# The College

## Mental Health Act 1983: Revised Draft Code of Practice

In late August 1987, the DHSS forwarded to the College the Mental Health Act 1983 Draft Code of Practice. The College immediately circulated the Draft Code for consultation to its membership, through its Divisions, Sections and Groups, and to the Executive and Finance Committee and the Standing Committees of Council. The Special (Code of Practice) Committee was reconvened, and met several times in September and October, to consider and collate comments as they arrived.

The final report of the Special Committee was approved by Council at its meeting on 15 October 1987. The report included detailed comments on the Draft Code and was prefaced by a letter from the President, Dr J. L. T. Birley, to the DHSS, summarising the College's views and principal concerns. The President wrote as follows:

"Our College welcomes this revised Code of Practice, and would want to thank and congratulate those concerned at the DHSS for producing a short document, in which the guidance is much clearer and more closely related to current practice.

Our detailed comments and amendments are enclosed. We would want to mention in particular six areas with which the College is still concerned, and where the Code needs to be revised.

(1) We appreciate that the issue of consent to treatment is a complex one which falls outside the Mental Health Act 1983. At the same time, our members, and our colleagues in other professions are looking after large numbers of patients who cannot give valid consent to treatment, and for whom detention and treatment under the Act would be inappropriate; this situation needs to be acknowledged. We have included a statement about these patients in paragraph 12.

(2) The guidance on the appropriate use of Section 2 or of Section 3 (given in para. 25) does not conform to current practice nor to the guidance of at least one office of the Mental Health Commission. We feel that it is too rigid and needs reconsideration.

(3) We acknowledge the value and importance of multi-disciplinary team work, and of the contributions which many professions make to the care of patients and their families. At the same time, as stated in para. 18, the responsible medical officer has specific legal responsibilities for the medical treatment of patients. Decisions concerning treatment cannot be taken by others unless responsibilities are clearly delegated by the responsible medical officer. Thus decisions on admission of patients (paras. 38 & 70) or on treatment plans (90), or on planning leave (141) must remain the responsibility of the responsible medical officer and this should be clearly stated in these paragraphs.

(4) We support the recommendation that an approved social worker should usually be involved in the decision to detain a patient, and, in most cases, should be the applicant (para. 36).

At the same time, there may be occasions when it is appropriate to arrange for a patient to be detained without involving an approved social worker. This is allowed under the Act and should be recognised in the Code.

(5) The advice concerning the plan of treatment (89, 90) is too detailed and rigid. A specially recorded plan of treatment is not necessary as a general rule. We agree that a written plan must be available for the second opinion doctor, and that all patients should have the opportunity, wherever possible, to discuss and to be involved in their plan of treatment.

(6) We feel that the guidelines concerning the transfer of patients to other health or local authorities (159–163) are too rigid and do not correspond to current practice."

The detailed comments on the Draft Code are available to members of the College, if they send me a written request.

Professor R. G. Priest
*Registrar*

*The response of the Mental Health Act Commission to the revised Draft Code of Practice is given below*

The Commission has now sent its response to the revised Draft Code of Practice to the Secretary of State. The reply was prepared during the Commission's plenary conference held on 15 and 16 October 1987.

Although the Commission acknowledges the good features of the revised Code (its succinct style and sustained reference to multi-disciplinary care) and the considerable effort of Department officials in preparing the draft, it is critical of the document in that:

It is not a document which makes much contribution by way of supplement to the Act, the Regulations and the Explanatory Memorandum.

It does not spell out the status of the revised Code as the Secretary of State proposes it to be used.

https://doi.org/10.1192/pb.12.2.68 Published online by Cambridge University Press

It contains some 25 legal inaccuracies which require amendment.

It offers little, if any, practical guidance on the correct steps to be taken in many difficult situations and who is responsible for taking the necessary decisions or devising the requisite procedures.

It ignores whole realms of problems and subjects (mental handicap, relatives, habilitation and rehabilitation etc) or treats them with an unhelpful superficiality.

On 2 November 1987 Lord Colville, Chairman of the Commission, said: "I do not believe that the revised draft Code will assist us or those with whom we are in contact in relation to a multitude of problems which daily confront patients and professional people in the community and in hospitals or nursing homes, nor the families of mentally disordered people. Our original draft Code was a direct response to requests for such solutions. We now realise that it was too long to be adopted as the Code itself; it contains imperfections; it is now about three years old and needs further thought. We believe, nevertheless, that it contains valuable guidance and therefore propose to revise it and issues it over a period as a handbook which I hope may be given some recognition by the Department, perhaps as a supplement to the Code of Practice."

## *Assessment of Mentally Handicapped Patients for the Severe Disablement Allowance*

The College wrote to the DHSS recently, expressing its concern that medical examiners appointed by the Department are not psychiatrists, and that consequently patients who may be suffering from severely handicapping psychiatric symptoms are deprived of benefit and, in some cases, forced back to work. The College recommended that a psychiatric opinion should be a statutory part of the assessment procedure.

The DHSS has replied as follows:

"Assessment of disability in connection with severe disablement allowance is carried out by the same adjudicating medical practitioners who carry out assessments in connection with industrial injuries disablement benefit and war pensions. Full-time medical officers of the Department carry out a small proportion but the great majority do this on a part-time basis. Most are, or have been, general practitioners but a number come from other disciplines. These doctors do not profess to any specialist expertise in any branch of medicine but they are experienced in making assessments on the scales which we use.

Adjudicating medical practitioners are not compelled to make their assessments without the benefit of expert assistance. In fact they are encouraged to seek additional information wherever necessary. This may be in the form of factual reports from the general practitioner or a hospital, extracts from hospital casenotes or a report and opinion from a consultant. Anxieties were expressed both before and after the introduction of the allowance that the adjudicating medical practitioners would and did make assessments in cases of mental illness without sufficient information. We accept that these fears were justified in some cases and some months ago we arranged that in all claims where a psychiatric symptom was mentioned and where the claimant had been attending hospital, either as an in-patient or out-patient, the documents would be studied initially by a full-time Medical Officer of the Department. This Medical Officer is able to arrange for whatever additional information he considers necessary to be obtained before the claimant is examined by an Adjudicating Medical Practitioner. In fact in a small number of cases this information proves so useful that 80% disablement can be awarded without any further examination."

## *Special Interest Groups*

In June 1987 Council approved the establishment of 'Special Interest Groups'.

Procedure for establishing a Special Interest Group:

(1) Any Member wishing to establish a Special Interest Group shall write to the Registrar with relevant details.
(2) The Registrar shall forward the application to Council.
(3) If Council approves the principal of establishing such a Special Interest Group then it will direct the Registrar to place a notice in the *Bulletin*, or its equivalent, asking Members of the College to write in support of such a Group and expressing willingness to participate in its activities.
(4) If more than 50 Members reply to this notice, then Council shall formally approve the establishment of the Special Interest Group.
(5) The administrative support provided will be similar to that enjoyed by College Divisions. It should be noted therefore, that the College will maintain the list of members, prepare and distribute notice of meetings but will not provide staff to attend meetings, organise conferences etc.

In accordance with this procedure, Council has approved the establishment of a Special Interest Group of Computers in Psychiatry and a Special Interest Group on the History of Psychiatry. Members are invited to write in support of these Groups and express willingness to participate in their activities. Members should write to Mrs Jean Wales at the College. If 50 members reply to this notice for each Group, then Council shall formally approve the establishment of these Special Interest Groups.

PROFESSOR R. G. PRIEST
*Registrar*

https://doi.org/10.1192/pb.12.2.68 Published online by Cambridge University Press