

## **A PRINCIPLED APPROACH TO LEGISLATION (September 2004)**

### **THE REVIEW**

1. The Review of Mental Health and Learning Disability (Northern Ireland) is based on a set of fundamental values, which emphasize respect for the autonomy of the individual, justice and fairness. A Framework of guiding principles has been detailed for service development and service provision, with three high level objectives set:
  - a. to recommend reforms of service for each user group;
  - b. to review the strategy for mental health promotion etc;
  - c. to review the law, including:
    - relevant legislation and other requirements relating to human rights, equality of opportunity and social inclusion of people with mental health needs or a learning disability and their carers;
    - the Mental Health (Northern Ireland) Order 1986; and
    - to make recommendations regarding future legislation to reflect the needs of users and carers, in the context of the framework values and principles.
2. For the review of the law, the Legal Issues Working Committee is tasked with reviewing the Mental Health (Northern Ireland) Order 1986 and to make recommendations regarding future legislation, while the Human Rights and Equality Sub Group has been similarly tasked to consider human rights and equality issues.
3. Mental Health Legislation reflects the values and concerns of the society of its time. As such, it is liable to change, as these values and concerns evolve and change. The Review is also required to keep pace with innovation and developments in the care and treatment of people with a mental disorder and those with a learning disability.
4. The aim is to produce a coherent and integrated strategy with supporting legislation. Indeed, evidence suggests that the level and type of service provision influences the pattern of use of legislative powers (Wall et al, 1999) and the setting out of values and principles within legislation and Codes can help guide and shape practice.
5. There are significant advantages for Northern Ireland, therefore, in having legislation reviewed in conjunction with service strategy, in that the same value base and principles can be applied in all aspects of mental health care. This should help to ensure that legislative powers are used appropriately and that there is continuity of service provision regardless of legal status.

6. We propose that the review of mental health legislation should begin with agreeing those fundamental principles which best reflect society's present and, perhaps, future values and aspirations to help guide and provide a foundation to this work. A set of principles not only allows a test of the present legislative position, but also gives a basis to reconsider the purposes for which legislation is required and under which legislative umbrella these purposes may be best served.
7. Whilst the primary purpose of mental health legislation has been to regulate the circumstances in which people with a mental disorder can be detained, and, if necessary, treated against their will, for their own protection and/or the protection of others, it is also used to protect the rights of vulnerable people with mental disorder and to protect them from abuse and exploitation. Previous gaps in legislation relating to capacity and decision-making, policy developments such as that relating to Vulnerable Adults and case law relating to Human Rights legislation must also be considered.

## CONTEXT

8. A number of significant local, national and international changes and developments have taken place since the previous Review of Mental Health Legislation (prior to the Mental Health (Northern Ireland) Order 1986), which need to be taken into account. These cover a number of areas including:
  - **The incorporation of the European Convention on Human Rights into domestic legislation in 2000 through the Human Rights Act 1998.** This has reinforced the importance of individuals' rights and freedoms and serves to make more explicit the duties and obligations of those who are charged with the responsibility of implementing and monitoring mental health and other related legislation. In addition and arising from the European Convention, there have been significant developments in both European and Domestic law in relation to equality and discrimination.
  - **Significant developments in community-based care within mental health services.** These have extended alternatives to hospital care and treatment, and the service strategies proposed by this Review should result in more local options in less restrictive forms of care.
  - **In the area of Learning Disability there have been developments in diagnostic practice.** These have further improved identification of mental illness and, in turn, more appropriate treatment and services. Developments in community care have enabled many people with a learning disability to live more independently with support in community settings.
  - **Issues of stigma continue to be identified and indeed some may see the use of legislation in relation to mental disorder as stigmatizing.** This is particularly an issue for people with a learning disability, many of whom will

never suffer from a mental illness and do not consider themselves to have a mental disorder.

