The Draft Code of Practice (Mental Health Act 1983)—in Pursuit of Agreement

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The Mental Health Act 1983[1] directs (Section 118(1)) that 'The Secretary of State shall prepare, and from time to time revise, a code of practice:
(a) for the guidance of registered medical practitioners, managers and staff of hospitals and nursing homes and mental nursing homes and approved social workers in relation to the admission of patients to hospitals and mental nursing homes under this Act; and
(b) for the guidance of registered medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder.'

The Secretary of State delegated to the Mental Health Act Commission (MHAC) the responsibility for preparing a draft Code of Practice and, as required by the Act (Section 118(3)), the Secretary of State has circulated the draft for consultation. The draft document consists of 209 pages with two pages of 'points for discussion' arising from minority opinion within the Commission and 25 pages of index added by the Department of Health and Social Security (DHSS).

Delegated legislation and quasi-legislation

Parliament has supreme legislative power to make whatever law it pleases. The resulting statute is often preceded by a complex consultative process and the clauses of the originating Bill will sometimes be the subject of detailed scrutiny and amendment. A further method of creating legal rules exists, whereby Parliament confers law-making power on a subordinate individual or authority by virtue of an enabling or parent Act; in this case the Mental Health Act 1983. Since *delegated legislation* has not been subject to scrutiny by Parliament such rules may be subject to judicial review in the courts which may declare them lawful or unlawful.

The purpose of delegated legislation is that it is time-saving in Parliament, it allows matters that are inappropriate for the statute itself to be incorporated in rules of policy or practice, it allows new schemes and ideas to be tried out and perhaps be incorporated in later legislation. It allows administrative rules to be drawn up and gives the opportunity to include future developments and trends. It can be revised. There are a wide range of different forms of delegated legislation which include the Regulations passed by statutory instrument in Parliament, in this instance for example to establish the administrative structure of the Act and the Mental Health Act Commission. Other forms of delegated legislation include Bye-Laws, Orders-in-Council, Directives and there are others.

Delegated legislation, since it is derived from a parent Act, has an equal force of law to the statute itself. The courts have no power to invalidate such legislation for policy reasons or to question the merits of the content, but may examine the procedures by which the instrument was constructed for instance, to see whether or not the required consultation procedures have been carried out or whether the instrument falls within or goes beyond the authority conferred by the parent Act.

In addition to these forms of delegated legislation there are other devices for implementing policy which are administrative rather than legislative in character.[2] They are to some extent analogous to delegated legislation and have been described as *quasi-legislation*. They include departmental or ministerial circulars, letters, guidance, statements of policy or intent and codes of practice. They are methods used to ensure uniform implementation of overall policy. If derived from an originating statutory power (a parent Act), even though delegated through a circular or code, the courts may sometimes interpret that circular or code as if it is delegated legislation.

Codes of practice

Codes of practice are a relatively modern development. They are not clearly legislative in character and there are a variety of forms of differing levels of authority derived from parent legislation.[3] The status given to a code depends upon the creative or 'trigger' section in the parent Act. In the *first* group the status of the code is unequivocal; a breach of the code is a criminal offence. In the *second* category the parent Act makes clear that the code may be relied upon in civil proceedings as tending to negative or establish liability (e.g. the *Highway Code*). In a *third* group the parent Act indicates that a code 'may be taken into account' if it appears to be relevant to a matter under consideration by a court or tribunal. In a *fourth* group the parent Act provides that those administering the Act 'shall have regard to' or 'must give consideration to 'certain matters, (a much weaker and imprecise requirement). A fifth group gives no indication at all of the significance to be given to the code either by those to whom it applies or by the courts. The Code of Practice established by the Mental Health Act 1983 is in this category. Other codes of practice have been drawn up by professions or trade organisations for the guidance of their members and may also in time establish a status which may be used in evidence with respect to disputes about standards of practice.

