Articles

A brave new (fused) world? The draft Northern Irish Mental Capacity Bill

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The lengthy process of reform of mental health legislation in Northern Ireland has recently taken a step forward with the joint publication of a draft Mental Capacity Bill addressing the first limb of a truly radical legislative project to 'fuse' mental capacity and mental health legislation. Under the Bill, 'conventional' mental health legislation with detention based on illness status and risk will disappear – there will be no provision for the compulsory detention and treatment of those with mental disorder who have capacity to take the material decisions but refuse. Those with mental disorder who lack capacity to take the relevant decisions will be dealt with on the same 'best interests' basis as all other forms of decision-making for those without capacity. The draft Bill therefore brings all those detained, whether in psychiatric hospital, general hospital or care home, under a single remit.

In this article, Alex Ruck Keene and Catherine Taggart summarise and critique the key provisions of the draft Bill, emphasising in particular those aspects which shed light on areas which should prompt reflection as to the approach that is adopted in England and Wales under the Mental Capacity Act 2005. They also consider its compatibility with the UN Convention on the Rights of Persons with Disabilities.

Introduction

The lengthy process of reform of mental health legislation in Northern Ireland has recently taken a step forward with the joint publication of the draft Mental Capacity Bill ('the Bill') by the Department of Health, Social Services and Public Safety, and the Department of Justice. A public consultation period has just ended, and the intention is that the draft Bill be finalised for introduction into the Northern Ireland Assembly early in 2015 with a view to enactment before the end of its current mandate in March 2016.

The Bill has been long in gestation and follows the recommendations of the Bamford Review of Mental Health and Learning Disability (named after its original chair, David Bamford who tragically died before its completion). The review addressed the reform of the Mental Health (Northern Ireland) Order 1986, and the absence in Northern Ireland of capacity legislation (questions relating to decision-making on behalf of those without capacity are currently determined under the common law). The Bamford Review emphasised the idea that having separate mental health legislation is discriminatory, and recommended a single legislative framework covering all health (mental and physical), welfare or financial decisions. The current draft Bill follows this recommendation. The proposals also extend to the criminal justice system, which are at an earlier stage of development and will be the subject of a further consultation at a later date.

The Bill and its key features

The civil provisions in the draft Bill appear at first blush superficially similar to the MCA 2005. Terms such as 'lacks capacity' and 'best interests' appear, and the tests for the assessment of both mirror (with some variations) the tests set down in the MCA 2005. But this superficial similarity hides the Bill's truly radical nature.

The draft Bill not only introduces capacity legislation to Northern Ireland, but notably replaces the function of the Mental Health (NI) Order 1986 in respect of those aged 16 and over (the Order will survive in respect of those aged 15 and below pending further consideration of how their position is best approached). As such 'conventional' mental health legislation with detention based on illness status and risk will disappear. There will be no provision for the compulsory detention and treatment of those with mental disorder who have capacity to take the material decisions but refuse. Those with mental disorder who lack capacity to take the relevant decisions will be dealt with on the same best interests basis as all other forms of decision-making for those without capacity (and with the same increased level of checks and balances for serious interventions as provided elsewhere in the Bill, and discussed below).

As such the Bill is an example of the 'fusion model' proposed by George Szmukler and others (mainly within psychiatry) (see eg G Szmukler, R Daw and J Dawson, 'A model law fusing incapacity and mental health legislation' (2010) 20 *Journal of Mental Health Law* 1, at pp 11–21) who have strongly criticised current mental health legislation for discriminating against people with mental illness because compulsory detention and treatment can be imposed regardless of a person's capacity to decide for themselves. This is in striking contrast to the right to self-determination outlined by the courts when dealing with people who require physical treatment.

If the civil provisions are enacted in substantially the same form as those issued for consultation – and if they are accompanied by a proper implementation programme – they will represent a truly ground-breaking shift in the approach to the care and treatment of those with mental disorder in Northern Ireland who will – in essence – disappear as a separate class of individual.

Like but not alike – comparisons with the MCA 2005

The civil provisions of the Bill make particularly interesting reading for those steeped in the MCA 2005, because they appear both familiar and unfamiliar.

Assessment of capacity

Similar to the approach adopted under the MCA 2005, a person is not to be regarded as unable to make the decision unless all practicable steps are taken to enable them to make a decision without success (clause 1(3)). The draft Bill places far greater emphasis on the provision of support to make decisions than in the MCA, by expanding this into an entire clause (4). This includes a requirement that persons 'whose involvement is likely to help the person to make a decision are involved in helping and supporting the person,' so far as is practicable. Also, timing and environment must be considered when the matter in question is raised with the person (clause 4(2)). Other than in emergency situations, 'serious interventions' require a formal assessment of capacity where the assessor must specifically document what help and support has been given to enable P to make a decision without success (clause 12(4)(d)).

Whilst the 'functional' test in clause 3 appears similar to that in s 3 MCA 2005, it includes in relation to the 'use and weigh' limb an additional element of not being able to 'appreciate' the relevance of the information as part of making the decision in question. The inclusion of appreciation goes some way to address the criticism that the test under s 3 MCA 2005 lends itself better to assessment of individuals with cognitive disorders than psychiatric illnesses, where the effects of unusual thinking, lack of insight and emotional colouring can affect decision-making ability (G Richardson, 'Mental capacity at the margin: the interface between two Acts' (2010) 18 *Medical Law Review* 56, at p 65). It is important in this context that (by contrast with the position under the MCA 2005), the capacity test in the draft Bill becomes the standard for psychiatric detention and

treatment, and needs to be workable with a range of disorders. However, 'appreciation' does not have a clear definition, and potentially could be open to interpretation. Further, a downside of its inclusion is the potential for a degree of elasticity to creep into the capacity test, which is already regarded by some as subjective (see P Bartlett, 'The test of compulsion in mental health law: capacity, therapeutic benefit and dangerousness as possible criteria' (2003) 11 *Medical Law Review* 326, at p 341, and also the exchange between Lucy Series and George Szmukler on Alex's website (www.mclap.org.uk)).

