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# Code of Practice 1999: navigating before reform of the Mental Health Act 1983

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Mental health legislation must steer a course between Scylla and Charybdis. Scylla represents the notion of individual liberties; Charybdis represents the notion of safety and, in particular, public safety. At the time of writing a Green Paper is expected in 1999, so reform of the Mental Health Act 1983 is on its way. Meanwhile, does the new Code of Practice (Department of Health & Welsh Office, 1999), in force since 1 April 1999, give us any indication as to the course we might be steering?

The Foreword to the new Code, by Frank Dobson and Alun Michael (which reminds us that the Act only covers England and Wales) certainly heads toward Scylla. In it they acknowledge that the present Act “is increasingly out of date” and new legislation is promised. They stress the experience of patients and carers and mention “a new emphasis on the patient as an individual”. Professionals must work together to provide effective care and treatment.

Much of the rhetoric of the new Code continues on this course towards Scylla. This is certainly in evidence in the Guiding Principles, published as Chapter 1 for the first time in this third edition of the Code. Many of these principles were scattered throughout the previous editions, but now they are prominent. There are some innovations. For instance, at the very outset it is stated that people should receive recognition “of their basic human rights under the European Convention on Human Rights”. The Care Programme Approach (although it was mentioned in the last edition) also receives heightened emphasis. Its component parts – assessment of health and social care needs, a care

plan, a keyworker and regular reviews – are spelt out both in Chapter 1 and again in the chapter on ‘after-care’. The Guiding Principles emphasise communication, confidentiality and the provision of information. The possibility of discussing the care of a patient detained under Part III of the Act (which concerns mentally ill offenders) with his or her victims is also discussed, but the bearing remains towards Scylla.

Since a revision of the Code is necessitated in part by recent case law (e.g. *Re: C*, 1994; *Re: MB*, 1997), it should come as no surprise to find extensive changes relating to consent and incapacity. An individual is presumed to have capacity to consent unless he or she is unable to satisfy three criteria. To have capacity, the patient must be able to: first, “take in and retain the information material to the decision”, especially concerning the likely consequences of having or not having the treatment; second, “believe the information”; and third, “weigh the information in the balance as part of a process of arriving at the decision”. Furthermore, it is made clear in the Code that it is the duty of the Responsible Medical Officer (RMO) to record conversations about capacity to consent in the notes, at least with regard to electroconvulsive therapy (ECT) and drug treatment after three months on a Section 3.

Into the Code comes an acceptance of the notion of advance refusal of treatment made validly in the past. This is another manifestation of respect for the individual’s autonomy. Any future legislation in this regard will have to splice with the recommendations in the Green Paper, *Who Decides?* (Lord Chancellor’s

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Department, 1997), for a Continuing Power of Attorney, which (going beyond the present Enduring Power of Attorney) will cover personal and health care matters as well as property and finance. But here the tiller is pulled back towards Charybdis, for “an advance refusal... does not prevent the authorisation of such treatment by Part IV of the Act in the circumstances where those provisions apply”. In other words, with a second opinion, the patient’s lack of consent to ECT (for instance) might be overruled.

Furthermore, the new Code incorporates the Law Lords’ decision on *Bournewood (R v. Bournewood Community and Mental Health NHS Trust, 1998)* thus: “If at the time of admission, the patient is mentally incapable of consent, but does not object to entering hospital and receiving care or treatment, admission should be informal”. The “should” here creates three categories of patients: informal (non-detained) patients, informally detained patients and formally detained patients. It ignores Lord Steyn’s “indefensible gap” in the mental health laws and it leaves “compliant incapacitated patients” without the safeguards of the Act (Edwards, 1998). The bottom line remains that a doctor may prescribe treatment for the patient who lacks capacity “in their best interests under the common law doctrine of necessity”.

Perhaps the strongest tack towards Charybdis is taken in discussion of after-care. Consider, for instance, the responsibilities of the RMO, who must assess risks, consider victims and their families and consider after-care under supervision and use of the supervision register. Those responsibilities are newly enunciated in the Code. ‘After-care under supervision’ – introduced in April 1996 under the Mental Health (Patient in the Community) Act 1995 – forms an entirely new chapter. While intended to protect patients, it is also a means of controlling them. In the absence of more resources, some regard “supervised discharge” as otiose and bureaucratic (Knight *et al*, 1998; Mohan *et al*, 1998). Some psychiatrists would prefer a form of community treatment order (Knight *et al*, 1998). Controlling individuals in the community – the challenge for any new Mental Health Act – makes the passage between Scylla and Charybdis even tighter to navigate.

In the case of the dangerous patient with severe personality disorder, the Government’s proposals clearly aim at better protection for the public (Home

Office & Department of Health, 1999). And, despite recognition of human rights law, to some the proposals seem routed only via Charybdis (Eastman, 1999).

Meanwhile, at the time of writing, we have the draft proposals for the reform of the Mental Health Act 1983 to give us some indication of the direction in which we are heading (Scoping Study Committee, 1999). Once again, the principles of non-discrimination on account of mental illness and respect for patient autonomy point us towards Scylla. The creation of a new Mental Illness Tribunal, however, might carry us hither or thither. Admittedly, its adjudication concerning hospital and community treatment might act as a check on unnecessary compulsion. But its judicial nature and functioning, distant from the therapeutic coalface, its control over discharge, and its duty to safeguard public safety, might all conspire in a drift towards Charybdis. Psychiatrists and patients cannot presume which way the wind will blow.

In any event, psychiatrists and their colleagues should read the new Code, which contains over 200 changes. For, although there is no legal duty to comply with the Code, it is a statutory document and “failure to follow it could be referred to in evidence in legal proceedings”.

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