*Who Wears the Chains Now**

A Personal Response

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In 1793 Pinel started the move towards modern psychiatry by removing the chains from patients at the Bicetre Psychiatric Asylum. In 1986 the Mental Health Commission through their draft Code of Practice (COP) are metaphorically attempting to place those chains upon the professionals whose job it is to treat psychiatric disorder. Psychiatry will not benefit by having either the patients or the carers chained. I feel that if the COP in its current form is accepted, then it is likely in the long-term to lead to a deterioration of services for the mentally ill and we should ensure through the Royal College that we are not forced into accepting proposals from people who are in a worse position than ourselves to determine what is best for our patients.

I personally feel that the concept of any branch of medicine having a code determined by non-experts is unacceptable. The embodied concept of the draft COP is that 'we know better than you how to practise psychiatry'. I feel this concept is probably false. There is no doubt that members of the Commission do have vast expertise in certain areas—but not in everyday psychiatric practice and the management of serious psychiatric disorder. Even those psychiatrists who work for the Commission may come to lose touch with clinical needs. The Commission has already stated that on average its members spend more than two days per week on Commission business and if, as they intend, they persuade the Minister of Health to extend their remit into the care of informal as well as formally detained patients, then it would appear to me that being a member of the Mental Health Commission will become a full-time job. The psychiatrists who are on the Commission and who currently have a clinical practice will in that case no longer be able to keep up their clinical commitments and after a few years will be out of step with their colleagues who continue to practise.

The draft COP is also unacceptable because it is a retrogressive rather than a progressive step. Recently psychiatry has made a determined effort to be seen as a branch of medicine and not as a totally separate entity. At last genuine progress has been made against the concept of mind-body dualism. The draft COP is potentially a large wedge that the Commission wishes to have driven between the mind and the body. It fosters the dangerous belief that mental illness is quite different from physical illness and therefore the carers concerned with mental illness require totally different principles, safeguards and legislation from all other medical and paramedical professionals. If the COP is accepted it will become a legal document and is likely to be used as a legal document to control psychiatric practice.

In my opinion the draft COP is not acceptable to us or to the medical profession as a whole.

All of us have been prepared through Section 118 of the Mental Health Act that a COP would be prepared by the Commission. Most psychiatrists had envisaged such a Code as being a document that would restrict itself to those items of good practice necessary for the implementation of the Mental Health Act. I feel that if a COP has to exist, then it should reflect a level of practice such that a lower standard would not be acceptable to a professional peer group and it should not try to outline an idealised and theoretical style of psychiatry that would be unattainable or impractical in current circumstances. A COP should not contain matters covered by other professional codes of ethics and practice and it should not contain matters concerned with clinical methods. A COP should not state opinions where there is little or no factual evidence to support the validity of the opinions and it should not be concerned with items that are dependent upon the provision of resources not under professional control. Finally, I feel a COP should be short, readable, expressed in clear language and one that can be easily remembered.

The current draft COP is far too lengthy and it is impossible to expect anyone to remember the content of such a massive document. If it is accepted we will have to memorise it because of its legal status, because if we transgress the Code with any patient we will be open for legal action to be instituted against us. It is perhaps acceptable in legal practice to have lengthy documents spelling out how the law should be enacted, but we must remember that lawyers have ample time to consult their books to ensure their procedures are correct. For doctors on the Commission there will also equally be much time for detailed and lengthy consideration of any patient they are asked to see. However, for the actual practising clinician who is faced with a disturbed mentally ill person, decisions have to be made quickly and there is not time to read through a 235 page document to make sure their practice is acceptable. Any COP therefore has to be short and one that is remembered after having been read once or twice, so that a psychiatrist can know in any given situation instantly whether or not his actions are acceptable.

The current draft COP is lengthy for a variety of reasons. Firstly, it is repetitious. Considerable portions of the COP are pure repetitions of the Mental Health Act and this should be excluded. Also the COP often repeats itself which again is unnecessary and it needs considerable redrafting so that it becomes a unified document rather than a collection of working party reports. Another reason for the length is that it is written in a bureaucratic and legalistic form, and there are many examples where lengthy paragraphs could be summarised into single short

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sentences. Lastly, the excessive length of the draft COP is partly due to it containing much information that is at best superfluous and at worst incorrect. An example of this is in the opening Section 1.1 where the Commission give a list of reasons why patients may need admission to a psychiatric hospital. Surely it is unnecessary to tell practising psychiatrists why their patients may need to be admitted.

