have full authority over their patients, issues of patient consent and patients' rights ultimately disappear in favor of legal and medical authority.

In its final arguments against violation of Article 5, section 4, the government made its most confusing and hostile arguments. Sidestepping the entire debate about Mental Health Tribunals, the government flatly denied that mental patients had any human rights to a periodic review of their detention or whether their mental state necessitated detention. Instead, it claimed that patients only had the right to an initial review of their mental state and of the legitimacy of their detention. After this, any subsequent recalls or periods of detention were legitimate if they were the will of the Home Secretary. In the case of X, the government therefore argued that "the applicant's court conviction and committal in 1968 provided sufficient juridical authority for any subsequent recall."¹¹⁶

The government seems to have missed the point since it argued that patients and inmates could always apply for a writ of habeas corpus if they were improperly detained. Yet this would do nothing for mental patients who had not gone through the criminal justice system. For those others who had like X, a writ of habeas corpus would be absolutely useless if patients wanted to argue before a court that their condition no longer justified detention or that the quality of their detention was commensurate with their condition. These arguments appeared particularly weak at the time and, in the oral arguments, the government was forced into an embarrassing debate with

¹¹⁶ *X. against United Kingdom*, Report of the Commission of 16 July 1980, 16

the European Commission on Human Rights on what the articles of the ECHR actually meant. As the Commission summarized at one point, “The government rejected the Commission’s apparently different interpretation of Art. 5(4).”¹¹⁷ Essentially, the government was trying to explain the ECHR to the ECHR’s judicial body. Unsurprisingly, the Commission would therefore reserve its sharpest criticisms of the government’s arguments for this section.

Indeed, after the government had presented on this final issue, the Commission was free to make its own decision. Its first closing deliberations occurred on 5 and 8 December 1979 and it then met further on 11 March 1980 before making a final vote on 13 May and 16 July 1980. At these sessions, the Commission rejected the government’s argument that X was a paroled criminal inmate whose rights could be removed under Article 5, section 1, subsection a. The Commission instead made the vital distinction that X was a mental patient because he had been committed to a hospital for treatment rather than to a jail for punishment.¹¹⁸ As a result, the Commission understood that the issue at hand was whether X was of unsound mind at the time of his recall: “To avoid arbitrary detention, it must be shown that there is objective medical evidence of the detainee’s mental disorder, warranting compulsory confinement.”¹¹⁹ As such, the Commission agreed that there had been a “serious risk of [...] an unjustified deprivation of liberty” since X’s alleged unsoundness of mind was not based on any formal medical review.¹²⁰ Nonetheless, the Commission was ultimately swayed by the legal authority of X’s probation officer and the fact that, at his Mental Health Review Tribunal meeting in December 1975, it was ruled that X still required medical supervision due to the seriousness of his disorder. As a result, the Commission

¹¹⁷ *X. against United Kingdom*, Report of the Commission of 16 July 1980, 17

¹¹⁸ *X. against United Kingdom*, Report of the Commission of 16 July 1980, 20

¹¹⁹ *X. against United Kingdom*, Report of the Commission of 16 July 1980, 22

¹²⁰ *X. against United Kingdom*, Report of the Commission of 16 July 1980, 23

ultimately decided that X had been of unsound mind and that his recall was therefore legal under both the ECHR and British law. Nonetheless, it is worth noting that one of the Commission's judges, noted Norwegian legal and human rights scholar Torkel Opsahl, wrote a scathing dissent agreeing entirely with X's argument.¹²¹

Despite this initial defeat, X's case was significantly more successful in regard to section 2 and 4 of Article 5. In these instances, the Commission flatly rejected the government's arguments. In the first instance, it argued that every mental patient has the right to know why they are being detained at any time. As it wrote, "The Commission is unable to accept the Government's submission that Article 5 § 2 only applies to arrest prior to a charge being laid" because it "applies to all cases of justifiable detention."¹²² Whether this information was provided by medical or legal officials was irrelevant to the Commission. Regardless, it agreed with X that neither medical or legal officials had provided this information as it was well documented that the government never gave just cause to X's counsel upon asking for the official cause of arrest. As a result, the Commission "unanimously conclude[d] that in the present case there was a violation of Article 5 § 2 of the Convention."¹²³

The Commission came to similar conclusions regarding section 4. Citing the recently concluded Winterwerp Commission case of 24 October 1979, the Commission concluded "that the applicant had the right to a periodic judicial determination of the lawfulness of his detention."¹²⁴ In addition, the Commission criticized the government's arguments arguing that habeas corpus proceedings were irrelevant to the proceedings and did not provide sufficient remedy for patients.

