Mental Health Alliance

Principles

House of Lords Report Stage briefing

Before Clause 1

EARL HOWE
BARONESS BARKER
BARONESS MURPHY
BARONESS MEACHER

Insert the following new Clause—

"Guiding Principles: incorporation in the 1983 Act

(1) Part 1 of the 1983 Act (Application of Act) is amended as follows.

(2) Before section 1 (Application of Act: "mental disorder") insert—

"GUIDING PRINCIPLES

A1 Application of the Act: guiding principles

(1) In discharging of a function by virtue of this Act, a person shall have regard to—

(a) the importance of the patient participating as fully as is possible in the discharge of the function;

(b) the present and past wishes and feelings of the patient which are relevant to the discharge of the function;

(c) the need to ensure that patients are not discriminated against, either directly or indirectly on the grounds of age, gender, disabilty, sexual orientation, race, colour, language, religion or national, ethnic or social origin.

(2) After having regard to the matters mentioned in subsection (1) above the person shall discharge the function in the manner that involves the minimum restriction on the patient that is necessary in the circumstances.""

Purpose of the amendment:

The purpose of this amendment is to insert a list of principles of the face of the Mental Health Act 1983. These include:

a) Patient participation
b) Taking account of present and past wishes and feelings
c) Racial equality, non-discrimination and respect for diversity
d) The overall requirement is that of minimum restriction on the patient

Reasons for the amendment

Principles are needed on the face of the Mental Health Act to ensure that it is implemented in the way it is intended to be. As Lord Hunt has explained, the Government is 'seeking to update (the) legislation, not only to ensure it meets the objective of protection, but to make sure that (it) is in line with modern service provision and promotes patient safeguards'[1]

The Mental Health Alliance (MHA) believes that inclusion of principles in the Act itself is essential to achieving this aim and established precedents for doing so are reflected in 'modern legislation'; such as Children Act 2002, the Mental Capacity Act 2005 in England and Wales and the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003.

Progress in the light of Committee Stage

The Amendment proposed by Earl Howe set out ten guiding principles (see appendix) which were very closely modelled on the Scotland (Care and Treatment Act) 2005, which is already operational.

All of the principles set out in this previous amendment are important. However, the Government has indicated that it may be more accepting of a limited set of principles being on the face of the Bill and that these 'should be broad, so that the codes of practice can provide more detailed information about the supporting considerations that need to be made in order to meet the general principles'[2].

The Government favours this approach because it contends that it would be extremely difficult to 'graft' a more comprehensive list onto an existing act and that therefore the most appropriate place for some of the principles is the Code of Practice. We would challenge the government to indicate which areas of the 1983 Act would be incompatible with a full list of principles. Indeed if any inconsistencies were to be shown it is a case for amending the Act rather than abandoning the principle.

However, taking note of the Government's current views, we have reluctantly reduced the number of principles to the bare minimum which are essential to include on the face of the legislation. The remaining principles, for example, relating to children and carers, must be included and fully explained in the Code of Practice.

If the Government includes a smaller number of principles, this would be consistent with its earlier positions. The 2004 draft Bill set out three general principles in the Bill to ensure that the principles contained in the Code of Practice achieved patient involvement in decision-making; decisions being made openly and fairly and minimum restriction. In its response to the Joint Scrutiny Committee on the draft Mental Health Bill 2004, the Government stated: 'The Government accepts that principles ought to be set out on the face of the Bill, provided that they can be drafted in a way that allows for due protection to an individual's rights and autonomy, while also facilitating practitioners and others to take decisions that are necessary to minimise harm'[3].

[1]Lords Hansard, Mental Health Bill Committee Stage Debate, 8 January 2007, column reference: 46

[2] Government response to the Joint Scrutiny Committee, Recommendation 5 page 9
[3] Government response to the Joint Scrutiny Committee, Recommendation 4 page 8

The importance of putting guiding principles in the Act itself

There is a view that 'a good code of practice can be much more effective in law than principles in a Bill'[4]

Some believe that practitioners will use the Code more readily than the law and that this is the most appropriate tool to influence behaviour and practice. The Code is indeed crucial, but the potential for deprivation of liberty and the use of invasive treatments are such that it is not a question of 'either or', but 'both and'. Member organisations in the Alliance who represent different groups of practitioners insist that their members regularly refer to the Act itself. Secondly, as the Joint Scrutiny Committee stated 'it is not appropriate to leave fundamental guiding principles to the codes of practice'. It is the Act which has a far greater influence on case law. 'The influence of a Code of Practice upon a court, on a take-account of basis is quite different from the influence upon a court, of principles in the statute[5] .Case law (Munjaz) says that Code can be departed from, but guiding principles are of general applicability. Furthermore, because practitioners must ' have regard to' the Code and the Government itself stresses its importance, it is illogical to suggest that inconsistencies can be tolerated between the Act and the Code but not within the Act itself.