The draft COP is also unacceptable because it has considerable proportions devoted to clinical psychiatry and in places reads like a textbook (and not one that the majority of us would recommend). Some of the clinical practice recommended I feel is potentially bad practice. In Section 4.9.7 we are told 'If a condition is a continuing one which, if not treated, will become life-threatening or seriously disabling, not immediately but at some time in the future, the treatment may be deferred until the point of no return...'. Personally I feel to leave a patient who is suffering till they have reached a 'point of no return' is bad practice. It is our job as doctors to alleviate suffering and distress and when we know that a person's life or health is seriously at risk we should act as soon, not as late as possible. Would any other branch of medicine be allowed to leave their patients to get to a point of no return before they instituted treatment? I would respectfully suggest that members of the Commission do not try to tell psychiatrists how to practice clinical psychiatry and would suggest that all clinical guidance not relating to specific use of the Act is omitted from the Code.

There are certain opinions expressed in the draft COP that are as yet unsubstantiated, unworkable or impractical. There are three particular 'false gods' that take on the concept of an idealised psychiatric practice. The first false god is the Commission's belief in the use of guardianship. In the Code the Commission state 'Guardianship is the least restrictive mode of compulsion with the minimal imposition on the patient', and later 'an increase in the use of guardianship in appropriate cases would demonstrate a committed interest by professionals to provide good care in the community'. I am not at all certain that professionals will necessarily show a committed interest to community care by the use of guardianship. I feel there will only be a very few people to whom a guardianship order will be applicable and for the provision of psychiatric treatment it is largely irrelevant. Patients on guardianship cannot be treated against their wishes and in the vast majority of cases when a psychiatrist detains a patient this is to enable him to provide treatment. I would suggest that until such a time that treatment can be ensured for patients on a guardianship order it will not be much used. I would also question whether guardianship would be seen by all patients as the least restrictive mode of compulsion. If an order to detain someone in hospital is used then at least within the boundary of the hospital some degree of freedom may be allowed, and often the patient can live and behave in the same manner as informal patients and may not be seen as particularly different. It is possible on a guardianship order in the community that it will be obvious to all one's friends and relatives that a person such as a social worker will be seen to be imposing considerable controls on the patient's actions thus making him very different.

The second 'false god' that the Commission appear to worship is the concept of the multidisciplinary team. In the draft Code there is frequent reference to the multidisciplinary approach in both the assessment and treatment of the mentally ill. In many psychiatric centres it is not possible to have a multidisciplinary team due to lack of social workers, psychologists and even nurses to enable such a team to be brought together; even if a team is available I do not know whether there is any real evidence that it produces better assessment and treatment for the mentally ill. Nowadays there is a tendency for the para-psychiatric professions to see the concept of multidisciplinary teams to mean that no longer should the consultant be in charge. This results in these professionals working quite separately from clinical psychiatry and not as part of a team and it is increasingly common for situations to occur where the RMO cannot get the advice of such colleagues because they are too busy with their own patients. This to me is not multidisciplinary team work and I am afraid unless a COP has considerably more emphasis on the RMO leading multidisciplinary teams then it may be seen by such professionals as an open invitation to foster the split and eventual complete separation of the psychiatric and para-psychiatric services.

Even if a proper multidisciplinary approach can be established with regular attendance at ward rounds by other professionals, I would still question the validity of total multidisciplinary assessment and treatment as the Code envisages. There are a number of instances where I feel the RMO and the RMO alone can make the correct and appropriate decisions. Whether our colleagues like it or not, in many areas of psychiatric practice it is the biological model of mental illness that holds most water and in these cases it must be a person with a biological background that remains in charge. People with backgrounds based in learning, dynamic or social theories will often contribute interesting points to discussion but may not be able to provide practical or effective contributions to management. Also I am afraid that many members of our so called multidisciplinary groups are inadequately trained and in some cases hopelessly naive and cannot be members of an equal democratic team. I feel strongly that the COP must be redrafted with the weight of responsibility being left with the RMO.