- **The Advocacy movement continues to grow and become more confident in relation to both people with a learning disability and those who live with mental ill-health.** This has enabled more effective participation of both groups in the planning and monitoring of services, and also for those who provide care for people with a learning disability and those with mental ill-health. The concept of partnership and the rights of users and their carers to have a more effective role in treatment and care is gaining momentum.

9. In acknowledging the various changes, the challenge is to have mental health legislation, which can continue to be relevant for the next generation.

## **WHY SPECIFIC PRINCIPLES FOR LEGISLATION?**

### **The Issues**

10. An essential function of mental health legislation has been to provide a balanced legal structure to regulate and balance the tensions among three basic claims:

- individual freedom;
- bringing treatment to bear where it is necessary and can be beneficial; and
- the protection of the public.

11. Historically in the United Kingdom, the use of compulsion has been permitted when significant harm is foreseeable, if an individual remains at liberty. Its purpose is to protect the individual or others from those risks that arise when a person's capacity to judge risks, or to control his/her behaviour giving rise to them, is impaired by mental disorder. The loss of such a fundamental right as liberty demands that special duties be imposed on those given such powers, that rights and protections be afforded to those subject to these powers, and that these are independently scrutinized.

12. It is accepted that the values and principles underlying the whole Review should also apply to legislation, and we must consider why legislation might need specific principles.

13. Mental Health Legislation presents a particular situation where the needs of people with a mental disorder and the demands of society require that the ethos of Health and Social Care and legal frameworks are bridged. Traditionally in medicine, the emphasis is on the principles of non-maleficence (least harm) and beneficence (benefit), whereas in the legal framework the emphasis is on autonomy and justice (Beauchamp and Childress, 1989). The social care model could be said to span aspects of both. A way must be found to address these

interfaces at which health and social care and legal systems meet, and it is proposed that this be the common ground of agreed principles.

14. However, having recognition and acceptance of principles does not provide a means of choosing between them. There remain fundamental tensions between autonomy and beneficence, for example. Having a principle-based legislation, however, can provide signposts to guide resolution of the dilemmas that are inherent when a person is deprived of his liberty, or has his rights interfered with.
15. It has been interesting when reviewing the international situation, and even more locally in the United Kingdom, to see emerging themes in the identification of principles. There has clearly been a shift from medical paternalism (with the emphasis on beneficence and non-maleficence) towards the human rights-based justice and autonomy (Scottish Executive, 2000).

### **International Perspective**

16. While the content of principles developing internationally show consistency, there is wide variation in the number, detail and focus of those selected. For example, for the care of those with mental illness, the list of principles issued by the United Nations extends to 25, the World Health Organization list is 9, and the Mental Health charity MIND has 8.

### **Locally**

17. Locally, the Code of Practice relating to the Mental Health (Northern Ireland) Order 1986, published in 1992, made significant advances in introducing principles to underlie the interpretation and implementation of legislation. However, the Code limited its purpose to providing guidance only to professional staff and not to the public or patients.
18. In addition, the delay in producing this document and what appears to be, in retrospect, a lack of commitment and consistency in promoting both the Code and the principles it contained among all those charged with implementing the Order, meant that for many they were effectively lost.

### **APPLYING PRINCIPLES IN THE REVIEW OF MENTAL HEALTH LEGISLATION AND CAPACITY**

19. The Richardson Committee reviewing the Mental Health Act 1983 in England and the Millan Committee reviewing Mental Health Legislation in Scotland have shown significant similarities in the principles they recommended, but also significant variations in their emphasis. There are lessons to be learned from the English and Scottish experience.

20. The Millan Committee strongly recommended that a list of principles be included within the legislation, and this has been done in the Mental Health (Care and Treatment) (Scotland) Act 2003. This was not achieved without considerable opposition, however, particularly to the inclusion of Reciprocity (the principle that those compelled to accept treatment have a right to have adequate services) as it has significant funding implications.
21. In England and Wales, the Richardson Committee made a similar recommendation to include Reciprocity, which the Government did not accept. Some principles proposed were accepted and not others, altering the overall balance (Department of Health, 2000).
22. We take our lead from the Scottish experience, where the consensus is that the legislation was strengthened by the inclusion of principles.