Most codes deriving from statutes have come into force

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since the Second World War. According to Lord Renton,[4] since 1973 the trend to establish codes has resulted in 25 statutes under which 48 codes of practice may be made. Codes serve as administrative or practice guide-lines and they provide an indirect method of affecting policy without using direct legislation. Their advantage to the administration is that they are usually based upon concensus agreement and they allow a greater amount of flexibility than rules of law. Codes are not subject to the scrutiny by Parliament that is given to the parent legislation, but they may be used to establish liability. When the Mental Health Bill was being considered by Parliament it was anticipated that sanctions against a doctor who gave a detained patient treatment without observing the Code of Practice could effectively be through professional channels including clinical complaints committees or through a civil action by or on behalf of the patient for assault or damages, where evidence that the doctor had failed to observe the Code might be held to be relevant by the Courts. Lord Colville of Culross, the Chairman of the Commission, has also recently foreseen that the Code may be used in this way.[5]

Examples of codes in current use include those for the Commission for Racial Equality, the pharmaceutical industry, the advertising authority, the Police and Criminal Evidence Act, and the Highway Code. There are many others.

The Code of Practice (Mental Health Act 1983)

The authority for this Code is Section 118 of the Mental Health Act 1983 which also indicates the scope and limits of the Code to be prepared by the Secretary of State. There is no statutory authority to range beyond the directions indicated in Section 118 (a) and (b). The situation was however complicated by statements made by ministers when the Mental Health Bill was before the Standing Committee of the House of Commons,[6] when the Government often resisted amendments proposed for the substantive legislation by giving an undertaking that the issue would be considered for inclusion in the Code. This is partly a Parliamentary device for avoiding further discussion and for obtaining agreement when it can be argued that the matter relates more to rules of practice than to decisions which should be established in law. An example of this was the frequent pressure by Members of Parliament to 'require' multidisciplinary consultation on a variety of matters. This seemed to the Minister to be more appropriate for the Code. The MHAC has taken these Parliamentary references into account in preparing this draft.

Basic principles

(1) It is suggested that the Code should be confined to the limits of the remit provided by Section 118; it should give practical guidance relating to the admission of patients under the Mental Health Act (detention) and in relation to the medical treatment of patients suffering from mental disorder, to improve patient care, and enhance the preservation of their civil rights.

(2) The Code should only incorporate generally accepted principles of current practice. It should not incorporate new practice principles unless a concensus of agreement is established following consultation. This would be an attempt to influence practice and there are often several acceptable ways of doing something.

(3) The Code should not be over-inclusive. It is impossible to predict and lay down practice directions for every conceivable situation or area of practice.

(4) The Code should not restate the law or attempt to clarify it. This might be appropriate for an explanatory memorandum or interpretative text. The Code might give margin references to the appropriate section of the Act.

(5) The Code should not attempt to interpret the Common Law or provide a legal opinion it should limit guidance within the law as it is established to be.

(6) The Code should give guidance in simple, intelligible language[7] using short statements and distinguishing imperative forms (the practitioner 'must', 'shall' or 'should' act in a certain way) from permissive forms ('may') or others less exhortatory ('it is recommended that').

(7) The Code should not constrain professional judgment or provide advice on diagnosis or treatment.

The draft Code of Practice

The draft has been prepared for the Secretary of State by the 91 members of the MHAC. To carry out this task the Commission divided itself into some 17 groups, each providing a substantial contribution to the final document which was subject to editing. The section on 'consent to treatment' was considered to be too long for the Code itself and this was issued as a discussion document prior to circulation of the draft Code. It is not clear what the eventual fate of this discussion document might be, but those parts of it incorporated in the draft code are the most important with respect to the consultation process.

