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Code of practice for the Mental Health Act 1983

The Mental Health Act 1983 required a code of practice to be prepared for the guidance of doctors, nurses, and other health professionals. We have invited comment from a psychiatrist and a general practitioner—ED, *BMJ*.

"Patronising and unrealistic"

The *Highway Code* tells motorists and pedestrians what they should and should not do on the road. Written in clear and precise terms, it does not use words such as certitude, vitiate, and purportedly. It is concise and easy to read, and it does not present the reader with dilemmas and ambiguities. One cannot say the same for the draft code of practice on the admission and treatment of psychiatric patients issued by the Department of Health for comment; but the final version will be the equivalent of the *Highway Code* for all doctors and others concerned with these matters.[1]

The purpose of a code of practice is to provide guidelines on practice which Acts of Parliament and regulations are unable to do because they have to be worded legalistically. Contravention of the code will fairly clearly not be a criminal offence, but the chairman of the Mental Health Act Commission has said that failure to comply with its terms might be held to be relevant in disciplinary proceedings or in the courts where a patient brings an action against a doctor for negligence.[2]

Section 118 of the Mental Health Act 1983 required the Secretary of State to prepare, and from time to time revise, a code of practice, firstly, for the guidance of registered medical practitioners, managers and staff of hospitals and mental nursing homes, and approved social workers in relation to the admission of patients to hospitals and mental nursing homes under the Act, and, secondly, for the guidance of registered medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder.

The task of preparing the draft code was given to the Mental Health Act Commission, and in its first biennial report the multidisciplinary commission described what it did.[3] It decided that comments on the "admission" of patients should apply only to those who were (or about to become) formally detained but that its suggestions on good practice on medical treatment should include the whole field of practice—nursing and also care, habilitation, and rehabilitation under medical supervision. Having interpreted its remit so widely, the commission had set itself a daunting challenge —and it had not been asked to write on one side of the paper only. In fact it wrote on 209 pages, and this will be the biggest single criticism of the draft code: it contains something approaching 100 000 words—about 100 times the length of this article.

Has the commission overstepped its remit? The government's proposals for reforming mental health legislation stated that some "irreversible, hazardous, or not fully established" forms of treatment would be listed in regulations,[4] and they subsequently were.[5] For some others, however, for which precise legal definitions might be difficult to phrase, the new Act provided for a code of practice. This would "not be legally binding, but doctors would take account of it in deciding how to treat their patients."

During the passage of the Bill through parliament, the government accepted the view that often long stay patients were only technically voluntary patients as they could easily be formally detained if they attempted to leave hospital.[6] As a result the code of practice was changed to provide guidance on the treatment of "all patients suffering from mental disorder." The effect of this change was not only to include all informal psychiatric patients but mental patients wherever they may be—attending as outpatients, in general hospitals, in prisons, or seeing their family doctors.

The commission added considerable confusion to views on consent to treatment in July 1985 when it sent to all health authorities a document, *Consent to Treatment*, which it said would be greatly condensed for the draft code of practice.[7] On the one hand the commission said that this document was for guidance, but on the other that it would welcome comments. Unfortunately, without the covering letter the

document looked as though it was the commission's views on consent to treatment, and much in the document angered psychiatrists, particularly in relation to research (see article by R E Kendall on p 1249). The July 1985 paper detailed a set of safeguards which would apply to "clinical research" using electroconvulsive therapy, medication, psychotherapy, and behaviour modification. The draft code of practice does not, however, specify what constitutes clinical research; if the term is interpreted widely research would be seriously hampered. When research does not entail treatment there can surely be no justification for including these matters in a code of practice on the admission and treatment of patients. All other matters are the province of local ethical committees.

As doctors we are all concerned to make sure that patients should receive the treatment they need. Psychiatrists know that an important limitation in achieving this aim is that a patient's mental disorder may so cloud his judgment that he is unable to appreciate what is in his own best interests. In those circumstances most doctors believe they have not only the right but the duty to use their training and skill to ensure that the patient receives proper treatment to restore him to the position in which he can reliably decide what is best for himself.

