The College

The Mental Health Act 1983 Draft Code of Practice

It was felt that Members of the College would be interested to see the comments of the British Medical Association and the Joint Co-ordinating Committee (The Medical Protection Society, The Medical and Dental Defence Union of Scotland and the Medical Defence Union) on the Mental Health Act 1983 Draft Code of Practice. The comments of the College were published in the *Bulletin*, August 1986, **10**, 194–195.

British Medical Association

The British Medical Association welcomes the opportunity to comment on the Draft Code of Practice prepared by the Mental Health Act Commission and issued for consultation by the Secretary of State for Social Services. The Association has given careful consideration to this document, and wishes to offer some general observations in addition to the detailed comments which follow later.

The authority and remit of the Code is Section 118 of the Mental Health Act 1983. We are concerned that the Code does not confine itself to the remit of Section 118. This section requires the Code to give guidance on the admission of patients to hospital under the Mental Health Act and on the treatment of patients suffering from mental disorder. In fact it ranges widely over every aspect of the management and care of such individuals, but without giving adequate *practical* guidance.

Codes of Practice deriving from parent legislation tend to acquire a quasi legal standing, and we are concerned that this Code will be referred to in relevant litigation. Our evidence suggests that it is already being quoted by Commissioners on the assumption that its provisions will be incorporated in the revised document. The Code as it stands is too ambiguous to be utilised in this way, particularly given the implications of certain sections for the medical profession as a whole.

We would suggest that the Code is over-inclusive, and frequently paraphrases the Mental Health Act itself. We would prefer to see margin references to the legislation. A Code of Practice of this nature should give guidance to doctors and other professionals to assist them in carrying out the parent legislation. Far from giving guidance, this Code contains a great deal of theoretical material and, moreover, attempts to direct the actions of medical practitioners in a way which interferes with their clinical freedom. In limiting the scope of medical judgement, the Association feels that the Mental Health Act Commission is acting *ultra vires*.

The Association is greatly concerned over the increased powers given to Approved Social Workers (ASW) in making compulsory admissions to hospital. The duties of the ASW and his relationships with other professionals reinforce the point that social workers in general and ASWs in particular need a higher level of training. We are also concerned that the role of the nearest relative may be usurped.

The Code does not sufficiently distinguish between those aspects relating to detained patients and those relating to informal patients, and patients in the community who are neither detained nor informal.

We have attempted to answer some of the points made in the *Side Letter* to the Code in the ensuing pages. However, we feel that where more than one practice could be acceptable, all of these should be incorporated in the Code itself.

Chapter 1: Admissions to hospital

The synopsis occurring at the beginning of this Chapter is felt to be unsuitable for inclusion in a Code of Practice, and we suggest its deletion. In general, many sections in this Chapter repeat legislation or are unsuitable for a Code of Practice.

Paras 1.2 and 1.3 We are concerned that an 'official' paper should imply that compulsory admission to hospital can be avoided by the provision of adequate services. This also implies that in districts and counties with inadequate services people may be compulsorily admitted owing to lack of services. The same implication is made in para 1.16.5.

Paras 1.5.1 and 1.6.1 This is a matter for clinical judgement, and we would therefore wish to see these paragraphs rewritten taking this into account.

Paras 1.7.3 to 1.7.7 With reference to all these paragraphs, they should be discussed further and re-drafted. We acknowledge the problematic relationship of doctors and social workers, and feel the Code does not take adequate account of the practicalities such as time constraints. In addition, we would like to see the second ASW opinion made mandatory.

Para 1.7.5 Once again it is implied that the intention of an Act of Parliament may be frustrated by the inability of Health Authorities to provide doctors approved under Section 12. Approved doctors should be made aware by the appointing authority of the extent of their commitment. Sufficient doctors need to be available to provide 24-hour cover, and it is helpful if they can be contacted through a single telephone number, e.g. Ambulance Control.

