

## Principles

The Mental Health Alliance believes that the stated principles on the face of the Draft Bill (least restriction, patient involvement in decision-making and fair and transparent processes) are commendable but insufficient as a framework for legislation.

The Bill also refers to “*general principles*” relating to decision-making under the Act which will feature in the Code of Practice. We believe that the Bill should contain this set of general principles on its face and that, (as in the Scottish Mental Health Act), the Act should stipulate that practitioners “*must have regard to*” them. We recognise that there are inherent tensions in the Bill’s aims to safeguard patient autonomy, least restriction and public safety, but like the Joint Committee, we support the Mental Health Act Commission’s view that the very existence of different and potentially conflicting objectives in the Bill provides all the more reason for principles to be set out on its face.<sup>1</sup> In England and Wales, both the Children Act 1989 and more recently the Mental Capacity Act 2005 set out principles within the legislation itself, as does the Scottish Mental Health Act. There is widespread agreement, as expressed in submissions to the Joint Committee, that principles need to be stated to give all users of the law (including service users and their families) confidence in the law, to support and guide professionals, to assist Tribunals in laying down principled and consistent case law and to inform the exercise of discretion under the law. If the principles are set out in an Act of Parliament, they have the force of an Act of Parliament. If they are set out in a code of practice which can be changed by a member of the executive, they lack the legitimacy that those principles should have.

Furthermore, the Government believes that principles that restate rights and duties in other legislation should not appear on the face of this Bill. We disagree. Where these principles are relevant to the current legislation, they should be restated and the Mental Health Bill should also be cross-referenced to the Race Relations (Amendment) Act 2000, the Disability Discrimination Acts, the Children’s Act 1989 and the Human Rights Act 1998.

Clause 4 allows for the general principles to be disapplied. We do not consider it acceptable that principles can be disapplied for a certain category of patients, or where they are deemed ‘inappropriate’ or ‘impractical’; nor that they can be excluded from applying to functions of the Secretary of State in making certain regulations or directions. This gives the legislator the power to stigmatise service users from the outset. As Professor Richardson has said, “*Principles do not have to be absolute to be effective*”,<sup>2</sup> and the Joint Committee has taken the view that “*the legal principle of proportionality will ensure a degree of flexibility when fundamental principles are in conflict*”<sup>3</sup>

### **Alliance position**

In our view the ten principles below need to be in place on the face of the Bill.<sup>4</sup> Each principle carries equal weight. Implicit within these principles is the notion that therapeutic benefit is derived by patients.

<sup>1</sup> *Report of the Joint Committee on the Draft Mental Health Bill, 2005. Volume I p. 24, para 63*

<sup>2</sup> Professor Geneva Richardson, *Report of the Joint Committee on the Draft Mental Health Bill. Volume II, 20 Oct 2004. Ev.4.*

<sup>3</sup> *Report of the Joint Committee on the Draft Mental Health Bill, 2005. Volume I p.28, para 75*

<sup>4</sup> This list has been developed since the Alliance gave evidence to the Joint Committee on the Draft Mental Health Bill to include a principle of ‘child welfare’. The work on principles within the Alliance’s policy group is ongoing.

- I. Patient autonomy
- II. Treatment being provided without recourse to compulsion
- III. Most effective and least restrictive and least invasive alternative
- IV. Reciprocity
- V. Non-discrimination
- VI. Respect for diversity
- VII. A holistic approach
- VIII. Right to information to enable full participation in care and treatment
- IX. Respect for carers
- X. Child Welfare

### **i. Patient autonomy<sup>5</sup>**

Respect for patient autonomy has been defined as “*the freedom to decide for oneself, the ability to make choices which others will respect*”.<sup>6</sup> The Code of Practice to the 1983 Act expresses the principle as the right to be treated, “*in such a way as to promote to the greatest practicable degree their self determination and personal responsibility.*” This in turn demands that a person’s view of himself or herself, their wishes and preferences must not be overridden without very good reason and if they have full capacity to make choices for themselves those choices must prevail, as they do for people with physical health problems.<sup>7</sup> It follows that patients must be fully involved in decisions about their care and treatment.

Health services increasingly adopt this approach<sup>8</sup> and the law states: “*A competent patient has an absolute right to refuse to consent to treatment for any reason, rational or irrational or for no reason at all even when the decision may lead to his or her death.*”<sup>9</sup> The corollary that advance refusals and advance statements should in general be upheld is gaining recognition.<sup>10</sup>

The Alliance strongly believes that where possible the principles governing mental health care should be the same as those which govern physical health. Any departure from this needs to be justified by a relevant difference between the nature of illness or service provision. The refusal to incorporate capacity as part of a test for compulsory powers promotes discrimination between mental and physical health.<sup>11</sup>

<sup>5</sup> The Expert Committee report recommends a principle of **consensual care** (programmes of care, treatment and support should as far as possible reflect the preferences of the service user, even where intervention in the absence of consent is expressly permitted by law). Whilst the Alliance has not adopted this principle, it is understood in the respect for autonomy principle. *Review of the Mental Health Act 1983*, November 1999, para 37.