¹²¹ *X. against United Kingdom*, Report of the Commission of 16 July 1980, 40-41

¹²² *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*, 33-34

¹²³ *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*, 35

¹²⁴ *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*, 37

With regards to Mental Health Tribunals, the Commission dismissed them as clearly in violation of section 4 since they were not a fair, speedy procedure. As the Commission rightly interpreted, the final decision ultimately lay with the Home Secretary rather than the Tribunals meaning they were not independent. Furthermore, given that patients were not allowed to access them sometimes for months, they did not constitute a ready and speedy resource for patients. As a result, the Commission “unanimously concluded that in the present case there was a violation of Article 5 § 4 of the Convention.”¹²⁵ In sum, while the Commission rejected two of X’s original claims, it had unanimously accepted the other two and had published a notable dissent with regards to Article 5, section 1.

With the case’s admissibility approved by the Commission, the case proceeded to the European Court of Human Rights. Overall, the case moved through the Court much quicker than it had through the Commission. This was partly by design as each side had already published and articulated their cases in the six-year Commission process. As a result, the entire process took just over one year from when the Commission brought the case on 13 October 1980 to the Court’s final decision on 5 November 1981 which changed the entirety of British mental health care. With the Court composition officially established on 6 November, the Court President, Balladore Pallieri, ordered the British government to submit a memorial responding to the Commission’s findings.

Despite its earlier arguments being unsuccessful at the Commission, the government decided to reiterate the same arguments with little variation. Indeed, most of the submitted memorial consisted of the verbatim submissions given to the Commission from 1976 to 1978.¹²⁶ Ignoring the fact that the Commission had actually rejected its arguments regarding Article 5,

¹²⁵ *X. against United Kingdom*, Report of the Commission of 16 July 1980, 39

¹²⁶ *Eur. Court. H. R., Series B no. 41, case of X v. the United Kingdom*, 86

section 1, the government chose to simply accept the ruling since the Commission had not found it of any wrongdoing. Regarding Article 5, section 4, the government reiterated its earlier arguments saying that the ECHR does not provide mental patients the right at all times to be able to contest their detention in a court. Nonetheless, the government still hedged its bets arguing explicitly that if this argument were to be rejected again then the Court should consider habeas corpus proceedings as legitimate for this purpose. These responses mirrored the government's submissions from the Commission.

There was, however, an interesting difference in the government's arguments concerning Article 5, section 2. Although it maintained that patients do not have a right under the ECHR to hear the reasons of their recall, it also made an alternative argument based on reforms already taking place at home. In response to the Commission's ruling, legislators were anxious to begin making reforms of the admissions process. This is clearly evident from the fact that, before the European Court, the government revealed new admissions procedures whereby it would now be mandatory for hospital staff to explain the reason of patients' detention within 72 hours of admission to hospital.¹²⁷ As will be seen, the quickness to introduce these reforms was just the beginning of the reforms that would come with the Mental Health Act 1983.

X's counsel stuck by their earlier arguments and, on 5 November, the European Court published its final decision taking into account the arguments of both sides. Reviewing the Commission's decision on Article 5, section 1, the European Court held up the Commission's ruling saying that there had been no violation of X's human rights since he was of 'unsound mind' at the time of his recall. With regard to Article 5, section 4, the European Court agreed with the

¹²⁷ Marc-André Eissen, ed., *Eur. Court. H. R., Series B No. 41, Case of X v. the United Kingdom* (Strasbourg: Carl Heymanns Verlag KG, 1985), 68–69.

Commission that the habeas corpus proceedings and the MHRTs were inadequate and that they constituted human rights violations. On the last point of Article 5, section 2, the Court agreed with the substance of the Commission's ruling finding that the government had withheld the reason for X's recall and that, therefore, there had been a human rights violation. Nonetheless, the Court interpreted this as a violation of Article 5, section 4 because the right to a fair trial necessitates a right to know the reason for one's recall. As a result, the Court agreed not to rule on the official violation of section 2, but agreed in essence that there had been a further violation of section 4. All told, when the European Court published its decision on 5 November, it condemned the United Kingdom of human rights violations for its treatment of X.¹²⁸

After the conclusion of the trial, Gostin and MIND moved quickly to invoke Article 50 of the ECHR which would allow "for reform of the domestic law to bring it into line with the requirements of the Convention."¹²⁹ This was the mechanism by which MIND would have its reforms forced into British law. This appeal for 'just satisfaction' under Article 50 called for major changes to the Mental Health Act that would make it comply with the human rights of the ECHR. In particular, MIND demanded an overhaul of the MHRTs and a removal of the Home Secretary's sole authority to discharge patients. Periodic review of all patients would be mandatory and all recalled patients would need to have a review shortly after arriving at a hospital. Significantly, all of these demands were made in the name of compliance with the human rights of the ECHR rather than the natural rights used in *A Human Condition*

¹²⁸ For the entirety of the European Court's final decision, see *Case of X. v. the United Kingdom*, Judgment of 5 November 1981, Application 7215/75.