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Para 1.7.7 This section is unacceptable as it stands, as it suggests no practical solutions. The Local Medical Committee could usefully be included in the bodies discussing the development of a common policy, though it should be made clear that one agency should have overall responsibility for the development of such a policy. We do not accept the proposal that the professional should stay with the patient, as the doctor is not able to ignore the rest of the patients on his list and deal solely with the problem of the potential admission.

Para 1.8 We believe this section is too contentious in its present form. There is no mention of any cost implication in the implied alteration to doctors' contracts, and we would like to see the scope of Regional Advisory Committees broadened to include GPs.

Paras 1.10.1–1.10.3 The definitions are unhelpful, restrictive, and repetitive of the Mental Health Act. We suggest these sections are deleted.

Paras 1.11.1 and 1.11.2 Paraphrases the legislation.

Para 1.11.3 The Association wishes to express grave concern at the increased powers given to Approved Social Workers (ASWs) in this section, and feels that the ASW should not always be the preferred applicant. We would like to know on what evidence the Commission has based its recommendations in this area, particularly as this paragraph might appear to exclude the nearest relative applying for admission where an ASW is not available.

We would like to see greater emphasis given to training in the field of mental health, rather than just in the legislation. Clarification is also needed on the situation arising when an ASW disagrees with a medical recommendation for compulsory admission to a mental hospital. Is the social worker considered legally responsible for his action in taking such a decision and afterwards?

Para 1.12.10 We suggest that this paragraph should be summarised as follows:

"Interpreters should be used where possible and necessary".

We do not think this should preclude the involvement of the nearest relative, though there are definite advantages in using trained interpreters when available.

Para 1.12.13 This paragraph is unacceptable as it stands in view of our opinion that the 24-hour availability of ASWs should be mandatory. We suggest:

"Properly trained social workers should be available on a 24-hour basis."

Para 1.12.15 This paragraph takes little account of the realities of the situation.

Para 1.13.1 Paraphrases the legislation.

Para 1.15.4 This section is welcomed as it will avoid problems previously encountered following admission of a patient to hospital.

Para 1.15.7 There may be times when the admitting doctor should give some guidance on admission. Ultimately it would still be up to the nurse or doctor on the spot to make their own judgement, but the situation on the ward often changes and it is sometimes difficult on admission to cover all possible eventualities.

Para 1.16.4 This paragraph is felt to be unsuitable for such a Code because it implies that deception and subterfuge seem to be acceptable if it avoids a 'dangerous situation for the patient and others'.

Para 1.16.8 Paraphrases the legislation.

Para 1.17.1 It is unacceptable to state that the nearest relative is less well equipped than an ASW to act as applicant, as this may not always be the case and Parliament confirmed in formulating the Mental Health Act 1983 that the nearest relative has the right to act as the applicant unless he is legally incompetent to do so. We endorse this right. The nearest relative often knows the patient better than anyone else.

Paras 1.17.2–1.17.3 The guidance is contentious and unsuitable for a Code of Practice as it impinges on the doctor's freedom of judgement.

Para 1.17.5 Paraphrases the legislation.

Para 1.17.7 The duty of the ASW to inform the nearest relative in writing when she/he does not agree to a compulsory admission should be extended to informing the doctor who made the initial request in writing. This procedure should occur even where the nearest relative has not required the attendance of the ASW.

Para 1.19.5 The Code should suggest the need for an ambulance to attend urgently.

Para 1.21.1 Paraphrases legislation.

Paras 1.22.1–1.22.7 Paraphrases legislation.

Paras 1.23.1–1.23.2 Paraphrases legislation.

Paras 1.24.1–1.24.5 Paraphrases legislation.

Para 1.25.1 An independent team is essential. If paragraphs 1.25.1 and 1.27.2 are read together, it is very unclear whether or not the doctor is in charge of such a team. This theme is prevalent throughout the document which is inconsistent on this point. The Association believes the RMO should be in charge.