There are inherent tensions in the aims mental health legislation such as to provide mental health treatment under compulsion whilst safeguarding the rights of patients and rightly protecting public safety. These tensions make it all the more imperative that guiding principles are clear and robust. As Professor Richardson has said, "principles do not have to be absolute to be effective"[6] and the Joint Scrutiny Committee has taken the view that "the legal principle of proportionality will ensure a degree of flexibility when fundamental principles are in conflict"[7] However, including principles of face of the Act is fundamental to both the effective operation of the Act and the service users and the wider public's confidence in it.

There is a view that the principles may change with time and that legislation does not give enough flexibility to respond. We fundamentally disagree with this view. First the government has not taken that approach in other similar legislation. Second these principles are so fundamental that their endurance can be assured.

Practical issues

Speaking on behalf of the Government, Lord Hunt said 'putting principles in the Bill is not a constitutional problem, rather we are concerned about the practical impact of those principles[8]

The Alliance believes that putting principles on the face of the Bill is fundamental to the successful operation of the Act, among its key stakeholders. These include:

- tribunals and lawyers faced with interpreting the Act;
- practitioners concerned about how to implement it;
- people who may be subject to the Act, who are worried about how it might affect them.

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[4] Lords Hansard, Mental Health Bill Committee Stage Debate, 8 Jan 2007, column reference: 38
[5] Lords Hansard, Mental Health Bill Committee Stage Debate, 8 Jan 2007, column reference: 36

[6] Ibid Professor Richardson Vol II p4 Q5
[7] Ibid Report Vol I p28 Para 75
[8] Lords Hansard, Mental Health Bill Committee Stage Debate, 8 Jan 2007, column reference: 46

Each of these is groups is considered briefly below.

1: Tribunals and lawyers interpreting the Act

The Council on Tribunals is extremely supportive of proposals to include guiding principles on the face of the legislation, to govern its operation and guide its interpretation. The Council is 'disappointed' that the principles currently in the draft Code 'could not be inserted in the Act itself. At the very least, the Council would wish to see in the statute those which reflect the internationally recognised principles of self-determination and respect for human dignity. A clear statement of principles would also greatly assist Tribunals in carrying out their judicial functions under the Act.[9]

Furthermore, experience from the Council on Tribunals in Scotland, who are already working with the Scottish (Mental Health) Care and Treatment Act 2003, suggests that having principles on the face of the Act is extremely helpful.

2: Practitioners

Like the Government, the Alliance understands the importance of having mental health legislation that promotes both the mental health of those using services and public safety. These aims are not mutually exclusive. It is essential to address legitimate public safety issues, and in particular the concern of the Government, expressed by Lord Hunt that 'putting principles in the Bill might well lead to a lack of clarity and lack of understanding by practitioners who have to operate day in day out.'[10]

We appreciate that decisions that the practitioners make about mental health, especially in the context of compulsory care, are extremely complex. Like the Government (Lord Hunt) we understand that the Act should 'leave practitioners with sufficient discretion to deploy their professional judgement proportionately with the patient's needs[11]. Adding principles would not undermine this situation, but on the contrary will help guide practitioners when making these extremely complex decisions.

If however, as the Government says the Act is 'is in large part' about clinical and professional judgements, it is all the more important to have fundamental underpinning principles, similar to GPs and the Hippocratic oath.

3: Service users

As Lord Hunt said himself 'there will always be a need for mental health legislation to protect a person with serious mental health problems from harming themselves or others'[1]. This is a strong case for why there will always be a need for putting principles on the face of the Bill

As already highlighted, discretion of individual clinicians is extremely influential. In contrast to physical health, the criteria on which decisions are made are necessarily less objective and always involve value judgements. Hence there is a need to provide a framework for making these judgements to minimise sometimes unintended injustice and promote confidence among service users, particularly those from BME groups.

The Government is naturally concerned about amendments which carry heavy resource implications. Although we have not conducted an analysis on this question, we believe that inclusion of the principles would have little resource requirements. Indeed, Lord Hunt has said, 'The 1983 Act already contains overriding principles, albeit that they are inherent in its

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[9] The Joint Committee on Human Rights – Memorandum by the Council of Tribunals on the Mental Health Bill.

[10] Lords Hansard, Mental Health Bill Committee Stage Debate, 8 January 2007, column reference:46

[11] Lords Hansard, Mental Health Bill Committee Stage Debate, 8 January 2007, column reference: 49

provisions and not separately spelled out'[12]. This amendment would be making explicit what is already implicit.

