Code of Practice

The Draft Code of Practice must be made available

The Draft Code of Practice must be made available alongside the Bill in order to fully understand the scope of its provisions and to interpret broad concepts that may or may not be amplified within the Code of Practice. There are numerous examples of vague and general concepts in the Draft Bill that will require further clarification, for example that a patient under a Non Resident Order will be prohibited from "specified conduct"; consultation with patients must not be "inappropriate or impracticable" and a "reasonable request" for an assessment must be acted upon. Therefore it is essential that the Draft Code of Practice must be published at the same time as the Bill. Without further clarification these provisions may lack the certainty required to comply with human rights law.

The Mental Health Act Commission pointed to four key areas with clear human rights implications which will appear in the code rather than the Bill itself, namely:

a) the principles upon which the law is to be interpreted;
b) seclusion and restraint;
c) other control and discipline issues, such as searching of patients or control and confiscation of patients' property;
d) consent to treatment issues, including the regard to be given to questions of mental capacity, refusal of consent and advance directives; the framework for consent to psychiatric medication for people subject to compulsion; and the emergency administration of psychiatric medication (for which the Bill proposes no powers, so that the common-law will be relied upon).[1]

As Professor Richardson stated in her evidence to the Joint Committee: "*You are going to be in a very difficult position if you do not have the Codes of Practice or some clear idea of what will be contained in the Codes of Practice, particularly in relation to the relationship between the Mental Capacity Bill and the Mental Health Bill, where a Code of Practice will be available.*"[2]

The Code of Practice should be statutorily enforceable

The status of the Code of Practice is central to the proper safeguarding of patients' rights under the Bill. As the Mental Health Act Commission has stated:
"*Government therefore has a role through its Code of Practice in providing guidance and standards to ensure that rights are respected by different authorities; to provide transparency and predictability in the operation of the law; and, not least, to help authorities avoid spending time and other resources 're-inventing wheels' in drawing up policies and attending to their own practice.*"[3] Provided that it has an adequate status, detailed issues can be left to the Code of Practice.

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[1] Mental Health Act Commission, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* Nov 2004. Ev. 13, para 7.3.
[2] Professor Genevra Richardson, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* 20 Oct 2004. Ev. 4.
[3] *Placed Amongst Strangers: Twenty Years of the Mental Health Act 1983 and Future Prospects for Psychiatric Compulsion: Tenth Biennial Report 2001-2003*; Mental Health Act Commission 2003. Page 68, para 6.23

The Alliance believes that the Bill should specify that the Code of Practice is statutorily enforceable. This means that:

a) compliance with the Code would be binding on practitioners unless there was a good reason to disregard it; and
b) there should be a formal procedure for its promulgation or amendment.

The Expert Committee decided against recommending that the Code should have statutory force because some parts of the Code operate more as good practice than as details of the implementation of the Act itself. However this may not necessarily be an obstacle if it were clearly stated which parts of the Code were to have statutory force (e.g. seclusion and restraint provisions) and which were to operate as 'good practice'. The Part III Code of Practice of the Disability Discrimination Act 1995 is an example of a Code that successfully combines good practice with interpretation of legal obligations.

A Code which has no enforceable status cannot reasonably be said to fulfil the Government's stated objectives of ensuring patients are lawfully and fairly treated with respect for their human rights. Those with responsibility for administering the new legislation would be able to pick and choose when to comply with the Code at their discretion. Such a "toothless" code is an illusory safeguard which merely creates a mirage of rights protection.

Clause 1(2) should be strengthened

Clause 1(2) of the Draft Bill merely requires people acting under the Act to "have regard to" the Code of Practice. As the Bar Council stated in its oral evidence to the Joint Committee:

"*What it means is that the code of practice is a relevant consideration but the weight to be given to that relevant consideration is for the practitioner to determine. That means that if it says, for example, that one must not carry out searches of patients except in certain specified circumstances, if the hospital has had regard to the code of practice but has decided nonetheless that they are going to go ahead and search, one cannot say that they have acted unlawfully; whereas, if it says on the face of an Act of Parliament that you cannot carry out a search except in these circumstances, if they do, it is unlawful.*"[4]

This creates a far weaker requirement than that laid down by the Court of Appeal in *R (Munjaz) v Mersey Care National Health Service Trust and others* and *R (S) v Airedale NHS Trust and others.*[5] The Court ruled that hospitals and professionals are required to follow the Code unless they can show that it is necessary and in accordance with the law not to follow it. This would seem to require that at least, the Code of Practice must be followed unless there is a good reason to depart from it in relation to individual patients. It would not be acceptable to depart from the Code as a matter of general policy. To depart from the Code with no good reason may be a tortuous (legally wrongful) act and also may amount to a breach of Articles 3 and/or 5 and/or 8 of the European Convention on Human Rights.

We believe that the phrase *"have regard to"* should be strengthened by a requirement *"to follow the guidance contained in the Code unless warranted by individual circumstances."* The Bill should make clear that the Code must be observed by all authorities where there are no such individual circumstances. Where these circumstances do exist, particular

[4] Paul Bowen, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* 3 Nov 2004. Ev.184
[5] *R (Munjaz) v Mersey Care National Health Service Trust and others* and *R (S) v Airedale NHS Trust and others* [2003] EWCA Civ 1036

departures from the Code should only be permitted in relation to individual patients. Breach of the Code should make a decision or action unlawful except where the decision to ignore the code is made in relation to an individual, is documented, and can be justified on this basis. The minimum requirement would be that authorities should record and provide reasons in patients' clinical records for departures from the Code's guidance.

The Joint Committee on Human Rights (JCHR) states in its Report on the 2002 Bill that:
"*While the proposed Code has worthwhile objectives breach of the Code of Practice would not seem to make a decision or action unlawful (although the legal status and effects of the Code of Practice are not specified in the Draft Bill, unlike those of the Codes of Practice issued under other legislation such as the Police and Criminal Evidence Act 1984). We note also the Local Authority Social Services Act which obliges authorities to act under the general guidance from the Secretary of State."*[6]

Any amendment of the Code of Practice should be opened to consultation and laid before Parliament

The Bill should lay down a procedure for amendment of the Code of Practice which involves a duty to consult and a duty to lay the amended Code before both Houses of Parliament. While it is important that the Code of Practice can be updated to reflect changing circumstances we do not think it appropriate for there to be unlimited flexibility and we note the problems caused by the last amendments. We consider that changes must be subject to consultation and be placed before Parliament in order to take effect. A model for this is contained in Section 53A of the Disability Discrimination Act 1995.

In this respect the Draft Bill can be contrasted with section 118(4) of the 1983 Act which obliges the Secretary of State to lay copies of the Code before Parliament and, if either House of Parliament passes a resolution requiring the Code or any alteration in it to be withdrawn, the Secretary of State shall withdraw the Code or alteration. That provision does not exist in clause 1(11) of the Draft Bill, so that the power of Parliament to compel an amendment to the Code of Practice is significantly reduced. We suggest that consideration be given to incorporating section 118 (4) into the Bill.

[6] *25th Report of the Joint Committee on Human Rights, Session 2001-02: Draft Mental Health Bill,* 11 November 2002, HL 181, HC 1294, para 21