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Para 1.25.9 It is unacceptable for the Code to suggest when compulsory detention is appropriate or inappropriate. This is a matter of clinical judgement whether or not it relates to children, the elderly (especially if demented) and others. Doctors will always seek to avoid compulsory detention if it is unnecessary.

Para 1.27.3 The nominating doctor is normally aware of his responsibility to ensure that his nominee is capable and adequately experienced!

Paras 1.27.4 & 1.27.5 Paraphrases legislation.

Para 1.28.1 Paraphrases legislation.

Para 1.28.3 We support strongly the view that the use of section 136 as an alternative to a hospital admission order is totally unacceptable. We suggest that local policies should be formulated through joint discussions between the Social Services Department, the District Health Authority, and the police.

Para 1.28.5 In general we would support the use of a police station as a place of safety, owing to the availability of police surgeons, but the Code should state that this is not always appropriate. Owing to the similarity of some serious medical conditions with mental disorders, a doctor should attend within 6 hours rather than 72 as at present.

Chapter 2: Admission through the Courts

Para 2.5.2 Suggested alternative:

> "Under Section 39 of the Act, before making a remand to hospital, the court is entitled to require the RHA to say whether and where a suitable bed is available, and should consider invoking this section whenever the lack of a suitable bed might make a prison stay likely. Consultation and agreement about the proposed admission should have occurred with all relevant professional staff."

Para 2.12.2 We would suggest that it is the responsibility of individual hospitals and health authorities to determine what facilities should appropriately be provided. On the issue of treatment of mentally disordered patients, this is a matter for clinical judgement.

Chapter 3: Guardianship

Para 3.5.2 The statement contained in this paragraph is too contentious.

Para 3.8.2 It is unacceptable that a social worker should judge the suitability of the nominated medical attendant. We would suggest a register of suitable medical attendants from whom the private guardian can choose.

Para 3.10.2 We feel that this plan may be unrealistic given the facilities available.

Paras 3.10.3 & 3.10.4 This paragraph is felt to be superfluous.

Para 3.10.5 This paragraph is too contentious for inclusion in the Code.

Paras 3.11.4 & 3.11.5 The decision to discharge is a matter for clinical judgement. We suggest that these sections should therefore be deleted.

Chapter 4: Consent to treatment

The Association has decided not to comment in detail on this Chapter.

We reject it in its present form as it has little to offer in practical terms consisting as it does of a speculative review of the common law.

The Chapter has implications for medical practice beyond the field of mental disorder and exceeds the remit of Section 118(1)(b), particularly in offering guidance to patients.

In view of our concern we shall be seeking to make further representations on this issue.

Chapter 5: Compulsory powers and second opinions

Para 5.2.7 Suggested alternative:

> "Where possible, in the light of all the circumstances, treatment plans should first be discussed with the patient."

Para 5.3.2. There are too few consultants to see each patient in this way and it denies the expertise of a trained registered medical practitioner below consultant grade.

Para 5.4.3 Suggested alternative:

> "For the visit of the Appointed Doctor, the managers in consultation with the RMO are responsible for:
> ensuring that the patient is available; ensuring that a nurse who has been professionally concerned with the patient's medical treatment will be available for consultation; ensuring that a second person (neither a doctor nor a nurse) who has similarly been professionally concerned will be available for consultation."

Chapter 6: Psychological treatment

As with Chapter 4, this section is unacceptable as it stands and requires further discussion and redrafting. It contains too much detail and some paragraphs were found to be patronising and unhelpful.

Chapter 7: Rehabilitation

Paras 7.1.1–7.7.2 As a general comment on these paragraphs, we are not happy with the paucity of reference to general practitioners, whose role needs much greater emphasis. The Code should make clear that the provision of proper and adequate rehabilitation facilities should always precede discharge from hospital.

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Chapter 8: Patients presenting particular management problems

Parts of this chapter are ambiguous. More precise practical guidelines would be of more relevance in a Code of Practice.

