

Use of the Guiding Principles for the Mental Health Act 2007 – Report on the findings from a sample review

A Report for the CQC Mental Health Act Team by The Collaborating Centre for Values-based Practice in Health and Social Care, St Catherine’s College, Oxford

SUMMARY

This report sets out the findings from a review of the use of the Guiding Principles for the Mental Health Act 1983 [amended 2007] (MHA).

Background and Brief

The CQC Mental Health Policy Team is tasked with drawing together information on the MHA Code of Practice for the CQC’s submission to the Independent MHA Review Panel chaired by Sir Simon Wessely.

As part of a wider consultation, the CQC Mental Health Policy Team asked the Collaborating Centre for Values-based Practice in Oxford to report on the use of the MHA Guiding Principles.

What we did

Our report is based on information from two main sources

- A sample of academic literature and other published materials
- Telephone and face-to-face meetings with expert witnesses including service users, clinicians, regulators, lawyers and clinical educators.

What we found

- There are very few published materials on the use of the MHA Guiding Principles: there is an account of the origins of the Guiding Principles; and there are implied references to them (notably to the principle of Least Restriction) in some CQC inspection reports
- There is information on the principles guiding related areas of legislation (notably the Mental Capacity Act 2005 and the Mental Health (Care and Treatment) (Scotland) Act 2003) where (in contrast to the MHA Guiding Principles) the principles in question are statutory
- The general view is that the MHA Guiding Principles currently have little or no impact in driving good practice essentially because their status is advisory rather than statutory
- There is support for strengthening the MHA Guiding Principles by moving them from the Code (where they have only advisory status) to the face of the MHA (thus giving them statutory force)
- There is recognition that changes in legislation alone are unlikely to lead to improvements in practice and that a package of supplementary measures will be required

Our conclusions

- The Guiding Principles currently have little impact on the way the MHA is used (though this conclusion comes with the caveat that absence of evidence is not evidence of absence)
- Giving the Guiding Principles statutory force by moving them from the Code of Practice to the face of the MHA is likely to strengthen their role in driving good practice
- If this move is beyond the scope of the current review the requirement in Section 118 of the MHA to ‘have regard to the code’ should be strengthened to include a recording requirement along the lines of ‘have regard to the code and record how regard was had to the Fundamental Principles’. (Note: the term ‘Fundamental Principles’ is used in the MHA; ‘Guiding Principles’ in the 2008 Code; and ‘Overarching Principles’ in the 2015 Code)
- Legislative changes should be accompanied by a package of measures designed to support services in implementing good practice in the use of the MHA including good practice examples in the Code of Practice and/or supplementary guidance
- The current list of five Guiding Principles could be reduced in number but should retain as a minimum a Principle of Least Restriction and a Principle of Participation

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This report sets out the findings from a review of the use of the Guiding Principles for the Mental Health Act 1983 [amended 2007] (MHA).

The report was prepared by the Collaborating Centre for Values-based Practice in Health and Social Care at St Catherine's College, Oxford, as a contribution to a wider review of the use of the MHA Code of Practice by the CQC Mental Health Policy Team in support of the CQC's submission to the independent panel reviewing the MHA chaired by Sir Simon Wessely.

Background and Brief

The independent review panel was set up in 2017 in response to concerns about rising use of the MHA in the last ten years. The panel's brief is to understand:

- the rising rates of detention under the Act
- the disproportionate number of people from black and minority ethnic groups detained under the Act
- processes that are out of step with a modern mental health care system

In its interim report¹ the panel recognizes, 1) that rising use of the MHA is not in itself necessarily a reflection of poor practice (it might for example mean that more people with mental health problems are receiving the treatment they need), and, 2) that there is probably more than one factor behind the rise. It is worth noting in addition that the rise continues a long-term trend² and that there may be different factors operating over different periods and in different situations.

