



Ethical Frameworks

- What is ethics?
- How do I know whether my actions are right or wrong?
- Are there a set of principles that can guide my practice to produce good intentions or outcomes?
- How do we balance respect for the individual with respect for our wider society?
- What right do I have to coerce an individual to take medication?
- What does it mean to be a good mental health worker?
- What is the difference between morals and ethics?

Four Theoretical Approaches

- 1. Deontology (Kant 1724 – 1804)
 - Morality is assessed on the motivation for action. We ask why and then assess the value of the action based upon an individual's motivation to perform that action.
 - Often referred to as duty based motivation, deontological ethics view people as being motivated to abide by the duty to others and society.
 - Kant referred to the 'Categorical Imperative' the idea that every moral action must be universalisable (i.e. good if everyone would do the same thing in the same situation).
 - This also views people as 'ends' and not 'means' and have the autonomy to decide their own future and be respected for that.
 - Think about the mental Capacity Act (2005).
 - However, what about scenarios involving telling the truth?

- 2. Consequentialist ethics (Utilitarianism)
- This is associated with Jeremy Bentham (1748 – 1832). Any action that increases happiness is good. We can calculate happiness within Society and devise policy geared towards maximising this.
- In fact, the Office for National Statistics does just this; since 2013, happiness figures have been informing public policy.
- However, Sandell (2012) identifies a number of problems associated with this;
 - 1. How do you feel about giving cash incentives to drug addicted women to be sterilised?
 - 2. Giving cash incentives to people to lose weight?
 - 3. Providing cash rewards to children to improve their grades?

• 3.Virtue Ethics

- Derived from Ancient Greece and Aristotle, virtue ethics focuses on `character`, the `flourishing individual` and being a good citizen, living a virtuous life (Eudaimonia).
- Virtue theorists ask:
 - What makes a good character?
 - What makes a good citizen?
 - What makes a good society?
- One element of virtue ethics that is emphasised in current health care practice is the DoH Compassion in Practice policy (2012) which lays out 6 C`s.
- Care, compassion, competence, communication, courage and commitment.
- However, think about the institution of the NHS and of wider Society. Where does the focus lie? With the individual or with the system?
- Take the following example of poor virtues: David `Rocky` Bennett (1998).

- 4. Narrative ethics of care
- This approach focuses on the attributes of ethical relationships.
- What qualities exist that are central to an ethical disposition?
- Key example to illustrate this is Gilligan (2003) In a different voice.
- Whilst ethics is an abstract concept, it operates within a situation
- One way of understanding this is by employing a narrative to afford meaning. This way, ethics is not seen as right or wrong (Paulsen, 2011).
- The main features of narrative ethics of care are:
 - A focus on relationships
 - Understanding an action in context (case) not in principle
 - Prioritising and understanding the identity of a person
 - Listening to them
 - Emphasising the affective aspect of morality (not the cognitive)
 - A focus on the qualities of a caring relationship
- Take for example Jasmin:

As a result:

- Beauchamp & Childress (2012) four principle framework
 - Autonomy
 - Beneficence (duty of care/best interests)
 - Non-maleficence
 - Justice

Beneficence Whatever is done or said is for the patient's good <i>e.g. benefits of treatment must outweigh risks</i>	Autonomy Respect for the person and his/her rights to self-determination <i>e.g. it is the patient's right to decide which treatments they do or do not have.</i>
Non-maleficence Whatever is done or said will do the patient no harm <i>e.g. never lie to patients</i>	Justice Equitable allocation of healthcare resources according to need - not wealth, class, creed or colour

Ethics and Values

(in more detail next week)

- What is the difference?
- Write down three words/phrases that you associate with values
- Are they positive or negative?
- Any points of self-interest?
- Values represent the `why` to people. We often overlook this and assume that we know why!
- Hence peoples values often get lost.
- Values are wider than ethics, are both positive and negative, present in the foreground and background of our thinking, are highly complex, and often conflicting.

Coercion and Autonomy

- Recovery requires self-determination, choice and self-control (Repper & Perkins, 2003).
- However, choice might be restricted by the very systems that are designed to support them.
- Think historically (Mental: A history of the mad house), our care programmes, risk assessments etc. are instruments of surveillance and highlight the dual agenda.
- What is the role of the Mental Health Act? What are the benefits of legislations? Who benefits?
- What are the potential costs and to whom?

Two arguments to coercion:

- Coercion is the legally sanctioned compromise of individual autonomy.
- 1. The person has a defined disorder that affects their competency (Olsen, 2003).
- 2. The person has the potential to do harm (DoH, 2008).
- Think about the implications from Treatment without consent, compulsory treatment (sectioning) and those who are treatment resistant.
 - Do these legal sanctions promote policing for marginalised groups within society?
 - Is coercion right or wrong?
- According to Olsen (2003) we should look at it another way: we should be considering moral discomfort.
- There is a movement towards this, with the right to appeal and independent advocacy (DoH, 2008).