### **The Broader Picture of Legislative Change on Capacity**

23. There are wider developments affecting legislative reform, in particular, the proposals for Capacity/Incapacity Legislation and developments in other aspects of the Review e.g. Human Rights and Equality Sub Group's work which interfaces with the fundamental issues in the review of mental health legislation.
24. There has been widespread support for the introduction of legislation to cover issues of impaired capacity for people whose decision-making is affected by their mental disorder or a learning disability. Previously there had been significant gaps in legislation (Lord Chancellor's Department, 1997). In relation to mental disorder, these were covered in part by Part IV of the 1986 Order, which imposes conditions on giving treatment with or without consent; and by some provisions within the Order in relation to the financial protection of people with mental disorder, who are unable to manage their financial affairs, and protection from sexual and other exploitation.
25. Proposals for Capacity Legislation look to protecting the interest of adults who lack the ability to make decisions about their own finances or welfare, including medical treatment, or who are unable to communicate their decision.
26. Developments in thinking about how best to approach issues of capacity have led to developments in thinking about the basis under which the loss of a person's rights to refuse interventions or treatment under the Mental Health Order might best be justified. There is a growing body of thought which would consider that the most significant (and perhaps only) grounds for depriving a person of his rights is likely to be on the basis of his impaired capacity to make decisions about his mental health, safety and/or the safety of others (Zigmond, 2001).

27. There are a number of reasons, therefore, why the Capacity Legislation is relevant to this Review, even though responsibility for recommendations for such legislation lies outside its brief with the Office of Law Reform.
28. In the first instance, the definition of mental disorder should be consistent across legislation, together with the concept of capacity and how it is assessed. A number of the functions previously permitted under the Mental Health Order for the protection of vulnerable people may in the future fall under capacity legislation, so the content of any mental health legislation will change.
29. It is likely that Capacity Legislation will apply for medical treatment of both physical and mental illness for patients who are without capacity (as legally defined) and, in the main, not resisting (compliant). In proposals for England and Wales, it appears that Mental Health Legislation will apply to those persons who are a risk to themselves or others because of their mental disorder, but are refusing treatment, and these powers specifically and only relate to treatment for their mental disorder. Some people with both mental and physical disorder who do not have capacity may fall under both.
30. For all these reasons, it is important that the same principles underlie and pervade both the construction of the legislations and their implementation. There is further work to be done on this interface, but whatever the outcome, the general principles should be common. The Office of Law Reform is working closely with this Review (see below).

### **The Principles Base for Incapacity/Capacity Legislation**

31. In Scotland, as well as principles being included in the new Mental Health Legislation, principles are also incorporated into the Adults with Incapacity (Scotland) Act 2000. The emphasis here is on benefit to the person, the least restrictive option, taking account of the person's wishes and the views of relevant others, and the encouragement of participation.
32. The original proposals for a Mental Incapacity Bill in England did not have this clear statement of principles, but following the hearings of the Parliamentary Joint Committee of the Houses of Commons and Lords on the Draft Bill, a recommendation was made to incorporate a statement of principles on the face of the legislation, which was accepted. In the spirit of "presumption of capacity", the name has also been changed to the Mental Capacity Bill.
33. It is interesting, again, to note both the similarities and the differences here. Scotland thought it was important to include that "account must be taken of the views of relevant others," whereas in England "individuals must retain the right to make what might be seen as eccentric or unwise decisions".