¹²⁹ Eissen, *Eur. Court. H. R., Series B No. 41, Case of X v. the United Kingdom*, 205.

With the authority of the European Court behind it, MIND was able to make more significant demands on reform of the Mental Health Act. At the time of the European Court's decision, a reform bill called the Mental Health (Amendment) Bill was already working its way through Parliament. This Bill had its roots in the previously-discussed Labour Party White Paper of 1978 and, in the meantime, had received a significant boost from the European Commission's decision in 1980. MIND, however, had been and remained unsatisfied with this Bill. After the European Court's decision, Parliament had to halt the progress of the Bill in order to make significant changes. As an article in the 6 November 1981 edition of the *Times* reported, the Bill did "not meet the criticisms of the European judges" and was "likely to be amended further."¹³⁰ Indeed, MIND said that the Bill did "not introduce any relevant reform following the Court's decision in *X. v. The United Kingdom*."¹³¹

In the immediate aftermath of the decision, the government tried to resist serious amendments, but ultimately, the decision forced their hand. On 13 November 1981, the *Times* reported that MIND and the government were in an escalating, public row over the necessary changes to be made to the Bill. The government continued to back it in its current form, but MIND argued that patient consent and patients' rights to a fair hearing needed to be protected. By January, however, the necessity for reform in the wake of the Court's ruling had reached Parliament. On 20 January 1982, the *Times* reported that Lord Belstead, Under Secretary of State and member of the House of Lords, was the first to introduce new clauses and amendments to the Bill to satisfy the demands of the Court. At the time, the *Times* quoted him as saying, "The need for this change is entirely bound up with our response to the judgment of the European Court in the case of *X v The*

¹³⁰ Lucy Hodges, "Britain Condemned Again on Mental Patients' Rights," *The Times*, November 6, 1981, The Times Digital Archive.

¹³¹ Eissen, *Eur. Court. H. R., Series B No. 41, Case of X v. the United Kingdom*, 213.

United Kingdom.”¹³² By April 1982, the government had made a variety of amendments in an attempt to modify the bill in accordance with MIND’s proposals and Court orders. As the court reported later that year, these reforms had brought the government in line with the Convention:

Subsequent to the judgment of the European Court of Human Rights of 5 November 1981, amendments were inserted into the Mental Health (Amendment) Bill, which was at the time being considered by Parliament, which amendments were designed to remedy [the] deficiency in domestic law found by the European Court.¹³³

These allowed for the successful passing of the Amendment Bill by the end of 1982 and the further passing of the new Mental Health Act of 1983.

In the end, the new Mental Health Act contained most of the proposals made in *A Human Condition*. The reforms directly inspired by the court’s ruling had to deal with the MHRTs and clarifying the process of admissions for involuntary patients. MHRTS were significantly reworked along MIND proposals.¹³⁴ For the first time, public funds became available to patients to hire specialized attorneys. MHRT members were required to have in-depth knowledge of administration and the social services. Any patients kept involuntarily for a period under six months could apply to an MHRT as soon as they entered the hospital. For patients admitted indefinitely, they had to wait six months at which time an appearance before an MHRT was mandatory. While the six-month waiting period was a setback in some respects, the main thrust of the changes meant that every involuntary patient would have the right to a Tribunal and a lawyer if they wanted them. The Act also expanded the powers of MHRTs granting them the ability to make delayed discharges and grant leaves of absences in the cases of non-restricted patients. The ability to discharge was also spread out to new authorities such as hospital managers and, with

¹³² Larry Gostin, “Law on Mental Patients,” *The Times*, January 28, 1982, The Times Digital Archive.

¹³³ Eissen, *Eur. Court. H. R., Series B No. 41, Case of X v. the United Kingdom*, 245.