That approach does not find support in the draft code. Some parts give clues to the attitudes of the authors—such as the recommendation that a report on a violent incident should include the time of calling medical staff and the time of their arrival and the statement that "chemical restraint involves medication for management purposes, either with or without an additional therapeutic intent." Yet the draft code offers no guidance whatsoever on the "urgent treatment" section of the Act, which allows doctors to dispense with consent when treatment is immediately necessary to save life, to alleviate serious suffering, to prevent a serious deterioration in the patient's condition, and to prevent his behaving violently to himself or others.

The draft code must be ratified by parliament when the consultation stage ends on 30 June. Much careful thought will have to be given to its contents and format. I hope that the final code will not include contentious matters on which there is no consensus and that it will not offer interpretations of the common law. Neither should the code repeat what the Mental Health Act 1983 and the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983 say. This is already available in the Department of Health and Social Security's memorandum on the Mental Health Act 1983.[8]

The final code should give reasonable and realistic guidance on ways to promote optimum care and at the same time recognise the importance of clinical judgment. A typical extract from the draft code deals with what it describes as the balancing process in the handling of a violent episode. It suggests that the factors which need to be considered include the extent and immediacy of the danger to the patient or to others or both (or, in extreme cases, to property); the existence and nature of any duty owed to others; the speed with which any danger needs to be prevented; the effect on, and the risks to, the patient from the carrying out of the treatment; the ethical aspects and the irreversibility of the treatment; the alternative treatments available, either immediately or later; other means available to avert the danger; the nature of the patient's condition; and the nature of the treatment and its acceptability to society. This sort of mixture of patronising and unrealistic "advice" challenges the whole credibility of the draft code of practice.

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1 Department of Health and Social Security. *Mental Health Act 1983: Section 118. Draft code of practice*. London: HMSO, 1985.
2 Lord Colville. Debate on codes of practice and legislation. *House of Lords Official Report (Hansard)* 1986 Jan 15;**469**:cols 1083-4.
3 Mental Health Act Commission. *The first biennial report of the Mental Health Act Commission 1983-85*. London: HMSO, 1985.
4 Department of Health and Social Security, Home Office, Welsh Office, Lord Chancellor's Department. *Reform of mental health legislation*. London: HMSO, 1981.
5 Statutory Instruments. *The Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983*. London: HMSO, 1983 (no 893).
6 Clarke K. Special standing committee on Mental Health (Amendment) Bill. *House of Commons Official Report (Hansard)* 1982 June 17;**367**:563-87.
7 Mental Health Act Commission. *Consent to treatment*. London: Mental Health Act Commission, 1985.
8 Department of Health and Social Security. *Mental Health Act 1983. Memorandum on parts I to VI, VIII and X*. London: HMSO 1983.

Codifying care

Considerable thought has gone into this 200 page document. The anonymous authors examined many awkward issues of consent and control in the psychiatric hospitals. They describe several conflicts of principle when compulsory care is required and rightly emphasise patients' rights to privacy, information, and consultation. They then go on to make numerous ex cathedra statements of what they consider to be "good practice." How would these proposals, if implemented, affect general practitioners and others outside the psychiatric world?

Firstly, we need to remember that detained patients form only a small fraction of patients in mental hospitals. Patients with psychological problems who are not admitted to mental hospitals at all form a very much larger group and remain at home in the care of their general practitioners. General practitioners refer to psychiatrists only twice in a thousand consultations.[1] The main difficulty with this document is, therefore, the iceberg phenomenon: that patterns of practice appropriate to a small, exceptional, and atypical group in the highly visible setting of institutional care may not be so appropriate in the much larger but more private arena of personal medical care, where privacy and one to one consultations with senior staff are still the norm.

The second problem is what is meant by psychological treatment. General practitioners are concerned with the physical, *psychological*, and social problems of their patients in the setting of their homes and families.[2] The code defines psychological treatment as "any systematic and constructive intervention which a patient may be offered or expected to participate in which is designed to influence, change, modify or reinforce the patient's thoughts, feelings and acts. The overall objective of psychological treatment is the care or alteration of the patient's disorder." Such a definition might be thought to cover most contacts in primary care—thousands of consultations and all health education. General practitioners intervene in this way 20 times in a morning, and