policy is a set of principles which affirm the legal and human rights of users of mental health services – principles which are to be found in many a patients' charter, in the Mental Health Act code of practice and even, increasingly, in the operational policies of NHS trust services. It is very worrying that such principles could be deemed anti-medical establishment and, worse, destructive.

Dr Gamble leaves his most outrageous accusation – of local advocates' "tacit encouragement of violence against staff" – till last. We are mystified as to why, if there have been genuine concerns of such a serious nature about employees in our service, no one has brought them directly to our attention.

We are very sorry that Dr Gamble's 'exposure' to advocacy during his training has made such a negative impact on him, but we also believe that the conclusions he draws from his limited experience are unwarranted. Of course there are sometimes problems in the practice of advocacy (just as there are sometimes problems in the practice of psychiatry), but we would expect any important concerns about our service to be discussed with us frankly and respectfully. We sincerely hope that other psychiatrists are more inclined to share the stand of Thomas & Bracken (*Psychiatric Bulletin*, June 1999, **23**, 329) that psychiatry needs to move 'away from a negative anti-psychiatry view of advocacy to a more constructive engagement'.

Richard Smith, Director, **Val Ford**, Service Manager, Mind in Tower Hamlets, 13 Whitethorn Street, London E3 4DA

Sir: We are grateful to Dr Gamble for his letter (*Psychiatric Bulletin*, September 1999, **23**, 569–570) which simply helps to reinforce the purpose of our original article (Thomas & Bracken, *Psychiatric Bulletin*, June 1999, **23**, 327–329). Dr Gamble's attitudes towards advocacy demonstrate how important it is that the College makes exposure to local advocates and advocacy services a mandatory requirement for all training schemes for the Membership Examination.

Phil Thomas, Consultant Psychiatrist, **Pat Bracken**, Consultant Psychiatrist, Bradford Community Health Trust and Senior Research Fellows, Bradford University, Bradford Home Treatment Service, Edmund Street Clinic, 26 Edmund Street, Bradford BD5 0BJ

Consent of 16- and 17-year olds to admission and treatment

Sir: Parkin (*Psychiatric Bulletin*, October 1999, **23**, 587–589) is correct in stating that current guidance on consent to treatment as set out in the 1999 Code of Practice "remains potentially confusing and is inconsistent with good practice". Although the Mental Health Act 1983 (MHA) has built into it greater protection for patients' rights regarding consent to treatment, if the child is not under a section of the MHA, the compulsory regulations of the MHA do not apply. For the child in the community or admitted 'informally', that is, not under the MHA, the new Code of Practice (Department of Health & Welsh Office, 1999) seems to be undermining the competent child's rights regarding consent to treatment. In doing so it is following the judicial paternalism of recent case law, which seems to subjugate one of the Code's guiding principles, that is, that people to whom the MHA applies should "be treated and cared for in such a way as to promote to the greatest practicable degree their self-determination and personal responsibility, consistent with their own needs and wishes", in favour of other 'best interests', which may be assumed to be a professional (whether judicial or medical) understanding of their physical or mental well-being. This makes the new Code internally inconsistent as well as "inconsistent with good practice". I echo Parkin's call to the Mental Health Act Commission to investigate such inconsistencies.

Reference

DEPARTMENT OF HEALTH & WELSH OFFICE (1999) *Code of Practice to the Mental Health Act 1983 (Pursuant to Section 118 of the Act).* London: The Stationary Office.

Moli Paul, Senior Registrar in Child and Adolescent Psychiatry, Parkview Clinic, 60 Queensbridge Road, Birmingham B13 8QE

Use of the Mental Health Act to treat compliant mentally incapacitated patients with electroconvulsive therapy

Sir: Having recently been involved in a difficult clinical dilemma, we have had it brought to our attention that our usual practice and what we believed to be the common practice of psychiatrists throughout the country is in fact contrary to the Code of Practice.

The dilemma involved the need to resort to the use of the Mental Health Act 1983 (MHA) when wanting to treat a compliant mentally incapacitated patient (due to mutism secondary to severe psychotic depression) with electroconvulsive therapy (ECT). Nobody would dispute the need to detain a mentally ill patient who verbalises refusal to consent to treatment. The difficulty comes when deciding to treat a patient who is uncommunicative from a functional or organic mental illness, with medication or ECT. Our common practice is to use the MHA in these patients, even though they have not actually refused treatment.

Having carried out a postal survey of all the consultants in elderly mental illness and their senior registrars in south and west Wales (20 responded out of 22), all agreed with this course of action.

It was brought to our attention by Richard Jones, a leading specialist in Mental Health law, that the criteria for admission under Sections 2 or 3 of the Act cannot be satisfied in respect of a compliant mentally incapacitated patient (i.e. one who is not "persistently and/or purposely" attempting to leave the hospital (see paragraph 19.27 of the Code of Practice; Department of Health & Welsh Office, 1999, and paragraphs 1–626A of the sixth edition of the Mental Health Act Manual; Jones, 1999). Hence, ECT (being a medical treatment for mental disorder) can and should be given to a mentally incapacitated patient under common law as long as the requirements for "treatment of those without capacity to consent" (see paragraph 15.19 of Code of Practice; Department of Health, 1993, and paragraph 15.21 Code of Practice, published 1999) are satisfied.

Perhaps it is significant that this has come to our attention following the Bournewood judgement which clarified our position in treating, under common law, those patients who are compliant but mentally incapacitated. Most would agree that this refers to individuals with learning difficulties or dementia or who are temporarily incapacitated from delirium, and these are indeed specified in paragraph 15.20 of the newly published Code of Practice. It unfortunately does not include such cases as mutism secondary to severe psychotic depression.

We are uncertain how such a widely held practice, which appears to contradict the Code of Practice, originated. We would be interested to hear from anyone who feels they can shed light on this interesting clinical conundrum.

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— & — (1999) *Code of Practice, Mental Health Act 1999.* London: The Stationery Office.

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Helen Chubb, Senior Registrar, **Delyth Alldrick**, Consultant Psychiatrist, EMI Directorate, Cardiff & District Community Healthcare Trust, Whitchurch Hospital, Park Road, Cardiff CF4 7XB

Alternatives to methohexitone

When the ECT anaesthetic methohexitone was unexpectedly withdrawn earlier this

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