Para 8.1 We feel this to be unnecessary in a Code of Practice.

Para 8.7 The Code should not be asking questions of its readers but should be suggesting unambiguously what is accepted as good practice. We do not feel this paragraph is acceptable in its present form.

Chapter 9: Social aspects

We would reiterate here our concern that throughout the Code inadequate mention is made of the role of general practitioners.

Paras 9.5.1–9.5.3 These paragraphs could be omitted as they are confusing and largely irrelevant.

Para 9.4.2 The word "discrimination" as used in this paragraph should be substituted by the word "prejudice". The last sentence should be deleted.

Para 9.10.2 The tone of this paragraph appears to negate the individual's personal liberty (e.g. to have socially unacceptable personal habits if he so wishes).

Chapter 10: Information

Para 10.1.2 The second part of this paragraph is repetitious and could be deleted. In this chapter, as throughout the document, the importance of the "multidisciplinary team" is over-emphasised.

Chapter 11: The process of discharge

Para 11.1.2 This is unrealistic.

Para 11.3.3 Suggested alternative:

"There should be consultation between the RMO and other professionals in planning a discharge to ensure that adequate resources are available in the community for the patient's needs. These discussions may take place in case conferences or with individuals. The patient should be given details of the discharge plan and its aims, and an idea of the timescale. With the patient's consent, the appropriate relative may be involved."

Para 11.3.4 Suggested alternative:

"The importance of full and early consultation and communication with the patient's general practitioner cannot be over-emphasised."

Not only has the general practitioner the duty to care for the patient at all times other than when he is a patient in hospital, but by his knowledge of the patient he can both anticipate deterioration before a crisis necessitating admission occurs, and ensure that the treatment and rehabilitation plan on discharge is complied with.

Para 11.6.2 The probation officer should have no automatic right to attend the case conference without the consent of the patient.

Chapter 12: Relatives

Para 12.7.2 Confusion occurs in this paragraph and in the Code as a whole as to whether the patient referred to is informal or detained.

Chapter 13: Duties of managers

Paras 13.7.1. and 13.7.2 Lay discharge power should only be used exceptionally, and not as an alternative to a Mental Health Review Tribunal. The RMO should be responsible for the discharge or otherwise of a patient. We would question whether section 13.7.2 is within the remit of the Mental Health Act Commission.

Joint Co-ordinating Committee

1. The three UK protection and defence organisations are grateful for the opportunity to comment upon the Draft Code of Practice produced by the Mental Health Act Commission. In making our brief comments, we wish to stress that we have consulted with the Royal College of Psychiatrists and with the British Medical Association (BMA) and we support the representations and comments which we know they are to make and which we have seen in draft form.
2. The three protection and defence organisations represent the medico-legal interests of more than a quarter of one million doctors and dentists practising worldwide (apart from the USA and Canada). Our UK-based members, practising in all branches and specialties of medicine and dentistry, have consulted us on a number of issues arising from the treatment of mentally ill and impaired patients and it is from this experience that we draw our comments.
3. We have, with the Royal College of Psychiatrists and British Medical Association, obtained the advices of leading and junior counsel on the Act and the Draft Code of Practice. Detailed comments on the Act and Code have been submitted by the College and the BMA and we wish to associate ourselves with their comments and views. We shall not repeat them here but we will set out certain matters of concern to our members.
4. We consider that the code, as drafted, is unacceptable in its present form and that parts of the code are *ultra vires* in that it contains material which is outside the scope of the matters specified in S 118(1) of the Act. It is too long and offers little practical assistance to doctors and dentists who are faced with clinical problems. It should not be regarded as a "textbook of revealed truth".

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5. The Act and Code are rightly concerned with the liberty of the individual subject. However, it is our view that the effect of cases such as *R-v-Hallstrom* and *R-v-Gardner* (*Times* Law Report, 28 December 1985) could be said to reduce the liberty of the individual patient because the effect of the judgement is that patients have to be detained before they can be treated compulsorily.
6. We consider that it might be helpful to legislate for a guardianship order which allows for treatment as well as for residence.