Community Treatment Order (CTO)

- Originally designed to solve the revolving door problem (Churchill et al., 2007).
 - What is the evidence base?
 - Are these individuals a danger to society?
 - It is a form of social control and an infringement on human rights?
 - What are the outcome measures?
 - What are the alternative treatment options?
 - What is the point of view of the service users?
- This relates to informed consent: having the capacity to understand, the knowledge of what is expected of you, and the ability to freely consent.

Daring to Care

- The diversity of values requires that we have a ***skills based approach of value based practice***.
- Diversity and dissensus- conflicting views in mental health care should be seen as the NORM and not the exception.
- The key is to work respectfully and creatively, balancing the conflicting demands of different individuals.
- There will always be power inequalities, but value based practice begins with mutual respect.
 - Do people feel respected and involved in their care?
 - What about inequality, prejudice, discrimination and the diagnostic process?
 - What about the silenced voices of services users amongst the literature?
- We have to acknowledge structural inequalities (Kirmayer, 2012) and we have to have an awareness of VALUES to understand the person`s perspective.

Working with the Vulnerable

- Who is vulnerable?
- What is the role of safeguarding?
- In Education...
- In Healthcare...
- In Social Care...
- In a Legal Context...
- In Charities...



What is the legal position?

- All organisations, including charities, are expected to comply with the government inter-agency statutory guidance **`Working together to safeguard children`**, *‘unless exceptional circumstances arise’*.
- Safeguarding is a term which is broader than ‘child protection’ and relates to the action taken to promote the welfare of children and protect them from harm. Safeguarding is everyone’s responsibility and is defined in **`Working together to safeguard children 2013`** as:
 - Protecting children from maltreatment
 - Preventing impairment of children’s health and development
 - Ensuring that children grow up in circumstances consistent with the provision of safe and effective care and
 - Taking action to enable all children to have the best outcomes



The Charities Commission - Policy paper: Strategy for dealing with safeguarding issues in charities (Updated December, 2017)

- Many charities come into contact with or provide activities for those who may be experiencing, or at risk of, abuse or neglect. This includes:
- Children and young people under 18 years of age
- Adults (aged 18 and over) at risk

Safeguarding and promoting well-being and welfare means:

- protecting the rights of adults to live in safety, free from abuse and neglect
- protecting children from maltreatment; preventing impairment of health or development; ensuring they are growing up in circumstances consistent with the provision of safe and effective care; and taking action to enable them to have the best outcomes

It is essential that organisations:

- know their responsibilities.
- have adequate measures in place to assess and address safeguarding risks.
- have adequate safeguarding policies and procedures appropriate for their organisation's particular circumstances and which reflect both the law and best practice.
- make sure that these policies and procedures are effectively implemented and regularly reviewed
- These steps are vital, given that organisations are accountable to the public and must operate for the public benefit.

The Charity Commission's regulatory role and risk based approach

- The Charity Commission has an important regulatory role in ensuring that trustees comply with their legal duties and responsibilities in managing their charity.
- In the context of safeguarding issues, it has a specific regulatory role which is focused on the conduct of trustees and the steps they take to protect beneficiaries and other persons who come into contact with the charity.
- The Commission's aim is to make sure that charities that work with or provide services to vulnerable beneficiaries comply with their legal duties, and take reasonable steps to protect them from harm and minimise the risk of abuse.



CHARITY COMMISSION
FOR ENGLAND AND WALES

Safeguarding Vulnerable Groups Act 2006

- Amended by the Protection of Freedoms Act 2012, and the effect on employers and other organisations that involve their employees, workers or volunteers in regulated activity with children or vulnerable adults.
- In particular, it considers the definitions of regulated activity and the requirements placed on both regulated activity providers (RAPs) and personnel suppliers, including that of providing prescribed information to the Disclosure and Barring Service (DBS). The DBS was formed on 1 December 2012 on the merger of the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA).

Mental Capacity Act (2005)

- The Mental Capacity Act 2005 provides a statutory framework for people who may not be able to make their own decisions. This might be because of a learning disability or an illness such as dementia – or it might be due to mental health difficulties.

- The Act says:

- Who can take decisions
- In which situations they can take those decisions
- How they should go about this.



Key provisions within the Act:

- Five key principles making it clear that a person should be assumed to have capacity unless proven otherwise.
- A 'best interests' checklist for people acting on behalf of others, including consideration of the person's wishes, feelings, beliefs and values (including any written advance statement made when they had capacity) and taking account of the views of their family and friends.
- Protection to carers and professionals, to lawfully care for someone who cannot consent.
- Lasting powers of attorney (LPA) – for people to appoint an attorney to act on their behalf if they should lose capacity.
- Provisions for the court to appoint deputies to make decisions on behalf of a person.
- Creation of Independent Mental Capacity Advocates to support and represent people lacking capacity who have no one else to speak for them regarding decisions about medical treatment or long-term residential care.
- New safeguards controlling many types of research involving people who lack capacity.
- For a person whilst they have capacity, to make an advance decision to refuse treatment.
- The introduction of a criminal offence of ill treatment or neglect of a person who lacks capacity, with a maximum sentence of five years.