<sup>6</sup> *Review of the Mental Health Act 1983*, November 1999, para 2.2

<sup>7</sup> Baroness Hale stated: “*I see the logic of saying that treatment for mental disorder should be no different from treatment for physical disorder. If so, it can only be given with the consent of a capable patient or where it is necessary in the best interests of an incapable one. The use of compulsion also raises some more fundamental questions about discrimination between people with mental disorders and everyone else. Why should the criteria for treatment for mental disorder be different from the criteria for treatment for physical disorder? In other words, why should not this too depend upon consent or incapacity? And why should capacitated people be able to make advance directives about treatment for future physical disorder but not about treatment for future mental disorder? If incapacity were the criterion, rather than the severity of symptoms or the prospect of harm to others, then some people might be given the help they need before their situation became too desperate.*” Paul Sieghart Lecture, 8th July 2004

<sup>8</sup> The recent Government document on choice *Fair for all personal to you* (2003) states “*Our ultimate objective is to improve patient and user experience and build new partnerships between those who use health and social care and those who work in them.*”

<sup>9</sup> *Ms. B (Consent to treatment: capacity) Re* (2002) EWHC 429, Dame Butler Schloss

<sup>10</sup> *R (on application of Burke) v General Medical Council* [2004] EWHC 1879

<sup>11</sup> The Social Exclusion Unit’s report into Mental Health and Social Exclusion found stigma to be the greatest problem faced by people with mental health problems. The Mental Health Act Commission reports, “*Of all mental health patients, none are so stigmatised as those who receive treatment under compulsory powers, because of widespread*

This principle is also important because patients should be able to retain as much autonomy as possible even if they are subject to compulsion. The need for compulsion in some aspects of their care does not mean that the person should lose autonomy in all aspects of their lives and decision-making.

Finally, it is important that patients should be able to express their views openly, without fearing that stating their opinions will be misunderstood by others as being evidence of non-compliance or challenging behaviour. This issue is particularly significant for people detained in forensic secure services.

## **ii. Wherever possible care, treatment and support should be provided without recourse to compulsion<sup>12</sup>**

Mental health legislation with provision for the use of compulsory powers has a specific role to play in the healthcare of patients with mental disorder, but it should only apply after all other alternatives have been exhausted. There are compelling reasons for this:

- A compulsory admission has been described by many patients as humiliating, deeply stigmatising and traumatic for them and those close to them;
- Use of coercive powers may not be therapeutic and may hinder recovery and the fear of compulsion may drive people away from services;
- A compulsory admission carries immediate legal consequences<sup>13</sup> and it can bring about discrimination in employment and housing;
- Research studies show that patients, service users and carers want to share in decisions about their treatment and care and this results in improved outcomes.

There is also a pragmatic reason for the numbers of people under compulsion to be restricted. The compulsory process is resource intensive. It takes front line staff away from voluntary patients and adds to over-stretched health and legal aid budgets. Legislation that sets a framework for a potential increase in compulsion can therefore exacerbate problems in mental health for patients, staff and the public, rather than diminish them.

## **iii. Most effective and least restrictive and least invasive alternative**

This principle is acknowledged in the Draft Bill as one of the general principles to be covered in the Code of Practice. We believe it should be on the face of the Bill. The most effective treatment should be provided in the 'least invasive' manner as well as in the 'least restrictive' manner and environment, compatible with the delivery of safe and effective care and the safety of other patients, carers and staff. Treatment that is provided through psychological interventions such as talking treatments should be promoted as non-invasive and non-restrictive.

Compulsion should not be an alternative to lack of appropriate resources. This may occur, for example, when a patient is unwilling to be admitted to, or stay in, hospital because the fabric of the environment or the level of care has fallen below Department of Health guidance standards.

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*ignorance and fear regarding the purpose and usual causes of detention under the Mental Health Act 1983.*" MHAC 9<sup>th</sup> Biennial Report p72, para 6.34

<sup>12</sup> The Expert Committee and the Mental Health Act Commission also recommend this principle.

<sup>13</sup> Including implications with relation to the DVLA, insurance providers and public office.

#### **iv. Reciprocity**

Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on health and social care authorities to provide appropriate services, including aftercare. The Government is placing much store in individuals having 'respect and responsibility' and we believe that these concepts should be mirrored on the part of mental health and social care services. The Government considers that the Bill meets the requirement of reciprocity but we do not agree. For example, the Bill contains no right to treatment and the provisions for aftercare are extremely limited. The Court of Appeal has recently reaffirmed this principle in respect of aftercare<sup>14</sup> and the House of Lords concurred in deciding that aftercare should be provided free of charge. The Alliance believes that that this principle should include a statutory duty on the authorities to assess the person's health and social care needs and then provide after care services once the person ceases to be detained.