¹³⁴ Reforms to MHRTs are described in Larry Gostin, *A Practical Guide to Mental Health Law: The Mental Health Act 1983 and Related Legislation* (London: MIND, 1983), chap. 6.

medical recommendations, nearest relatives. This marked an attempted to strip authority away from the Home Secretary who had come under significant unwanted and critical scrutiny during the European Court trial.¹³⁵

These reforms to the MHRTs were significant, but the reforms that ultimately came about with the Act were of a much larger scope than the reforms to MHRTs that the European Court case had necessitated. While the European Case was the catalyst for the reform of the Act, the content of most of it was derived from *A Human Condition*. Nonetheless, MIND still played a central role in drafting these changes as most of them can be traced back to Gostin's 1975 text. Many of these reforms addressed the violations of rights that Gostin had made at that time. For instance, the Act lifted restrictions on correspondence and put a stop to the ability to ship patients anywhere in the country.¹³⁶ Hospital staff retained the ability to read patient mail if they believed it constituted a danger, but they had to inform the patient and provide a justification.¹³⁷ Correspondence with lawyers, politicians, judicial figures, hospital managers, and MHRTs were specifically restricted from ever being opened by hospital staff. Patients were also given greater access to courts in line with Gostin's earlier proposals. Patients still were not allowed to sue hospital staff for bad treatment, but they could sue hospital managers and the Secretary of State.¹³⁸

In the area of compulsory admissions, the Act introduced significant changes and clarifications. In an attempt to make the psychiatric classifications less normative, the category of 'subnormality' was replaced by 'mental impairment' though the general meaning of the category remained the same. Emergency detentions were reduced to a maximum of 72 hours and required

¹³⁵ Reforms to discharge process are described in *Ibid.*, chap. 4.

¹³⁶ *Ibid.*, 6.

¹³⁷ *Ibid.*, 60–61.

¹³⁸ *Ibid.*, 62.

that all such admissions had to be examined within the first 24 hours of arrival. After this medical examination, patients had to either be released or formally admitted within a day. Patients could still be admitted involuntarily for a period of 28 days for assessment but only with the recommendation of two doctors and a social worker or a nearest relative. This in itself marked little change, but for the first time, these short-term involuntary admissions were given the right to apply to MHRTs immediately after arrival.¹³⁹ Indefinite detention was officially discarded and replaced with an initial six-month period then renewable at intervals of every one year. Patients under any of the four classifications could be held this way, but a new ‘treatability test’ was introduced for psychopaths and the mentally impaired.¹⁴⁰ Hospitals could only hold these patients as long as it was possible for doctors to improve condition. If they could not, they would have to release the patients.

Patients were also empowered through protections on their ability to give consent. For all patients detained involuntarily for short periods of 72 hours or less, the Act granted the ability to refuse any treatment¹⁴¹ For involuntary patients admitted for long periods, such as for 28-day assessment or long-term care, Part IV of the Act forbade certain treatments without patient consent and a second opinion namely psychosurgery, lobotomization and sex hormone therapy.¹⁴² Controversially, doctors could administer electroshock therapy and drug treatments without patient consent but only after receiving a second opinion from a doctor who had consulted with two other members of hospital staff. This meant that patient consent remained limited in some ways. To prevent serious abuses, however, the Act instituted one of Gostin’s proposals from *A*

¹³⁹ Ibid., 12.

¹⁴⁰ Ibid., 13.

¹⁴¹ Ibid., 47.

¹⁴² Ibid., 49–50.

Human Condition: the Mental Health Act Commission. This Commission was empowered to investigate patient complaints, their living conditions and treatment regimens, and their ability to effectively give consent.¹⁴³

Some of the reforms supported by MIND never made it into the new Mental Health Act. Section 136 granting police special powers to remove the mentally disabled from public spaces was retained. Under section 92 of the Act, courts retained the ability to take control of patients' finances and property if the court ruled them to be incapable of making their own decisions.¹⁴⁴ This decision only required the recommendation of one doctor and was, in theory, easily manipulated. Patient consent still retained notable caveats and the principle of involuntary, indefinite detention was not directly challenged. Greater protections were ensured with a restricted MHRT system and the Mental Health Act Commission. Yet considering MIND had adopted a rights-based approach for its arguments, accepting oversight of rights violations does not seem sufficient enough. Furthermore, none of MIND's more fundamental criticisms of psychiatric practice were taken up. Ultimately, the workable solutions were taken up at the expense of radical alternative visions. When the Mental Health Act came into effect in 1983, it represented a major step forward in protecting some aspects of patients' rights and consent. Yet MIND's radical and fundamental critiques disappeared as they could not be incorporated into rights-based politics.

5. Conclusion

Mental disability and intellectual capacity have been at the heart of debates about liberalism and rights for centuries. Underlying discussions of liberal rights has been an assumption that one must possess a certain level of self-control and rationality to possess them. This same belief

¹⁴³ Ibid., chap. 8.