Rising use of the MHA is of concern because involuntary detention and treatment run counter to contemporary recognition of the importance in healthcare of patient autonomy and human rights as against risk (important as risk remains). Of particular concern are the indications that in some contexts factors other than clinical need may be contributing to the rise. This is why the independent panel is focusing on the long recognized but still poorly understood disproportionate use of the MHA in certain BAME groups. There are also possible 'post code' differences in rates: a recent report in *Lancet Psychiatry*³ noted 'strong evidence of significant variation in compulsory admission between both local

¹The Independent Review of the Mental Health Act: Interim Report (2018), available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/703919/The_independent_Mental_Health_Act_review_interim_report_01_05_2018.pdf

² See the CQC Report (2018) on *Mental Health Act: the rise in the use of the MHA to detain people in England*, at: <http://www.cqc.org.uk/publications/themed-work/mental-health-act-rise-mha-detain-england>, Figures 1 and 2

³ *Variation in Compulsory Psychiatric Inpatient Admission in England: a cross-classified, multilevel analysis*. Scott Weich, Orla McBride, Liz Twigg, Craig Duncan, Patrick Keown, David Crepaz-Keay, Eva Cyhlarova, Helen Parsons, Jan Scott, Kamaldeep Bhui. *Lancet Psychiatry* 2017; 4: 619–26. Published Online June 21, 2017: [http://dx.doi.org/10.1016/S2215-0366\(17\)30207-9](http://dx.doi.org/10.1016/S2215-0366(17)30207-9)

areas and services, independent of patient characteristics’.

In the run up to the launch of the independent panel the CQC was asked by the Department of Health to evaluate the impact of the MHA Code of Practice. The CQC’s evaluation would inform the work of the independent panel in looking at possible legislative changes and how these might interact with other aspects of practice. The CQC Mental Health Policy Team is tasked with this evaluation and as part of a wider review asked the Collaborating Centre to look specifically at the use of the Guiding Principles.

The following sections set out what we did, what we found, and our conclusions.

What we did

In undertaking our review we were aware of the tight time frame within which the independent panel has been asked to report to government and the requirement for implementable solutions rather than merely aspirational aims.

Given these constraints we opted for a purposive sampling approach based on two main sources of information

1. Published materials

We carried out a sample review of academic literature and other published materials. This was based primarily on a search of key databases including searches kindly completed on our behalf by colleagues with expertise in particular aspects of the use of the Guiding Principles (notably from legal and service user perspectives)

2. Expert witnesses

We carried out telephone and face-to-face meetings with people with relevant expertise including service users, clinicians, regulators, lawyers and clinical educators.

The interviews were governed by ‘Chatham House rules’: we would report the ‘what’ but not the ‘who’ of the comments we received.

In exploring these sources we adopted an open questioning approach with the aim of eliciting as wide a range as possible of information and ideas about the use of the Guiding Principles. This approach reflects the wide scope of application of the Guiding Principles themselves. Practitioners and service users understandably tend to focus on the use of the Guiding Principles in the clinical encounter. But the principles are relevant also in any context bearing on the use of the MHA including commissioning and other aspects of service provision.

Consistently with the remit of the independent panel we focused on the use of the Guiding Principles for the MHA although we received relevant information also on related areas of legislation including the MCA (Mental Capacity Act 2005) and the Mental Health (Care and Treatment) (Scotland) Act 2003.

By way of exclusion we did not look separately at the use of the Guiding Principles in particular clinical subspecialties such as forensic psychiatry and child and adolescent mental health. Nor did we look separately at issues arising from their use in connection with particular sections of the MHA, such as CTOs (Community Treatment Orders).

What we found

Our headline finding was that there are few if any significant published sources on the use of the MHA Guiding Principles either in academic journals or in professional or other publications. The Guiding Principles have a low profile even in what are otherwise comprehensive accounts of mental health law⁴

Two sources were however identified: 1) an account of the origins of the Guiding Principles, 2) implied references in CQC inspection reports

1) Origins

A chapter in a recent Oxford University Press *Handbook of Psychiatric Ethics* gives background information on how and why the Guiding Principles came to be located in the Code of Practice to the 2007 revision of the Mental Health Act 1983⁵. The chapter was written by three authors directly involved at the time representing, respectively, theoretical, service user and training perspectives, and thus provides context for the current review. It spells out the strengths but also the limitations of the approach adopted at the time.

2) CQC inspection reports

Implied references to the Guiding Principles are to be found in a number of CQC inspection reports. Such references are mainly to the Least Restrictive Principle. They occur for example in support of CQC's campaign against the use of blanket restrictions.