## **Developments within the Review**

34. We have liaised with and taken account of the deliberations and findings of the Human Rights and Equality Sub Group and find it very helpful to reiterate some points from their draft paper SC 32/04 “Human Rights and Equality Principles”. In particular that “there may be circumstances when it is appropriate to curtail a person’s human rights, but this should be limited to the minimum extent necessary”. Also, that “the human rights of any individual have to be considered in the social context in which they live, which is one of relevant and often competing rights, interests, responsibilities and duties. Ultimately, law and decision-makers must attempt to strike the appropriate balance in relation to these relevant and often competing rights, responsibilities and duties”.
35. That paper helpfully lays out the legislative obligations and makes the strong point that rights are ultimately of no value unless people enjoy the protection offered by human rights in their daily lives. They must, therefore, know about their rights and be able to enforce their rights, where these have been breached.
36. The paper also emphasises the importance, especially for people with a learning disability, of the need for additional support, information and training to maximise understanding and participation, and stresses the importance of how language is used, and the necessity for education. Additionally, it points out the increasing importance and recognition of the role of the advocate, the potential of conflicting interests of the nearest relative and the special requirements of children as a vulnerable group with their own Convention on the Rights of the Child.
37. Finally it says that resources, although finite, should not compromise human rights and equality obligations or standards. The Group’s recommendations resonate with our own.

## **CONSULTATION**

38. A Conference was arranged in January 2004 specifically to address the place of principles and the issue of capacity. Invitations were issued to all members of the Review, its Working Groups and relevant guests. The programme was designed to incorporate presentations from experts involved in the English review and the Scottish implementation of their new legislation, and a Principle-Proofing of the Mental Health (Northern Ireland) Order 1986. Significant time was devoted to workshops where participants were able to propose principles to underpin legislative reform in Northern Ireland. The results, which were captured and reported on the day, are incorporated into our proposals.
39. Following the conference, 3 small working groups were established within Sub Group 1 specifically to elaborate principles in detail and examine the applicability of these principles to specific populations i.e. Adults, Children with Mental Health Problems and People with a Learning Disability.

## **ISSUES ARISING FROM THE WORKING GROUPS**

40. Each group used similar processes, including reviewing all the papers already prepared. Previous work had principle-proofed the Mental Health (NI) Order 1986 and found it wanting in a broad number of areas, including autonomy and equality, non-discrimination, privacy, lack of participation and lack of transparency. A useful exercise was carried out examining the principles proposed by the Richardson and Millan Committees, in the Code of Practice for the Mental Health (Northern Ireland) Order 1986, and the principles proposed by the Workshop Groups at the January conference.

### **Adult Mental Health**

41. It was acknowledged that while the principles in the Code of Practice were forward-looking in their day, the legislation itself does not even meet some of its own principles, which seems to be a consequence of the process whereby the principles and the Code of Practice were formulated after the review.

42. The issue of how to ensure that principles are meaningfully incorporated and then translated into practice must be addressed. It seems essential to agree principles before any other developments in the review of legislation so that they can underpin all the basic concepts, and then to consider what mechanism will best ensure that they guide the implementation of the legislation.

### **Children With Mental Health Problems**

43. This sub-group emphasized the particular vulnerability of children and young people with mental illness and disability. Reference was made to the Children (NI) Order 1995, which is the basis of the main statutory framework for the provision of services to children in Northern Ireland and which provides a legal framework for the provision of services to children in need. This legislation has been ground-breaking in establishing the value of guiding principles within the face of the legislation.

44. There is an important interface between the Children Order and any Mental Health legislation that might be applied to children. The general principles under the Children Order should still apply in so far as practicable if a child is to be treated under the Mental Health Legislation.

45. In addition, there are a number of aspects of principle that the Mental Health Legislation might emulate, including that delay should be avoided in the interests of justice and that services provided should draw on effective partnerships between Health and Social Services Boards and other agencies.

46. There are a number of further significant points highlighted by this working group, including the difficulties in deciding on how a child is defined, since

different services and different legislations use a different age threshold. This leads to confusion. There is a particular difficulty experienced by young people at times of transition, often with a consequent loss of services and support, and the necessity for continuity across services was emphasized.