¹⁴⁴ Ibid., 69–70.

supported restrictions on the civil and political rights of women, minorities, and the poor all over the western world up until the twentieth century. Those with mental disorders have been affected by the same language and have therefore struggled to acquire even the most basic civil and political rights. For mental health activists, it was therefore essential to constantly assert the ‘humanity’ of mental patients. This project has therefore been not only a description of a particular organization with a certain program, but rather an exploration of how ‘humanity’ is reformulated and constructed to include and exclude.

In speaking about the human rights revolution and the human rights decade of the 1970s, most authors take it for granted what the ‘human’ in ‘human rights’ is. For them, the emergence of human rights implied an extension of the very definition of ‘humanity’ to refer to everyone regardless of gender, race, or class: women and people of color gained their rights when society was willing to recognize them as equal and ‘human.’ Such a process might seem natural, but definitions of ‘humanity’ are always shifting. To liberal rights theories in particular, mental disorder has presented challenges. Are there mental faculties or abilities that one must retain to be worthy of equality and ‘humanity?’ If democracy rests on the assumption of the stable, rational, and autonomous individual capable of free choice, where does this leave those who are deemed irrational, unstable, socially dangerous, and deviant?

In 1970s Britain, answers to these questions were polarized and anything but clear-cut. Mental health activists were asserting the common humanity and the equal, fundamental rights of the mentally disabled in a society that still connected mental disorder with criminality, deviance, and danger. Developing out of late-nineteenth-century theories of degeneration and ‘mental defectiveness,’ twentieth-century mental illness retained the baggage of social stigma long after legal and medical authorities stopped officially classifying it as a social, racial, and moral problem.

With the Mental Health Act of 1959, legislation gave ultimate authority over patients to psychiatrists and medical experts at the expense of patient consent and patients' rights. In the face of potential dangerousness, medical professionals claimed for themselves the power to exercise significant authority within the context of confining institutions.

This medical authority over the body translated into a concrete denial of political and legal equality. Denied the most basic of rights because of their condition, mental patients lost control over their bodies and entered a world cut off from society and the body politic. In practice, of course, patients could retain extensive contacts with the outside world. In theory, every such interaction was allowed and overseen by medical and legal authorities. As such, this project lends itself to discussions of shifting conceptions of the body and the relationship of bodies to medical, legal, and social control.

Ultimately, these issues remain unresolved. Tensions and problems still exist in psychiatric care. Gostin and others made fundamental criticisms of psychiatric theory and practice that essentially went unheeded. While MIND's proposals for legislative reform were largely accepted, its deeper charge against the validity of psychiatric diagnosis and treatment was not taken up. Though psychiatric definitions, categorizations, and treatments continue to change decade after decade in response to social, cultural, technological, and economic factors, the inherent assumption regarding psychiatry's value remains largely unchallenged. Furthermore, while mental health activists called for major reforms to institutional care, most of these institutions eventually disappeared in the 1980s and 1990s without effective replacement. This process of deinstitutionalization is intimately connected with the history of neoliberalism and capital crises as those with mental illness have frequently been jettisoned from formal care. In its place, the community care advocated for by mental health activists has not robustly emerged. Instead, drug

treatment remains a profitable and growing industry. The history of these recent developments goes beyond the scope of this paper. Nonetheless, the issues raised about patient consent, patients' rights, and psychiatric alternatives remain just as relevant, perhaps even more so.

In a larger work, researchers could take this project in a number of directions. One direction would be to continue the above discussion connecting histories of mental health activism with the recent history of capitalism. Another avenue might be to investigate and problematize MIND's own activism with a deeper dive into the day-to-day work. Despite MIND's importance as an activist organization, there are no recent and robust monographs detailing its work or its emergence out of the mental hygiene movement. Within the more limited chronological focus of this paper, however, there is still much to be done. For instance, one could look at MIND's failed European Court cases and consider what made them less successful or palatable.

There could also be fruitful work done examining activism in general during this period. One might find interesting similarities and differences between the tactics and rhetoric of MIND and other organizations. Another route might involve establishing the wider intellectual, political, and social context through an examination of the connections between mental health activists, politicians, academics, and doctors to show how MIND constructed its own rights language and its particular knowledge about mental patients and their health. Perhaps just as fruitful would be an exploration of changing constructions and conceptions of the body especially as it pertains to detention and medical and legal authority. Such a project could look at contemporaneous debates about indefinite detention in Northern Ireland or prison reform movements. Hopefully, one would also look at the vital connection between the human sciences, changes in social scientific theory, and redefinitions of humanity and human rights. All told, there is still much work to be done.

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