As is well recognized, absence of evidence is not evidence of absence. However, the absence of published materials on the use of the Guiding Principles was in this instance consistent with the view (expressed unanimously by our expert witnesses) that there is little awareness (still less use) of the MHA Guiding Principles in practice.

There were however two examples of where Guiding Principles had been used effectively in driving good practice.

1) Use of the MHA Guiding Principles in CQC inspection reports

One expert noted that the Guiding Principles were helpful in identifying and describing poor practice in CQC MHA inspection reports. The challenge for inspectors is to justify any criticism of services against objective standards. The expert in question said that the Guiding Principles were often more helpful in this respect than other more specific provisions of the Code.

2) Use of the Guiding Principles in the Mental Health (Care and Treatment) (Scotland) Act 2003

In *McCann (Appellant) v The State Hospitals Board for Scotland (Respondent) (Scotland)*⁶, the UK Supreme Court ruled that a smoking ban and related powers to search for and confiscate tobacco products were unlawful on the grounds that they were inconsistent with the principles in section

⁴ For example, the fourth edition of Peter Bartlett and Ralph Sandland *Mental Health Law: Policy and Practice*, 2013, Oxford, Oxford University Press; and the edited collection *Principles of Mental Health Law and Policy*, 2010, Oxford, Oxford University Press (edited by Lawrence Gostin, Jean McHale, Philip Fennell, Ronald D. Mackay, and Peter Bartlett).

⁵ Fulford, K.W.M., Dewey, S., and King, M. (2015) Values-based Involuntary Seclusion and Treatment: Value Pluralism and the UK's Mental Health Act 2007. Ch 60, in Sadler, J.Z., van Staden, W., and Fulford, K.W.M., (Eds) *The Oxford Handbook of Psychiatric Ethics*. Oxford: Oxford University Press

⁶ The 'Carstairs' case as it is sometimes called is reported in full at:

<http://www.bailii.org/uk/cases/UKSC/2017/31.html>. MHLO summary:

[http://www.mentalhealthlaw.co.uk/McCann_v_State_Hospitals_Board_for_Scotland_\(2017\)_UKSC_31_\(2017\)_MHL_O_22](http://www.mentalhealthlaw.co.uk/McCann_v_State_Hospitals_Board_for_Scotland_(2017)_UKSC_31_(2017)_MHL_O_22)

1 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Legal commentary has been to the effect that the Supreme Court was able to rely on the principle of least restriction in this case because (being on the face of the Mental Health (Care and Treatment) (Scotland) Act 2003) it was statutory rather than advisory (the Guiding Principles for the MHA being only in the Code of Practice).

These examples are important in indicating how the Guiding Principles although to date largely ignored by practitioners might nonetheless in a strengthened form have a role to play in driving good practice. The use described in CQC inspection reports suggests that the balance of considerations represented by the Guiding Principles properly reflects the requirements of good practice. *McCann v The State Hospitals Board for Scotland* suggests that giving the Guiding Principles statutory force by moving them from the Code of Practice to the face of the MHA would strengthen their use in driving good practice.

A number of witnesses pointed to the MCA as further evidence of the importance of the Guiding Principles being on the face of the MHA. The MCA Principles (as they are called) are set out right at the start of Part 1 of the MCA⁷ and as such figure prominently in a various aspects of the how the MCA is applied. Thus, witnesses noted that the MCA Principles are in the minds of clinicians and others making decisions under the MCA; that they figure prominently in legal and regulatory oversight; and that they are highlighted in legal and clinical educational materials.

In the next section we outline our conclusions focusing on how the role of the MHA Guiding Principles in driving good practice might be strengthened.

Conclusions

The findings from our review suggest that while there is currently a low level of awareness and little use of the MHA Guiding Principles, in a strengthened form they could have a potentially important role to play in driving good practice.

Our findings indicate four ways in which the role of the Guiding Principles might be strengthened. We will first state these and then describe how they are supported by the arguments and evidence from our review.