Consent to treatment

7. We consider that Chapter 4 of the code, dealing with consent to treatment, requires complete re-drafting. At present it is, in our view, too legalistic, academic and negative. It is of little practical assistance to doctors and dentists faced with acute clinical dilemmas. Some of the statements of the law are inaccurate; others are ambiguous or too theoretical to be of practical help to clinicians.
8. Junior medical staff faced with an acute problem, perhaps at night or weekends, would be unlikely to have the time—and might not have the opportunity—to read the whole of Chapter 4. Even if they did, they would find little practical assistance to help them to resolve their problems and difficulties over consent to treatment (see, for example, 4.5.1. and 4.5.16.) in 35 pages of text. If more practical and constructive guidance cannot be devised, it might be preferable to omit the whole of Chapter 4 from the Code.
9. Section 4.7 is too concerned with the requirements of the law of battery and the exceptional cases in which a court might hold that an apparent consent was not a real consent. Again we consider that this is too theoretical to be of practical help to clinicians. We consider that a Statutory Code should adhere to decided legal principles, explaining relevant existing law, and should not be speculative and theoretical. The Code attempts to provide some definitive answers which simply do not exist in English law. Our law tends to proceed on a case-by-case basis and decisions of English judges are informed on the principle of trusting the doctor who exercises his skills *bona fide* for the care of his patients, not on the basis of attempts to codify doctors' powers and rights.
10. Our medical and dental members have already expressed grave disquiet and concern about the law relating to the non-emergency treatment of mentally-impaired adult patients who cannot give a personal consent to treatment but of whom it is said that no one can consent on their behalf. Routine medical and dental treatment for mentally subnormal patients has been given for decades, if not centuries, without being declared unlawful. Is it now to be assumed that such treatments have been civilly unlawful or criminally illegal and that practitioners offering, in good faith, treatments for adult, mentally-impaired patients are now at risk of censure by the courts? (4.9). Some rather more positive guidance and assurance would be welcome to the practising clinician 'at the sharp end', and would be of benefit to patients.

Consent to research

11. We suggest that a distinction needs to be drawn between consent to research in the course of treatment (arguably within the ambit of S.118) and consent to pure research, not involving treatment (arguably *ultra vires* the Code and S.118). With regard to research which is not of direct benefit to the individual, this is arguably unlawful in the case of minors and mentally-impaired adults.

Confidentiality

12. Paragraph 4.11.1 appears to suggest that relatives should be involved irrespective of the agreement of patients. On grounds of confidentiality we consider that those patients who are capable of giving a personal consent to treatment should also assent to the involvement of their relatives. This point is made at 4.11.5 but, we suggest, should be made at the start of section 4.11. Similar considerations apply to 4.9.11.

Legal responsibilities for patients

13. We believe that clarification is desirable as to who is—and remains—responsible for patients. We have noted the published remarks of the Chairman of the Mental Health Act Commission, Lord Colville, writing in the *Bulletin* of the Royal College of Psychiatrists in January, 1985. In circumstances (e.g. S.58) where a second opinion is given which differs from that of the responsible medical officer (RMO), whose view is to prevail and who is to retain responsibility for the patient and his treatment?
14. Whilst we do not wish to question the benefits of multi-disciplinary teams, we consider that a multi-disciplinary committee cannot take clinical decisions. The responsible consultant must be allowed to exercise those responsibilities for patient care which are imposed by common and statute law.

Miscellaneous

15. Code 1.7.7: If the approved social worker and the general practitioner had an 'unresolved dispute', is it thought likely that the general practitioner would undertake to stay with the patient?
16. Paragraph 1.27.3 of the Code (Act, S.5) requires clarification. Who are to be named deputies and what is to happen if the one nominated deputy is unavailable (e.g. because of illness or other leave)?

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