### **People with a Learning Disability**

47. Many of the situations in which people with a learning disability are likely to fall under legislative provisions may now fall within the broad umbrella of capacity-based legislation, which can be described as “enabling legislation”. The proposed Capacity Legislation in England and Wales does allow in some circumstances for enforcement of particular social arrangements, welfare arrangements and treatment for the person, including necessary restrictions.
48. As it is not clear, however, at this juncture within which legislative framework some of these provisions may fall, the principles chosen were, therefore, those which could be applied in all circumstances, but particularly where it is necessary to take decisions on behalf of a person with a learning disability, or to restrict in some way.

### **Emerging Consensus**

49. There was a very high degree of consistency and agreement across the 3 Sub Groups on principles recommended, although the emphasis was different given the differing needs of the client groups considered. There was also agreement that a small number of specific rights in relation to children and people with a learning disability should be included.
50. The principles chosen must be grounded in the broad principles underpinning the whole Review, and it has become clear that the special circumstances created by the restrictions invoked by legislation demand a special emphasis and balance to be applied particularly to protect best interests and reduce possible harm.
51. In addition, the shape of future legislation remains open at this stage, as the Capacity Legislation to be introduced has a close interface with Mental Health Legislation, which must be further explored and clarified. There is the potential for conflict and confusion if legislation for different purposes is applied to some of the same group of people. Ensuring that different pieces of legislation share a principle base is one way to reduce this, but since the breadth and focus of the legislative purposes are different, the principles chosen would have to be capable of broad applicability.

## **HOW MAY PRINCIPLES BEST BE FORMULATED AND INCORPORATED IN LEGISLATION?**

52. When the decision is taken to use a principle base as a foundation, the breadth and content of the legislation should be determined by this. The principles chosen should also be sufficiently robust to ensure applicability and usefulness throughout the lifetime of the legislation.
53. The process we have gone through, of research, consultation and detailed small group examination, has produced a set of recommendations which are consistent across the diverse characteristics of those commonly considered under “mental disorder.” We believe that they reflect the principles we require.
54. However, if all of them were detailed this would produce a very long list to be included in legislation. In addition, some would be too specific to meet the broader requirements outlined above, ie to allow joined-up thinking with Capacity legislation and to ensure longevity in applicability.
55. A balance must be reached, therefore, between having principles which are broad enough to influence the shape and direction of evolving (and perhaps different) legislation and specific enough to be usefully applied as a living instrument in its implementation for groups of people with different needs.

### **Carers**

56. While the principles must be primarily directed to the potential subject of legislation, the essential role of carers is acknowledged throughout the Review. Those who provide care to service users on an informal basis should receive respect for their role and experience, be given appropriate information and advice and have their views and their own needs taken into account.

### **Proposed Solution**

57. To best meet these differing requirements, the principles recommended could be usefully grouped under 4 recognized high level principles from which all the detailed, express principles flow (Beauchamp and Childress, 1989). The high level principles (which would give examples of the express principles which they encompass) could then be included in the face of legislation, with the express principles specified in a Code of Practice, which we strongly recommend be issued at the same time as the legislation is enacted.

### **Implications of a Principle-Based Legislation**

58. Using a principle base for legislation has implications not only for content and operation, but also for its publication and accessibility. If the principle of participation etc is to be respected, a training programme will be required for staff

to support and facilitate users and a system of Advocacy established. Easily understandable information must be made available to the general public and to patients about the principles underlying legislation and the legislation itself before it comes into effect.

59. An immediate consequence is the language used in legislation. The words beneficence and non-maleficence, while having the advantage of specific meaning, also have the disadvantage of unfamiliarity. We prefer to use benefit and least harm, while respecting the full meaning of the original terms.

## **RECOMMENDATION**

60. The proposal, therefore, is for the following 4 high level principles to be incorporated into the face of legislation and to be directed primarily to the subject of legislation:

(1) **Respect for Autonomy**

(To respect the individual's capacity to act on his/her own and his/her right not to be subject to restraint by others.)

(2) **Justice**

(Fair and equal application of the law.)

(3) **Benefit**

(Beneficence/acting in an individual's best interests.)

(4) **Least Harm**

(Non-maleficence/acting in a way which does not harm an individual.)

