having already been examined at St Thomas's Hospital:

> Worthy Gentlemen Whitehall 6th September 1692
> Being certified by the Governors of St Thomas Hospital that the bearer hereof Thomas Marshall belonging to their Majesties Ship the suffolk, is in a condition more proper for yours than their Entertainment. We pray to you to take such care of him as is requisite that if possible he may be returned into a capacity of serving their Majesties and his Country again. We earnestly recommend him to you not doubting your compliance.
> We are Gentlemen Your most Humble Servants.
> Office For Sick and Wounded Seamen Whitehall.

The continuous register of admissions to Bethlem that began in 1683 is unique, but contains little information about individual patients until the early 19th century. The collection of 20 referral letters from the last two decades of the 17th century that are included in the register represent (to our knowledge) the first of their kind. Although they supply only sketches of the sort of behaviour that could lead to admission, the letters give valuable insights into the attitudes of the period to the mentally disturbed and the perceived function of Bethlem in dealing with them.

Reference

NICHOLAS, H. (1834) Acts of the Privy Council, London.

(The complete Admissions Registers from 1683 are kept in the Bethlem Archives. The invaluable assistance of the Archivist Patricia Allderidge is gratefully acknowledged.)

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Trainees' forum

Ode to the Code

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The Mental Health Act Code of Practice has recently been published. Its introduction has been discreet, low-key and virtually unnoticed. Yet in a quiet and determined way it points out the direction that all professionals involved in the case of mentally disordered people must now anticipate. It has a smart, blue cover and is eminently 'user-friendly'. Its contents will make it essential reading. Indeed it would not be an exaggeration to suggest that it might soon be any ambitious lawyer's pocket *vade mecum* as he prepares his case. Its arrival has been anticipated since 1983. There have been a few miscarriages on the way which probably explains why its mother finally consented to artificial insemination techniques and conceived of her Code without formal consultation with its potential fathers.

The overall tone is firmly based on the dignity due to any mentally ill person when faced with the caring professionals at any stage in his illness and not simply when formal admission is being considered. In fact the spirit of the broad principles outlined in the introduction would make America's founding fathers proud since they are based on basic human rights. However, these values are not caused by grandiose, optimistic delusions and the authors do not have impaired reality testing. Here I am referring to the preface, a brief, stark paragraph on a big empty page just after the contents list. It has that unmistakable, ubiquitous scent of Eau de No Money, and we are reminded that all this is subject to funding.

The Code provides guidance but will it have clout? It is advisory not mandatory. The Mental Heath Act does not impose a legal duty to comply with the Code but failure to follow the Code could be referred to in evidence in legal proceedings.

An act or omission in contravention of the Code will not be unlawful but may be negligent if it establishes an allegation of breach of duty of care. So the 'take-home' message is that you can presume that 'reasonable care' is demonstrated by compliance with the Code. Implementing it will demand enormous effort and multidisciplinary co-operation. It will be

as good as we are prepared to make it! But it behoves us to do so because not only is it good practice but others will say, "this is what you should be doing, why aren't you?". Herein lies one of its strengths since compliance with the Code, if used effectively, should attract resources to mental health services and ensure consistent treatment in an institutional setting.

There are 29 chapters, each divided into numbered paragraphs, a glossary and statutory references – a veritable feast to be savoured in small quantities; consuming the whole would necessitate excessive use of antacids. There are some nuggets that will require prolonged mastication. In the chapter on assessment, there are recommendations concerning the availability of professional interpreters and the need for a written policy covering this eventuality. Such a requirement will put enormous strain on financial resources. Indeed, throughout the manual there are at least 20 references to requirements for written policies that will keep the regional 'think-tanks' on overtime for quite some time. Social workers and doctors will be forced to lay aside their traditional rivalries and see patients together, trust each others' perspective and co-operate. Health authorities and local social service authorities will have a responsibility to ensure that just such communication does happen.

The nurse's holding power is clearly explained; that it is the personal decision of the nurse and that he/she cannot be instructed to exercise this power by anyone else is reinforced. Concerning the police power to remove to a place of safety, the issue of that place actually prejudging the outcome is highlighted. Funnily enough, the police management of a person detained under Section 136 of the MHA is such that they do not see it as an arrest under Section 56 of the PACE Act and hence are not obliged to allow the Section 136 individual the same rights as, say, a thief. Hospital managers are going to play an increasingly influential role in the admission, in-patient treatment, and after-care of patients. For instance, the managers will be involved in in-patient behaviour modification programmes and will be obliged to keep themselves well informed of up-to-date research in this area. I was particularly struck by the Code's attitude to Guardianship. An innovation here is that Guardianship is to be considered as an alternative to sectioning in one's assessment factors. Sadly, throughout the Guardianship chapter, the mentally disordered individual is consistently referred to as the patient, although he/she resides in the community. The Aftercare chapter is very much in line with a recent College document(CR8). The emphasis is on a key worker once the patient has returned to the community. However, with all the statutory bodies involved, one could ask, "What happens if the key worker falls ill?"

The concluding chapter deals with children and young people under 18. We are reminded that there is no minimum age limit for admission to hospital under the Act. The same principles apply and communication is the operative word. There is a presumption of autonomy when the child has sufficient "understanding and intelligence". This is a very complex issue since the law on the autonomy of the teenage child is complicated. However, common sense questions are posed to help us do our best in such a situation.

In conclusion, I feel that the Code will be of particular benefit to trainees. Clinically it should clarify how best to implement the various sections of the Mental Health Act, especially when the patient's presentation proves awkward. It could be used as a research tool. An interesting project might be an audit of the changes needed in a district to implement the recommendations. However its primary value was to remind me of how insecure my role as a doctor may be in the future. The caveat is, of course, resources. What happens when the legal eagles come knocking at my underfunded, understaffed, and creaky door? Should I put my faith in a trust?