#### **v. Non-discrimination**<sup>15</sup>

The Mental Health Alliance supports the wording suggested by the Mental Health Act Commission: "*All powers under the Act shall be exercised without any direct or indirect discrimination on the grounds of physical ability, age, gender, sexual orientation, race, colour, language, religion or national, ethnic or social origin.*"<sup>16</sup>

We believe that social justice demands fair treatment for all people with mental health problems. In particular, given the extent of discrimination faced particularly by people from black and minority ethnic backgrounds, a statement of non-discrimination would give these groups a basis for confidence in the law.<sup>17</sup>

The Alliance is concerned that mental health legislation should be implemented equally among all groups in society. There is considerable evidence that the current Act is applied more heavily among African and Caribbean people than within other groups.<sup>18</sup> It is vital that the face of the Bill contains a statement about non-discrimination and the promotion of race equality. Beyond such a general statement, each stage of the process must have built-in safeguards for ethnicity. This may include, for example, the provision of advocates from different ethnic groups and who can interpret for those whose first language is not English. It should also be specified that services people are compelled to use must be gender sensitive<sup>19</sup> and culturally appropriate. The detail of these provisions may be best placed in the Code of Practice.

#### **vi. Respecting diversity**

As the Mental Health Act Commission has suggested, the Alliance believes that in particular service users should receive care, treatment and support in a manner that accords dignity and, "*respect [for their] individual qualities, abilities and diverse cultural and religious backgrounds and that properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background, without making*

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<sup>14</sup> R v Manchester City Council exp Stennett et al (2000) QB 370

<sup>15</sup> The Expert Committee called this principle 'Equality'

<sup>16</sup> Mental Health Act Commission, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev.15, para.1.6.

<sup>17</sup> The Expert Committee supported this principle, but said that it should be in the Code of Practice and not on the face of the Bill. Their reasoning was that non-discrimination followed to the letter would not be congruent with treating people against their will under any circumstances whilst they retain capacity to refuse, whilst it is widely accepted that serious risk of harm to self or others is an acceptable condition for compulsory treatment to be imposed.

<sup>18</sup> For example in *Breaking the Circles of Fear*, Sainsbury Centre for Mental Health 2002

<sup>19</sup> The need for services to be gender sensitive is highlighted in several recent Government documents including: the NSF Mental Health; *Safety, Privacy & Dignity in MH Units 2000*; *Into the Mainstream: The Strategy for Woman's Mental Health* DOH 2002/03

*general assumptions on the basis of any of these characteristics.”*<sup>20</sup> Examples include: means ensuring that female only wards are made available for all women patients; making patients aware of their right to apply to be moved to another hospital where there is a greater ethnic mix,<sup>21</sup> or the recognition that Gillick competent children should be empowered to make the same decisions as a competent adult.

### **vii. A holistic approach**

The approach to care, treatment and support in mental health should be holistic, incorporating a service user’s social care needs as well as medical treatment. A multidisciplinary approach should be central to patients’ care and treatment as provided in the care plan.

### **viii. A right to information to enable full participation in care and treatment**<sup>22</sup>

Service users should be provided with all the information necessary, in a format they can understand, to enable them, as far as possible, to participate in all aspects of their assessment, care, treatment and support. This information should also be provided in the appropriate format for the patient and take into account those with literacy problems.

### **ix. Respecting carers**

Those members of families, friends or partners, who provide care to service users on an informal basis should receive respect for their role and experience and have their views and needs taken into account. They provide the bulk of care in the community, whether or not the patient lives with them. They have much experience to give to professional staff through their long association with the patient.

### **x. Child Welfare**

The Alliance welcomes the government’s recognition that the Bill needs to have special provisions for children. In our view this should form a separate division of the Bill. In addition to being cross referenced to the Principles of the Children Act 1989, mental health legislation should contain an explicit principle about child welfare, and recognition that decision makers take account of the child’s wishes and feelings, in line with the White Paper.<sup>23</sup> The latter would mirror the Children Act section 1(3) (a). *“When either informal or compulsory care, and treatment of a child is considered, the child’s welfare shall be the paramount consideration. In all decisions relating to a child decision makers shall have regard to the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding).”*

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<sup>20</sup> Mental Health Act Commission, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004. Ev. 17, para 1.6.

<sup>21</sup> The latter is one of the recommendations of the Inquiry into the death of David ‘Rocky’ Bennett.

<sup>22</sup> The Expert Committee is more explicit in calling for a principle of ‘**participation**’ rather than the right to information which might enable such participation.

<sup>23</sup> *Reforming the Mental Health Act 1983- Part I*, Dec 2000, p.15, para 2.10.