The third 'false god' that is revered in the draft Code is the 'treatment plan'. The Commission's concept of a treatment plan is outlined in Sections 5.2.4–5.2.8 of the Code. These Sections detail a very rigid plan that the Commission wish to be written in the patient's notes; for each change in treatment this would too have to be written in the notes after discussion with the multidisciplinary team. Good practice involves continual assessment of patients and changes of treatment perhaps on a daily basis; RMO's cannot be tied to having always to write this down and on paper justify their actions and decisions. Often when treatment has to be altered it must be done quickly because of sudden changes

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in the patient's condition. It is rarely feasible or even necessary to call the usually non-existent multidisciplinary team together to discuss this. If the Commission wish psychiatry to be effective their concept of a treatment plan must be changed.

A further criticism of the whole Code is that in many instances the practice outlined is determined by political, not clinical practice. At various points the draft COP claims that it is essential there are adequate staff and appropriate facilities in hospital and the community to ensure good treatment and rehabilitation. Most of us, I am sure, would support this view but clinical psychiatrists will have very little say in whether such staff and facilities are made available. In a number of hospitals nursing levels are woefully inadequate and little more than basic containment of the mentally ill can be carried out. Equally, few hospitals have sufficient occupational therapists, social workers etc. to provide an effective service and we are all only too aware that community provisions do not exist. Will the RMO be seen as carrying out bad psychiatric practice if he continues to manage his patients with poor staffing levels and non-existent community facilities—and will he therefore be held to be negligent?

I would wish to very much encourage anything that the Commission can do to increase staff and facilities, but their comments should be directed at those who control the finances and resources allocated to mental health, not at clinicians, and therefore I would recommend that any comments in the draft Code that are ultimately determined by resources should be removed.

I have outlined just some of the aspects of the draft Code that make it unacceptable in its current form. The result of the COP if accepted will be greatly to restrict clinical psychiatry and such restriction will harm, not help, the mentally ill. My final point concerning the draft COP is that basically it is a document whose underlying ethos may be seen as potentially antipsychiatric. It seems that the document has the philosophy that current psychiatric practice is wrong and has to be altered. In many instances it implies that psychiatrists may be negligent and are likely to misuse treatments and undermine patients' rights. I must disagree with this philosophy—we, like all other professionals, make mistakes and if we are genuinely negligent we must face the consequences, but I would suggest this is rare. I think the Code should be altered so that it appears to support rather than attack psychiatry.

I have outlined some of the problems with the current draft COP that I personally feel exist. There are other problems which will be outlined in the College's special Code of Practice Committee in their report to the Minister of Health. Although there are many areas that need changing there are also some good aspects of the COP which should be retained, but I feel it is much more likely that we will obtain a COP acceptable to both practising psychiatrists and the Mental Health Commission if much greater liaison could be made between us, perhaps with the ultimate aim of jointly producing the final Code.

Corrected reference

KENDELL, R. (1986) The Mental Health Act Commission's 'Guidelines': a further threat to psychiatric research. *British Medical Journal*, **292**, 1249–1250. (Not as previously stated in *Bulletin*, April 1986, **10**, 78).

VOCAL

VOCAL (Voluntary Organisations Communication and Language) was granted charitable status in June 1982 and is concerned with the care and assistance of people with speech and language disorders. This organisation was formed at the initiative of the College of Speech Therapists when they invited other organisations concerned with the communication handicapped to meet representatives from the speech therapy profession. There are now 28 affiliated charities; each work in their special fields but they are all concerned that more needs to be done for people with a communication handicap. It is intended to make VOCAL the central organisation for information and action to seek to combine the best interests of patients and therapists in this work. Further information: Audrey Maxwell, Director, VOCAL, 336 Brixton Road, London SW9 7AA (telephone 01 274 4029).

Handbook on the Management of Private Practice in Health Service Hospitals in England and Wales

The Department of Health and Social Security has prepared a Handbook which consolidates and where necessary revises all previous circulars on the collection of health authority income from private medical practice in the NHS and aims to provide a standard body of guidance for all concerned as an aid to ensuring proper management of private practice and that private patient charges are recovered. It has been produced in a looseleaf format and will be kept up to date by the publication of amendments or additions from time to time as necessary. It has been printed in sufficient quantities for it to be supplied by health authorities to all medical, dental, nursing, administrative and other staff involved in the reception, admission or treatment of private patients, the management of private practice, and the collection of charges.

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