Four ways to strengthen the role of the Guiding Principles

- 1) Moving the Guiding Principles to the face of the MHA
Giving the Guiding Principles statutory force by moving them from the Code of Practice to the face of the MHA is likely to enhance their role in driving good practice
- 2) Introducing a Recording Requirement
If moving the Guiding Principles to the face of the MHA is beyond the scope of the current review the requirement in Section 118 of the MHA to 'have regard to the code' should be strengthened to include a recording requirement (along the lines of 'have regard to the code and record how regard was had to the Fundamental Principles')
- 3) Developing a Package of Supporting Measures
In either case legislative changes should be accompanied by a package of supporting measures; these should include good practice examples in the Code of Practice and/or supplementary guidance, training materials and impact research
- 4) Reducing the number of Guiding principles
The current list of five Guiding Principles could be reduced in number but should retain as a minimum a Principle of Least Restriction and a Principle of Participation

⁷ See <https://www.legislation.gov.uk/ukpga/2005/9>

Supporting Considerations

1) Moving the Guiding Principles to the face of the MHA

Our witnesses were united in the view that giving the Guiding Principles statutory force by moving them from the Code of Practice to the face of the MHA would strengthen their role in driving good practice. Their experience was that so long as the status of the Guiding Principles was merely advisory (which is the status of the MHA Code of Practice as a whole) it was inevitable that in the pressures of everyday practice they would be sidelined in the face of what were inevitably perceived as the more immediate statutory demands of the Act. Moving the Guiding Principles to the face of the MHA would raise awareness of them among practitioners and patients, and it would strengthen their use in CQC inspections.

There is support for this view in the evidently greater impact of the principles for both the MCA and the Mental Health (Care and Treatment) (Scotland) Act 2003 (these being on the face of their respective acts and thus having statutory force). Additionally, the considerations that in the run up to the 2007 amending bill led to the Guiding Principles being in the Code in the first place, now no longer apply. It was argued at the time that it would be easier to amend the Guiding Principles in response to changes in practice if they were in the Code rather than statutory. There was awareness that this might reduce their impact. But the hope was that this would be counter-balanced by training and other initiatives developed by the Department of Health to support implementation. That hope has clearly not been realized. Neither has there proved to be any significant clinical need for changing the content of the Guiding Principles in response to changes in practice. There have been such changes, certainly: since 2008 there has been for example a shift in practice towards promoting independence and recovery; and this shift is correspondingly emphasized in the principles produced for the 2015 revision of the Code. But besides such differences of emphasis the ‘Overarching Principles’ (as the 2015 principles are called) emerged from the revision of the Code essentially unchanged both in substance and in the way in which it was intended they were to be used⁸.

The essentially unchanged nature of the Guiding Principles between 2008 and 2015 is no doubt in part a reflection of the unchanged constraints set out in Section 118 of the MHA (which specifies the matters that the Secretary of State requires the Guiding Principles to cover). These constraints were however derived from the wide ranging consultation carried out in the run up to the 2007 revision and reflected points of agreement on good practice between stakeholders with otherwise very disparate views. The consistency of the Guiding Principles across editions of the Code thus reflects consistency of view about the nature of good practice in the use of the MHA.

Our witnesses however recognized that moving the Guiding Principles to the face of the MHA might be beyond the scope of the current review. Such a move would require an amending bill some aspects of which could prove contentious. Experience in the run up to the 2007 amending bill suggests that resolving such issues could prove legislatively time consuming.

2) Introducing a Recording Requirement

If moving the Guiding Principles to the face of the MHA is considered to be beyond the scope of the current review some of the same benefits could be achieved by introducing a recording requirement into the MHA. For example, the current requirement in Section 118 of the MHA to ‘have regard to the code’⁹

⁸ A table comparing the 2008 Guiding Principles with the 2015 Overarching Principles is given in the Appendix to this report.

⁹ Subsection 2D of section 118 specifies that ‘In performing functions under this Act persons mentioned in subsection

could be strengthened by adding a recording requirement along the lines of 'have regard to the code and record how regard was had to the Fundamental Principles'.¹⁰

A recording requirement on the face of the MHA would have statutory force. As such, it would raise awareness of the Guiding Principles and strengthen their use in legal and regulatory contexts. It would be implementable through NHS Digital's improved recording and reporting abilities. It would require primary legislation but avoid the potentially contentious and time-consuming processes required for changing the status of the Guiding Principles. It would amount to and could be presented as an interim move towards making the Guiding Principle statutory at some future date. As such, the move is likely to attract cross-party support and could thus prove to be implementable with a minimum of legislative time.

