



editorials

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The Draft Mental Health Bill in England: without principles[†]

A Joint Committee of the House of Commons and the Lords has been charged with considering the Draft Mental Health Bill 2004. Despite 6 years of preparation and consultation, the Bill still provokes strong and largely adverse reactions from most quarters. The work of the Joint Committee is to address ten key themes and here we discuss their first question, 'Is the Draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?' This paper summarises the key national and international policies relevant to the Draft Mental Health Bill, presents a comparison of their recommendations in terms of guiding principles, and comments on the degree of fit between the Bill and these policies.

The Bill in relation to key national and international mental health policies

Along with reference to the recently enacted Mental Health (Care and Treatment) Act 2003 in Scotland (Scottish Executive, 2003), and the recommendations of the Richardson Committee (Richardson, 1999), the following national and international mental health policies can be used as points of reference to assess how far the Bill is consistent with their recommendations:

- The National Service Framework for Mental Health (Department of Health, 1999)
- Social Exclusion Unit report, *Mental Health and Social Exclusion*, published by the Office of the Deputy Prime Minister (Social Exclusion Unit, 2003)
- World Health Organization report, *World Health Report on Mental Health 2001* (World Health Organization, 2001)
- United Nations report, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care 1991* (United Nations, 1991)
- World Psychiatric Association, Declaration of Madrid 1996 (World Psychiatric Association, 1996).

As the Draft Mental Health Bill 2004 does not give an explicit account of its guiding principles, we must infer how far its measures, if implemented, would be consistent with the principles set out in these policies, and this is summarised in Table 1.

Discussion

Table 1 makes it clear that most of the principles seen as fundamental to good practice in mental health (in the relevant national and international policies) are *neither explicit nor implicit* within the current Bill. It is also apparent from this table that of the 12 key principles that

consistently emerge from this review, the Bill conflicts with five (choice, therapeutic benefit, autonomy, dignity, least restrictive treatment), the Bill does not refer to or is unclear for five (participation, non-discrimination, access, capacity, family involvement) and the Bill may support only two (advocacy, safety).

Of particular importance is the fact that there is no reference to the principle of 'therapeutic benefit', explicitly stated in all of the key references. The Bill requires that medical treatment be available which is 'appropriate in the patient's case, taking into account the nature or degree of his mental disorder and all other circumstances of his case'. 'Appropriate' is ambiguous and has no necessary connection with 'therapeutic benefit'.

The proposals for the Non-Resident Order (a form of community treatment order) do not currently fulfil the principle of effective interventions, as the international research on these arrangements does not show strong evidence for their effectiveness (Ridgely *et al*, 2001; Preston *et al*, 2002).

Although the principle of safety is given salience in the Bill, it is unlikely that its expression is consistent with the intended meaning, for example, in the United Nations Principles. The third criterion for the application of an involuntary treatment order states that protection of the patient should be on the basis of *serious* self-harm or *serious* neglect of his health or safety. Yet the 'protection of others' in this criterion is not qualified by a phrase containing the word *serious*. A difference in threshold for compulsion is thus implied. This conclusion is reinforced by a further clause which states that another criterion – that medical treatment cannot lawfully be provided without the patient being subject to compulsion – may be (or must be – it is not clear which) waived when there is a '*substantial risk of serious harm to other persons*'. So the risk of harm to others is to be divided into two classes with that for the 'protection of others' in the third criterion being less than 'substantial' and 'serious'. Thus the 'protection of others' applies to risk that may be 'substantial' but not 'serious', or 'serious' but not 'substantial', or neither serious nor substantial. The gulf then between an acceptable level of risk to the patient's own health or safety, which must be serious, as against the non-serious risk to others is even wider than appears at first.

The waiver when there is a '*substantial risk of serious harm to other persons*' of the requirement that no lawful alternative exists to the use of compulsion (the most common alternative being the patient's acceptance of informal treatment) is a radical departure in mental health legislation, whose underlying philosophical basis has not been discussed. It is clearly contrary to the 'least

[†]See pp. 248–249 and 250–251, this issue.

Table 1. Principles relevant to the Draft Mental Health Bill (2004) in relation to key national and international mental health policies