It is evident that no basic principles were established in advance, from which to produce the draft, and the result is an inconsistent document which is far too extensive and over-inclusive to be helpful, practical or influential in guiding practice. The draft is in general couched in a legalistic format, much of the content is a restatement or inaccurate rephrasing of sections of the present Act much of which might be appropriate for a textbook, new edition of the DHSS Memorandum on the Act, or a Commission Occasional Paper. It is not appropriate in a Code.

The draft does not sufficiently distinguish between comment concerning detained patients and that which refers to non-detained patients. It can be argued that the extension of comment to the latter group has drifted far beyond the remit of Section 118. Indeed, if this can be justified, the draft gives little attention to general practitioners or recognises their practical problems in using the Code.

In other places (e.g. mental handicap) the draft extends inappropriately beyond its remit in discussing the basis of forms of mental handicap and providing guidance for diagnosis.

The guidance relating to consent to treatment is of vital importance for all medical practitioners (not only in relation to mental disorder) and provides a basis for discussion. It would be appropriate in a discussion document but its relevance here is questionable in that the law is not unequivocal in this area.

The extension of rules to research has been discussed elsewhere,[8] and is clearly of vital concern to many workers. Here, as elsewhere, the full implications of the recommendations do not appear to have been considered.

There are relatively few practice directions appropriate to the Code and these have to be distinguished with difficulty from the detailed comment, explanation, observations and other matter in the draft.

Discussion

The draft Code of Practice has been circulated widely to the representatives of professions, to the Royal Colleges, Regional and District Health Authorities and Community Health Councils. It has serious implications for all the professions concerned with the care of the mentally disordered and for the future treatment and management of patients. It is of equal concern to all members of the medical profession, not only as the first code to influence medical practice but also because its ramifications, in draft, will concern all doctors, not only psychiatrists.

It is important that all those consulted should respond only after careful scrutiny of the draft to ensure that the final document is concise, pertinent, relevant, simple to understand, advances the rights and care of the patient and respects the obligations and professional judgement of practitioners. It is important to be aware of its possible future legal status.

The gems of practice guidance must be filleted out from all the rest and these may then form the basis for a simple and useful Code.

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The Sheffield Cognitive Psychotherapy Training Course

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This paper describes a basic training course in cognitive therapy for trainee psychiatrists on the Sheffield rotational scheme. Cognitive therapy, as represented by the work of Beck and Ellis, has emerged over the past decade as a potent therapeutic tool, particularly in the treatment of depression. It is a structured, directive, short-term therapy aimed at eliciting and modifying the dysfunctional cognitions which are hypothesised to play a central role in initiating and maintaining emotional disorders.

To date, guidelines for psychotherapy training for psychiatrists issued by the Royal Medico-Psychological Association *British Journal of Psychiatry* (1971)[1] and personal recommendations, e.g. Brandon (1982)[2], have omitted any reference to training in cognitive therapy. However laudable these basic guidelines are, it can be argued that they are significantly under-inclusive. Training in cognitive therapy is, as a result, not likely to receive the emphasis and support it deserves and in future years trainee psychiatrists who have had no training in cognitive therapy could be seen as lacking a genuinely comprehensive psychotherapeutic approach to the psychological management of their patients. It was this point of view that led to the development of the basic training course in cognitive psychotherapy described below.

Trainees in the Sheffield rotational scheme all receive regular supervision in dynamic psychotherapy throughout their training, in line with the Royal College 1971 guidelines, and in addition have the opportunity for supervision in behaviour therapy, group therapy and psychological management of marital and sexual problems. The cognitive therapy group was designed to build on the general psychotherapeutic skills acquired by trainees in dynamic supervision. Trainees are required to have at least six months prior general psychotherapeutic supervision, as a good grounding in relationship-building and interviewing skills are essential if the confronting and directive techniques of cognitive therapy are to be optimally effective.

Aims

The course firstly aims to provide a systematic presentation and a study of Beck's cognitive therapy. Beck's work is used as a basis for the course because it is clearly described in numerous publications, backed by detailed treatment manuals and audio-visual materials of real and simulated

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