61. The express principles that flow from each of these high level principles and which would be included in a Code of Practice, are proposed as follows:

(1) **Respect for Autonomy**

- Provision of care and treatment should be on a consensual basis, wherever possible.
- Participation – Service Users should be fully involved to the extent permitted by the individual's capacity, in all aspects of their care, support or treatment. Users should be provided with all the information and support necessary to enable them to participate. This may include the involvement of advocates. Account should be taken of past and present wishes in so far

as these may be ascertained. The use of Advance Directives or Advance Joint Care Plans to support participation may be appropriate in some cases.

(2) **Justice**

- Non-discrimination – people with a learning disability and/or mental disorder should, whenever possible, retain the same rights and entitlements as other members of society.
- Equality and respect for diversity - people should receive treatment, care and support in a way that accords respect for and is sensitive to their individual abilities, qualities and cultural backgrounds. It should not discriminate on grounds of age, gender, sexual orientation, ethnic group, social class, culture or religion.
- Reciprocity – the loss of an individual’s rights by compulsion to treatment and care should be matched by an obligation to provide adequate treatment and care.
- Services should develop effective partnerships to ensure continuity of care across age and service boundaries.
- Due process, fairness and transparency in the decision-making process, and the right to representation. Delay in proceedings to be avoided.
- The specific rights of children, including the right to education, should be protected.

(3) **Benefit**

- Interventions should only be undertaken using the legislation to achieve benefits which cannot be achieved otherwise.
- The best interests of the person should be protected, including protection from abuse and exploitation.

(4) **Least Harm**

- Service users should be provided with the necessary care, treatment and support in the least invasive manner and in the least restrictive environment compatible with the delivery of safe and effective care.
- There should be clear guidance on the use of restrictive practices.

## **FURTHER WORK TO BE ADDRESSED**

62. This will involve consideration of:

- The interface with Capacity Legislation;
- The necessity for Mental Health Legislation after examination of the powers/scope of Capacity Legislation;
- The definition of mental disorder and of learning disability for the purposes of such legislation.

## **REFERENCES**

The Adults with Incapacity (Scotland) Act 2000

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New Directions: Report on the Review of the Mental Health (Scotland) Act 1984. 2000

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Reforming the Mental Health Act. Department of Health 2000

Report of the Expert Committee: Review of the Mental Health Act 1983. London Department of Health 1999

Review of the Literature relating to Mental Health Legislation. Scottish Executive Central Research Unit 2000

Wall S, Hotopf M, Wassely S, et al 1999. Trends in the Use of the Mental Health Act: England, 1984-96. British Medical Journal, 318, 1520,1521

Zigmond A.S., Reform of the Mental Health Act, 1983 Psychiatric Bulletin (2001) 25, 126-128

## PROCESS

### Papers

Issues and Principles of Mental Health Legislation:- Dr A O'Hara - SG1 4/03  
Review of Ethical Issues and Related Developments in Law Relating to People with Mental Health Problems: Professor Roy McClelland - SG15/03  
Principle-Proofing the Mental Health (NI) Order 1986:- Mrs Bernadette Hamilton, Dr Pauline Prior and Dr O'Hara - SG1 23/03

International Comparison of Mental Health Legislation: Dr Janice Thompson - SG16-03

### **Consultation**

A conference "Mental Health Legislation, Who Needs it?" was organized on 16 January 2004, including Workshops.

### **Liaison**

#### **a. On Capacity**

The Sub Group has liaised closely with Sub-Group 3 on Capacity; and with Miss Orla Ward (Office of Law Reform) who attended our meeting on the 13 October 2003, the Legislation Discussion Forum on the 29 March 2004, in the Lagan Valley Civic Centre, and the Conference on the 16 January 2004.

#### **b. On Human Rights and Equality**

Dr McGinnity attended a number of meetings of this Sub Group.

#### **c. On Learning Disability**

Two Sub Group members sit on the Learning Disability Working Committee.