		England							
		National Service Framework for Mental Health (1999)	Social Exclusion Unit (2003)	Scottish Executive (2003)	Richardson Committee (1999)	United Nations (1991)	World Health Organization (2001)	World Psychiatric Association (1996)	Relation to Draft Mental Health Bill (DMHB) (2004) ¹
Principle									
1. Participation	Involve service users	Involve service users	Effective care to prevent crises	Regard to past and present wishes of patient, . . . full patient participation	Participation by service users	Right to the best available mental healthcare. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs . . . in the best interest of the patient	Consumer involvement . . . right to information and participation	Patient should be accepted as a partner by right in therapeutic process	Code of practice must secure patient involvement in decision-making <i>Principle not explicit in detail.</i> <i>No clear mechanisms proposed for participation</i>
2. Therapeutic benefit to the individual patient	Effective care	Effective care to prevent crises	Effective care to prevent crises	Importance of providing maximum benefit to patient	Reciprocity between detention and right to treatment	Right to the best available mental healthcare. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs . . . in the best interest of the patient	Efficient treatment	Providing the best therapy available consistent with accepted scientific knowledge. Treatment must always be in the best interest of the patient	<i>No therapeutic benefit principle stated. Treatment definition (including habilitation, training and education) may not be consistent with international definitions of treatment</i>
3. Choice of acceptable treatments	Acceptable care and choice	Acceptable care and choice	Genuine choices	Importance of providing appropriate services to patient	Non-discrimination	These principles shall be applied without discrimination of any kind	Wide range of services	Allow the patient to make free and informed decisions	<i>Choice not an explicitly stated principle</i>
4. Non-discrimination	Non-discriminatory	Fair access regardless of ethnicity, gender, age or sexuality	Fair access regardless of ethnicity, gender, age or sexuality	Have regard to encouragement of equal opportunities	Non-discrimination	These principles shall be applied without discrimination of any kind	Equality and non-discrimination	Fair and equal treatment of the mentally ill. Discrimination by psychiatrists on the basis of ethnicity or culture, whether directly or by aiding others, is unethical	<i>This principle not explicit or implicit except to introduce a due legal process of mental health tribunals. Concerns that previous patterns of greater use of the Mental Health Act 1983 in relation to African and Caribbean patients may persist</i>
5. Access	Accessible	Accessible	Accessible	Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives	Local services	Local services	Local services	Principle addressed in part in the Non-Resident Order (community treatment order, CTO). International evidence base for CTOs is weak	

continued overleaf



6. Safety	Promote safety	To protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others	Physical integrity of service user	Safety through the emphasis on risk assessment, and risk management is a prominent implicit principle in the DMHB
7. Autonomy and empowerment	Independence	Service user autonomy	Patient empowerment, autonomy	This principle not explicit or implicit
8. Family involvement	Maintain employment	Consensual care	Partnership with families, involvement of local community	Relates to the role of the nominated person, a person whose roles and responsibilities are not yet stated in detail. Need not be a family member
9. Dignity	Social and family participation	Have regard to needs and circumstances of patient's carer	Preserve dignity	This principle is neither explicit nor implicit
10. Least restrictive form of care	Respect for diversity	Respect for the inherent dignity of the human person	Therapeutic interventions that are least restrictive to the freedom of the patient	Code of practice must secure that interference with, and restrictions of patient must be kept to minimum necessary to protect their health or safety or other persons. Principle is not given in explicit detail
11. Advocacy	Informal care when possible, least restrictive alternative	Every patient shall have the right to be treated in the least restrictive environment	When the patient is incapacitated and/or unable to exercise proper judgement because of a mental disorder, requires psychiatrist to consult others and safeguard human dignity of patient	Explicit function via Independent Mental Health Act Advocates
12. Capacity	Base provisions on principle of capacity	The person whose capacity is at issue shall be entitled to be represented by a counsel. Criterion of impaired judgement for involuntary treatment		

1. Commentary in italics.



restrictive alternative' principle. The health benefit to the patient, usually seen as the primary purpose of mental health legislation, is thus subverted by the primacy of avoiding risk to others.

Yet a further problematic consequence of the concern with risk to others is the granting of powers, in civil cases, to mental health tribunals to reserve to themselves the decision to grant leave to or to discharge a patient. This is a form of 'restriction order' such as that used in the forensic arena, which is now to be applied generally. It means that the clinical supervisor's decision that it is appropriate for the patient to now be treated informally can be overridden by the tribunal.

The manner in which the principle of safety is given salience in the Bill is likely to reinforce common and stigmatising stereotypes that associate mental illness and violence. This conflicts with the principles of participation, autonomy and empowerment, and dignity. It is also in direct conflict with the policies contained in the Government's recent policy paper by the Social Exclusion Unit (2003).

Apart from the support for advocacy, it seems reasonable to conclude that this Bill is lacking in the remaining principles enunciated in the key policy documents that have provided a framework for our discussion. Why is this important? We doubt that legislation not founded on the national and international principles underlying modern mental health services can further the objectives of those services. Instead we have concerns that such ungrounded law will undermine the aspirations of both users and providers of mental health services to act in accordance with fundamental principles such as dignity, autonomy, empowerment, access and non-discrimination. In this sense it may not only be without principles, but there is a danger that in some circumstances (for example, when there are

pressures for increased social control) its use could become unprincipled. We therefore agree with the report of the Joint Committee that 'the fundamental principles underpinning the legislation must be set out on the face of the Bill' (Joint Committee, 2004–5).

Declaration of interest

None.

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