Two risks in particular were identified with this proposal

1. Increasing the demands on services.

If practitioners ended up carrying the burden of reporting, the proposal would add to the already considerable pressures on service provision. This would be counterproductive not least because over-stretched services have been identified as a potential contributory cause of rising use of the MHA (as noted in the CQC report referenced in footnote 2).

This risk could be mitigated by additional guidance in the Code of Practice on who is expected to provide the required record and in what circumstances. There will inevitably be some additional work for practitioners (though as discussed further below, if employed in the right way this need not be burdensome). The guidance should however make clear that the required record would be expected to extend to provision by the service as a whole of alternatives to compulsion such as street triage services, crisis cafes and joint crisis plans¹¹. Evidence of such provision could count in CQC inspections towards an organization's leadership score.

2. A tick box response

We were given examples of other areas of legislation where the response to a statutory recording provision was to produce a standardized form of words unsupported by any genuine improvement in practice.

Again, this risk could be mitigated with supplementary guidance in this case indicating (with examples) what is expected of good practice. The guidance should emphasize systemic as well as individual responsibilities. It should also make clear the positive role of the Guiding Principles in providing a clear way of documenting the balance of considerations required for positive risk management aimed at empowerment and recovery. This is of particular importance given the evidence that at least in some areas of mental health restrictive practices are widely regarded as being essential risk management tools¹².

(1)(a) or (b) shall have regard to the code.'

¹⁰ Note on terminology: a different term is used for the principles in the MHA ('Fundamental Principles'), in the 2008 Code of practice ('Guiding Principles'), and in the 2015 Code of Practice ('Overarching Principles')

¹¹ The effectiveness of these and other alternatives to compulsion is noted both by the Interim Report of the Review Panel and by CQC in their report on rising rates of detention, see respectively footnotes 1 and 2

¹² See for example from Australia: Eimear Muir-Cochrane, Deb O'Kane and Candice Oster (2018) Fear and blame in mental health nurses' accounts of restrictive practices: Implications for the elimination of seclusion and restraint. *International Journal of Mental Health Nursing* doi: 10.1111/inm.12451

Taken together these two risks both reflect current perceptions of legislation and regulatory oversight as being concerned only with preventing bad practice. Mitigating these risks correspondingly involves getting across the positive message that the aim of the Guiding Principles is also to *support good practice*. A package of supporting measures could have a key role to play in getting across this positive message.

3. Developing a Package of Supporting Measures

Our expert witnesses agreed with the interim report of the review panel (footnote 1, p8) that legislative changes alone would not be sufficient to drive good practice. There was recognition, too, from experience with the 2007 amending bill (footnote 5), that even a robust package of supporting materials of the kind produced at the time, will not be sufficient without legislative changes to strengthen the status of the Guiding Principles. The aim of the package should thus be to complement rather than provide an alternative to legislative change.

The aims of the package, our experts further agreed, should be positive (providing a supportive carrot for good practice) rather than merely negative (providing a bigger stick to punish bad practice). One way to provide carrot as well as stick would be to spell out exactly what is needed to fulfill the proposed recording requirement. As already noted, the requirement might be taken to indicate something on the lines of a merely bureaucratic form filling exercise. Good practice however (as set out in both the 2008 and 2015 Codes of Practice¹³) requires an exercise in clinical judgement in which the demands of the Guiding principles are balanced according to the particular circumstances presented by the case in question.

A form of some kind would no doubt be required to record how the required balance was carried out. But instead of being a merely bureaucratic exercise the form would act as a record of how and why in coming to the decision in question, those concerned balanced the Guiding Principles in the way they did. Such a record would in principle support clinicians in situations in which for example they considered the demands of human rights and recovery outweighed concerns about risk. The need for clinicians to be supported in making decisions of this kind is important in promoting recovery and development of self-management skills. As such therefore the Guiding Principles become a support for rather than a burden on good practice.