Reasons for including specific principles on the face of the Bill

(a) Participation

Patient choice and participation in their care and treatment are central tenets in the new NHS. The old maxim that "doctor knows best" is no longer accepted and a partnership between professionals and their patients is favoured.
For example, 'giving people a say' was one of the guiding principles of the consultation in '*Your health, Your care, Your say'* which informed the development of the White Paper on social care and community health services.[13]

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The use of compulsion should not negate participation. When the context is one of using compulsory powers, it is all the more important that service users are fully involved as much as possible, at all stages of their assessment and care. This is not merely good practice but is likely to enhance engagement, treatment outcomes and where relevant, public safety. This principle is fundamental to achieving trust between clinicians and patients. One service user has described her experience of being sectioned as follows: 'Its like you lose trust from others, so that they don't trust you or your opinions are no longer valid. You feel an outcast'[14]

As the Mental Health Act Commission's Biennial report for 2003-5 explains: "Too many patients feel that they are excluded from decision-making. This is likely to exacerbate the likelihood of non-compliance after discharge and may contribute to the problems of 'revolving door' readmissions."

(b) Present and past wishes and feelings

In its response to the pre-legislative Scrutiny Committee on the 2004 Draft Mental Health Bill, the Government accepted the importance of the principle that 'practitioners should have regard to the past and present wishes of the patient', and that 'these considerations are an integral part of any principle about patient involvement'[15].

Unlike the Government, the MHA believes that this principle should be in the Bill and not in the Code. The importance of ensuring that the patient has a strong voice in relation to decisions is now the basis of the Mental Capacity Act 2005 which recognises that, even where a person is not able to make a decision for himself or herself, the person still may have views which should be ascertained and to which others should have regard. The same principle should apply in relation to mental health law, and underlies many of the new directions of practice, including the development of advocacy and advance statements, which will be included in a revised Code of Practice.

Example – John has written a crisis plan for mental health professionals to consider if he becomes unwell again in the future. This includes asking that if possible when he is admitted

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[12] Lords Hansard, Mental Health Bill Committee Stage Debate, 8 January 2007, column reference: 47
[13] 'Our Health, our care, our say: a new direction for community services' DH Jan 2006
[14] Graham Morgan quoting other service users in 'A users view of the Mental Health Act' ADSW and Mental Health Nursing Conference Feb 2004
[15] Government response to the Joint Scrutiny Committee Recommendation 7 page 9

to hospital that he is accompanied by his father (rather than a social worker and the police) and that he is not taken to the locked ward where he has had bad experiences in the past. This makes John feel that he can participate in the sectioning process.

(c) Non-discrimination

There are some general and specific reasons which suggest that a principle of non-discrimination on the face of the Bill is essential.

Firstly, in spite of the Government's anti stigma initiatives, such as the Shift campaign[16], the very recent British Social Attitudes[17] survey shows persistent confusion and prejudice. Amongst most members of the public, people with mental illness are not seen as 'disabled' in the same way as those with physical conditions, but still face some of the most discriminatory attitudes. In this context, the influence of mental health legislation extends far beyond compulsory care. It has a powerful symbolic value, reflecting the priorities of Government and the mood of wider society.

Secondly, a principle of non-discrimination is particularly important in relation to 1) sexual orientation and sexual identity and 2) those from BME groups.

1) The Joint Committee on Human Rights has drawn attention to the broad definition of mental disorder which, which now brings within its scope disorders sexual preference which are currently excluded from the 1983 Act. The Committee believes that the effect of this is that paedophiles can be subject to indeterminate detention under the Mental Health Act, without an accompanying mental disorder. It believes that there is lack of clarity in the scope of the Bill and concludes that 'given the Bill's new, broad definition of mental disorder, it is desirable to state on the face of the Bill, key non-discrimination principles so as to avoid discrimination on the grounds of sexual orientation and sexual identity.[18]

2) Based on its Race Equality Impact Assessment, the Government believes that any changes to the patterns of detention will not be significant under the new Bill. The MHA takes a different view. In particular, we fear that the single definition of mental disorder and the provisions to allow treatment in the community, (not only in a hospital), will lead to more people being detained, perpetuating over-representation of BME groups. However, if there is no significant change, in current patterns, BME people will continue to be over-represented[19]. This represents a failure to eliminate unlawful racial discrimination, promote racial equality of opportunity, and promote good relations between people of different racial groups as required by the Race Relations Amendment Act.

The consensus within the BME Mental Health Network is that specific measures must be built into the primary legislation which sets the parameters of acceptable behaviour of mental health professionals and others when dealing with an ethnically diverse client group'[20]. The

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[16] Shift, Tackling Stigma And Discrimination; The National Social Inclusion Project (NSIP); And The Delivering Race Equality In Mental Health Care Action Plan (DRE).