Mental Health Act (2007)

- The 1983 Mental Health Act remains the important piece of legislation setting out the legal framework for compulsory powers in England and Wales.
- The 2007 Act amended the 1983 Act, meaning that mental health law has become more complicated.
- We will briefly look at where the law has changed, and also where it remains the same.
- The 1983 Act was previously amended in 1995 which created “supervised discharge” or “after-care under supervision”, and this has been important for people receiving “Section 25 aftercare”.
- This 1995 Act is replaced by the 2007 Act, and “Section 25 aftercare” has ended. It is replaced by Supervised Community Treatment which we look at later.

- Along with the 1983 Act there is a Code of Practice providing guidance on applying the Act in England and Wales.
- This Code now reflects changes in the 2007 Act and, there is a separate version specifically for Wales: The Mental Health Act Code of Practice for Wales (November, 2008).
- The Code of Practice is not law, but an important document offering “statutory guidance”. Professionals who do not follow this guidance can be challenged in court.



What has not changed

Hospital Admission, Guardianship and Aftercare

- Section 2 used to admit and detain a person in hospital for assessment for up to 28 days,
- Section 3 used to admit and detain a person in hospital for treatment for up to 6 months,
- Section 4 used in an emergency to admit and detain a person in hospital for up to 3 days,
- Section 5 again used in an emergency to detain a person already in hospital for up to 3 days by a doctor (S5.2) or 6 hours by a nurse (S5.4),
- Section 7 used to receive a person into Guardianship,
- Sections in Part 3 of the Act, including Sections 37 and 41 used for people who come before a Court,
- Section 117 placing a duty on authorities to provide aftercare to a person who has been detained for treatment,
- Sections 135/136 about taking a person to a place of safety for assessment.

What has changed: Seven areas

- How mental disorder is defined
- The professionals who have specific roles within the Act
- Additional rights for patients to displace their Nearest Relative
- How treatment is defined, and when it can be given
- The introduction of Supervised Community Treatment (SCT) and Community Treatment Orders (CTO`s)
- A new right for patients to have an advocate
- Some changes about how Mental Health Review Tribunals operate.

The Code of Practice for Wales

- Whilst key sections of the Act have not changed, how they are applied in practice has. This is why the Welsh Code of Practice is important.
- The Code sets out in great detail how professionals and organisations should undertake the roles and responsibilities given to them under mental health legislation. It also sets out in detail the rights of service users, their relatives and carers.
- The Code has 34 chapters including the Guiding Principles, Care and Treatment Planning and Advance Statements of wishes and feelings.

And...THE MENTAL HEALTH (WALES) MEASURE 2010, and TOGETHER FOR MENTAL HEALTH 2012.

- Hafal had long campaigned for a mental health law specifically for Wales to offer a balance to the compulsory powers in the 1983 and 2007 Mental Health Acts by giving people with serious mental illness the right to appropriate assessment, treatment and advocacy.
- The Welsh Assembly passed this law, the Mental Health (Wales) Measure 2010, giving people with serious mental illness new legal rights.
- The Welsh Government launched a new mental health strategy, “Together for Mental Health” (October 2012), in which it sets out the “vision for 21st century mental health services” referred to as
- ‘The Mental Health and Wellbeing Strategy for Wales’.



The Mental Health and Wellbeing Strategy for Wales

- Mental Health and Wellbeing
- It is Wales' first MH and VWB strategy, and has the aim of promoting mental wellbeing, preventing MH problems, improving MH services and early intervention for people diagnosed with psychiatric illness, to reduce the impact.
- A Strategy for all Ages
- It is also the first MH strategy to include all age groups – children, adults of working age and older people. Services will be delivered separately to these age groups, but the Strategy seeks to improve transitions for people who move between these services.

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- The Mental Health Measure
 - Builds on the Mental Health (Wales) Measure which places legal duties on Health Boards and Local Authorities to improve how treatment, care and support are offered to people with mental ill-health.
 - The focus on improved individual Care and Treatment Planning and on recovery and enablement, a key feature of the Mental Health Measure, is central to the Strategy.
 - Outcome focused
 - The Strategy seeks to be outcome focused with six high level outcomes and 18 lower level outcomes which try to ensure that the strategy does make a real and measurable difference, through “a service user lens”.
 - Human Rights
 - The Strategy also seeks to take a human rights approach, tackling stigma and discrimination and addressing issues of equality and diversity.
 - Delivery Plan
 - The initial three years (2013 to 2016) included a three-year programme of improvement, setting out the progress required and making “best use of resources”. Implementation was overseen by a “Mental Health Partnership Board”.

So... why does this all matter and what does it mean?

- This module focuses on legal, ethical and professional frameworks that support both the service users and the service providers and assist in guiding decision making in an array of unique, complex and challenging situations.
- This afternoon we will be looking at individual case scenario`s and applying some of what we have considered this morning, in our journey to becoming effective health care professionals.