Just what should be included in a package of supporting measures requires further consideration. The importance of supplementary guidance in the Code of practice and/or elsewhere in the form of good practice examples has already been noted. Training materials to support the guidance (some of which could be available on-line) should be developed. These could helpfully include the proposed resource of good practice examples. Training materials should be co-produced and there should be on-going impact assessment from both service user and service provider perspectives.

One witness wondered whether a package of supporting materials was really necessary and expressed the concern that its resource implications might act as a barrier to legislative change. Developing and assessing the impact of an effective package of supporting materials would certainly not be resource-neutral but it could be resource-light. Existing organizations such as NHS Digital, Health Education England, and Research for Patient Benefit, have between them the expertise and resources to commission the work required. Materials on which to build are still available from the 2007 implementation package. CQC could contribute to impact monitoring via its MHA inspection reports.

A further important resource is the expertise and experience of those with first hand experience of the

¹³ See Appendix

use of the MHA from both service user and service provider perspectives. The former includes groups representing key minority perspectives such as, in London, Black Thrive¹⁴. This resource makes it possible to adopt a co-productive methodology in developing the required package. There are *prima facie* reasons for believing that co-production is essential to developing a package that is both enabling of service users and supportive of staff.

4. Reducing the number of Guiding principles

There is an argument – expressed among our witnesses particularly from a training perspective – for reducing the number of Guiding Principles. Three items are widely thought to be easier to remember than five¹⁵. Two some thought would be even better.

There is a balance to be struck here. On one side of the balance, are the dangers of what might be called principle inflation. In the run up to the 2007 amending bill there was pressure to include this or that principle from different groups. The current list of five was derived from twelve. Another form of principle inflation is principles becoming over-inclusive: this is where a given principle covers so many aspirations that it ceases to convey a coherent message. On the other side of the balance to be struck are the dangers of over-simplification. An important example of over-simplification is the adoption of an over-arching or ‘top’ principle. Asserting such a top principle is an understandable response to any given set of particularly pressing concerns. The danger however is that the proposed top principle inevitably comes under pressure from exceptions demanded by the realities of practice. In the Children Act for example the welfare of the child is paramount¹⁶. Few would deny the importance of the child’s welfare. Yet even the paramouncy principle of the Children Act has been held to be capable of exception¹⁷.

Whether the current Guiding Principles strike the right balance between inflation and simplification is a matter on which there may be different views. Two points have already been noted: 1) that the Guiding Principles were derived originally from shared perceptions among stakeholders of the requirements of good practice, and 2) they have been through a major review essentially unchanged. It is also worth noting that any change in the number or scope of the Guiding Principles would require amendments to the provisions of Section 118 of the MHA. Given though the pedagogic argument for ‘the rule of three’ we have summarized some of the views we received on the relative importance of the current list of five MHA Guiding Principles in contemporary practice.

- Purpose principle

This principle was introduced originally to emphasize the importance of using the MHA strictly for clinical purposes. Its inclusion was seen to be important at the time because of concerns about the dangers of the MHA being used as a means for controlling deviance. The history of psychiatry shows that this risk is ever-present¹⁸. However, given CQC’s recent finding that there is ‘no evidence that professionals are using the MHA to admit people who do not meet the criteria for detention’ (see footnote 2, p4), it may be that the aims of a purpose principle could be sufficiently served by regulatory oversight.

¹⁴ <http://www.healthwatchlambeth.org.uk/black-wellbeing-partnership/>

¹⁵ Sometimes called without attribution, ‘the rule of three’

¹⁶ Section 1(1) of the Children Act, 1989, specifies that ‘the child’s welfare shall be the court’s paramount consideration’ – see:

<https://www.legislation.gov.uk/ukpga/1989/41/section/1>

¹⁷ Butler-Sloss LJ, Hoffmann LJ, Sir Tasker Watkins V-C. RE: M (A Minor) (Secure Accommodation Order) (1994) Exceptional Secure Accommodation Orders – Children Act 1989 S.25 – S.41 – Guardian Ad Litem. Document No. AC0001701.