[18] Joint Committee on Human Rights Legislative Scrutiny: Mental Health Bill Report Jan 2007 HL Paper 40 p3 Summary

[19] Healthcare Commission : Count me in 2005 "Overall, inpatients from the Black Caribbean, Black African, and Other Black groups were more likely (by 33% to 44%) to be detained under the Mental Health Act 1983 when compared with the average for all inpatients. The rate of detention for inpatients from the Other White group was also slightly higher than average. Differences among other minority ethnic groups were not statistically significant.
Men from the Black Caribbean, Black African, and Other Black groups had a higher rate of detention (25% to 38% above average). A similar pattern was noticed for women, with the rate of detention 56% to 62% higher for those from the Black Caribbean, Black African and Other Black groups. The rate of detention for those women from the Indian, Other Asian and Other groups was also somewhat higher."

[20] Letter from BME Network to Patricia Hewitt 13 November 2006.

population of England and Wales is extremely ethnically diverse and so such measures must be at the heart of the new Mental Health Act.

The MHA applauds the work of Delivering Race Equality in Mental Health (DRE). However, as presently drafted, the legislation undermines such initiatives instead of complementing them.

Furthermore, the Government intends to introduce the availability of appropriate treatment as one of the criteria governing compulsion (replacing the 'treatability' clause). A principle would help to ensure that the treatment being considered is also culturally appropriate

(d) Minimum restriction

The purpose of this clause in the amendment is to ensure that exercising this function in the manner that involves the minimum restriction should apply at all stages under the Act. This includes the assessment stage, when practitioners should first consider whether all other alternatives to compulsion have been exhausted, not only once the decision to use compulsory powers has been taken.

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. The fear of compulsion may drive people away from services.
- A compulsory admission carries immediate legal consequences[21] and it can bring about discrimination in employment and housing.
- Compulsory treatment is costly both in terms of over-stretched health and legal aid budgets and of staff time.
- Health outcomes are improved when patients have control over medical decisions which affect their health. Under compulsory powers they lose this degree of autonomy.

Compulsion is seen as, and may sometimes be used as, an easy or cheap option. This is a strong safeguard against compulsion being used as 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 national guidance standards.

Adopting the approach of minimum restriction is important in several situations. It relates to the way the powers under the Act are used – for instance in the granting of leave of absence, supervised discharge and the use of powers of transfer of patients between hospitals. It relates also to the form of treatment, which should be given in the least invasive manner as possible. For instance there is widespread concern about inappropriate and excessive use of seclusion and physical restraint especially among patients from African-Caribbean communities. In some cases, this has proved fatal[22]. This principle is one crucial way of reinforcing appropriate conduct among practitioners and allaying the legitimate fears of service users.

[21] Including implications with relation to the DVLA, insurance providers and public office and foreign travel

[22] For example, the death of David 'Rocky' Bennett at the Norvic Clinic on 20th October 1998

APPENDIX

List of principles in the Committee Stage Amendment 8 January 2007

Before Clause 1

EARL HOWE
BARONESS BARKER
BARONESS MURPHY

1 Insert the following new Clause—

"Guiding Principles: incorporation in 1983 Act

(1) Part 1 of the 1983 Act (Application of Act) is amended as follows.

(2) Before section 1 (Application of Act: "mental disorder") insert—

"Guiding principles

A1 Application of Act: "guiding principles"

(1) In discharging a function by virtue of this Act a person shall have regard to—

(a) the importance of the patient participating as fully as is possible in the discharge of the function;

(b) the importance of providing such information and support to the patient as is necessary to enable the patient to participate in accordance with paragraph (a) above;

(c) the present and past wishes and feelings of the patient which are relevant to the discharge of the function;

(d) the views of any carer of the patient, or other person who is involved in a professional capacity, and which are relevant to the discharge of the function;

(e) the full range of options which are available in the patient's case;

(f) the need to ensure that, unless it is justified in the circumstances, the patient is not treated in any way that is less favourable than the way in which a person who is not a patient might be treated in a comparable situation;

(g) the need to ensure that patients are not discriminated against, either directly or indirectly, on the grounds of age, gender, sexual orientation, race, colour, disability, language, religion or national, ethnic or social origin;

(h) the importance of maximising the benefit to the patient from the discharge of the function;

(i) the need to ensure that when either informal or compulsory care and treatment of a child aged under 18 years is considered, the welfare of the child is the paramount consideration; and

(j) the need to ensure that compulsory treatment or detention of a patient under this Act should be matched by a reciprocal duty to provide treatment and support of a likely health benefit to that patient.

(2) After having regard to the matters mentioned in subsection (1) above the person shall discharge the function in the manner that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances, including a preference for informed care and treatment when circumstances permit.""