¹⁸ Chodoff, P. (1999) Misuse and Abuse of Psychiatry: an overview, Chapter 4 in Bloch, S., Chodoff, P. and Green, S.A., Eds, *Psychiatric Ethics*, third edition, Oxford: Oxford University Press.

- **Equality/Equity**
This principle, too, was considered less important though in this instance because it was relevant more to commissioning than to face-to-face clinical decision-making. A further consideration is that as a principle it applies across the board in health and social care rather than applying specifically to involuntary care and treatment. It is anyway among the 'optional' matters specified in Section 118.
- **Respect**
Like equality, respect is a principle that applies across the board in health and social care. Against this, it remains of particular significance for use of the MHA given that as the review panel among others have found (see footnote 1, p6), many service users experience lack of respect in the way the MHA is used.
- **Least restriction**
A principle of least restriction is both directly relevant to use of the MHA and a priority for good practice. The principle makes clear that even where the criteria for the MHA are fully met, care planning should still aim to place the minimum restrictions on the freedom of choice of the individual concerned. A principle of least restriction is crucial for example to avoiding blanket regulations and as such important for compliance with Human Rights law. From the perspective of staff (who have responsibility for safety) it is important that the principle is of *least* restriction rather than *no* restriction (see note 11 above). From the perspective of service users, a principle of least restriction is one side of the enablement that is widely recognized to be crucial to recovery.
- **Participation**
Participation is the positive counterpart of the principle of least restriction in supporting enablement. Taken together with the principle of least restriction, the participation principle makes a vital contribution to balancing concerns about risk with the need to promote recovery¹⁹.

Given the importance of enablement as key to good practice in the use of the MHA, a combination of a negative principle of least restriction and a positive principle of participation, together balancing the need for compulsory detention and treatment, is in our view and the view of our expert witnesses, irreducible. Retaining in addition an explicit principle of respect would highlight a key area of good practice in the use of the MHA.

Acknowledgements

We are very grateful to our expert witnesses who generously supported the production of this report with their time and expertise. Our particular thanks go also to Professor Michael Loughlin for his thorough work on the initial literature search.

¹⁹ See for example the CQC report cited in footnote 2 that notes (at p8) that service users considered rising use of the MHA was in part a result of 'A culture based on the level of risk the person poses to themselves and others, rather than a culture that focuses on their recovery.'

APPENDIX

A Table Comparing the Guiding Principles in the 2008 Code of Practice with the Overarching Principles in the 2015 revision of the Code

Note: the 2015 Overarching Principles have been reordered for ease of cross-comparison with their 2008 counterparts

2008 Code Guiding Principles	2015 Code Overarching Principles
Use of the Principles	
<p>1.1 ... guiding principles which should be considered when making decisions about a course of action under the Act</p> <p>1.8 The principles inform decisions, they do not determine them. Although all the principles must inform every decision made under the Act, the weight given to each principle in reaching a particular decision will depend on the context.</p> <p>1.9 That is not to say that in making a decision any of the principles should be disregarded. It is rather that the principles as a whole need to be balanced in different ways according to the particular circumstances of each individual decision.</p>	<p>1.1 It is essential that all those undertaking functions under the Act understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act. This chapter provides an explanation of the overarching principles and stresses that they should be considered when making decisions under the Act. Although all are of equal importance the weight given to each principle in reaching a particular decision will depend on context and the nature of the decision being made.</p>
Specification of the Principles	
<p>Purpose principle</p> <p>Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm.</p>	<p><i>Purpose and effectiveness</i></p> <p>Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.</p>
<p>Least restriction principle</p> <p>People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's</p>	<p><i>Least restrictive option and maximising independence</i></p> <p>Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not</p>

<p>liberty, having regard to the purpose for which the restrictions are imposed.</p>	<p>be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.</p>
<p>Respect principle</p> <p>People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.</p>	<p><i>Respect and dignity</i></p> <p>Patients, their families and carers should be treated with respect and dignity and listened to by professionals.</p>
<p>Participation principle</p> <p>Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.</p>	<p><i>Empowerment and involvement</i></p> <p>Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.</p>
<p>Effectiveness, efficiency and equity principle</p> <p>People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.</p>	<p><i>Efficiency and equity</i></p> <p>Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.</p>