Protection against liability

The familiar protection against liability in ss 5–6 MCA 2005 is developed substantially into an entire Part in the draft Bill, clause 8 of which is essential to its operation. In particular, there is a fundamental distinction between general acts done in connection with the care, treatment or personal welfare of P, and acts to which additional safeguards apply before reliance can be placed upon the protection (save in an emergency situation). Such acts include –

- acts of restraint;
- serious interventions (which has a statutory definition including, but going beyond, major medical interventions) – requiring formal assessment of capacity and the consultation of a nominated person (who, if not nominated by P, is chosen by reference to a statutorily defined list, with P's primary carer being at the top of the list);
- certain treatments for which a second opinion is required;
- serious treatment (where there is objection from P's nominated person or compulsion) – requiring authorisation and consultation with an independent advocate;
- attendance and community residence requirements, both new concepts within the Bill – requiring authorisation and consultation with an independent advocate;
- deprivation of liberty – requiring authorisation and consultation with an independent advocate;
- other compulsory/serious interventions not listed above – requiring the involvement of an independent advocate.

The concept of 'protection from liability' is a considerable change in emphasis for those in Northern Ireland currently working with the MHO 1986. Although a familiar part of capacity legislation, it is a departure to have compulsory admission and treatment in psychiatric hospital predicated on this basis, rather than legislation that confers statutory powers.

Authorisation for deprivation of liberty

Unlike under the MCA, the circumstances requiring authorisation for deprivations of liberty are not to be found in a Schedule, but rather in the main body of the Act. In very broad terms, the following deprivations of liberty can be authorised (initially for up to 6 months) by a panel convened by the relevant Health and Social Care Trust:

- the detention of a person in a hospital or care home in which care or treatment is available for that person;
- the detention of a person while being taken, transferred or returned to a hospital or care home for the purposes of the provision to that person of care or treatment;
- the detention of a person in pursuance of a condition imposed during a permitted period of absence from a hospital or care home.

It is important to note that even though such a deprivation of liberty has been authorised under Part 2 that does not mean it can go ahead if the other safeguards and conditions applicable under that Part are not complied with.

Different provisions apply in relation to short-term detentions in hospital for examination for up to 28 days, which can be authorised on the basis of a medical report stating that the criteria for authorisation are met.

It is of note that, by contrast with the position that prevails in England and Wales, the deprivation of liberty provisions in the Bill have teeth – clause 135 proposes the creation of a criminal offence of the unlawful detention of a person without capacity.

As with the MCA 2005, deprivations of liberty arising in settings other than a hospital or care home will have to be authorised by a court (this will be the Northern Ireland High Court, as the decision has been taken that the size of the jurisdiction does not warrant the establishment of a dedicated Court of Protection). This aspect of the Bill may likely be revisited during the passage of the Bill through the Assembly in light of the Supreme Court decision in *Cheshire West* and the implications of the clarification of the 'acid test'. It will also be interesting to see in due course the extent to which the inherent jurisdiction in Northern Ireland develops along similar lines to the way it has in England and Wales to cater for the circumstances of vulnerable but capacitous adults.

Appeals against authorisations will be heard by a Review Tribunal, which is a renamed and reconstituted version of the Mental Health Review Tribunal. This is particularly interesting reading for all those who advocated that the deprivation of liberty safeguards regime should be brought within the ambit of the MHA 1983 in England, and it will be interesting to see how this fares as an appeals mechanism, especially if the numbers of individuals requiring authorisations for deprivations of liberty approach the same proportions as in England. It is perhaps worth noting also that an individual deprived of their liberty in a care home who does not seek to exercise a right of review before the Tribunal will automatically have their case referred to the Tribunal after sufficient passage of time.

In stark contrast to the major disparity between those subject to the compulsory provisions of the MHA 1983 and those deprived of their liberty pursuant to Sch A1 to the MCA 2005, the draft Bill brings all those detained, whether in psychiatric hospital, general hospital or care home, under a single remit. The Northern Irish Bill therefore entirely side-steps the extraordinarily (and unnecessarily) complex interface between the MCA 2005 and MHA 1983 that causes such difficulties in England and Wales.

Other provisions

Other provisions adopted in England and Wales that are mirrored in the draft Bill include the replacement of enduring powers of attorney by lasting powers of attorney (LPAs) (and the creation of LPAs in relation to health and welfare matters), the creation of court-appointed deputies for health and welfare and property and affairs (replacing in the latter regard controllers; the former being an innovation), the creation of an Office of the Public Guardian, the codification of the concept of payment for necessities, and provisions in relation to research upon those unable to give consent. An offence of ill-treatment or neglect is created, which sets out that the victim of the offence should lack capacity 'in relation to all or any matters concerning his/her care.' The wording of this proposed offence no doubt reflects the heavy judicial criticism of the vagueness of the wording of s 44 MCA 2005.

Finally, it should perhaps be noted that the Bill rather delicately side-steps the issue of advance decisions to refuse treatment by giving them statutory force, but not defining them save by the reference to the common law relating to such decisions. As has been noted by John Dawson in an article forthcoming in the *International Journal of Law and Psychiatry*, there is an interesting question as to whether the interaction between the provisions relating to advance decisions to refuse treatment and the provisions relating to deprivation of liberty operate so as to allow a person to make an advance decision preventing them from being detained should they lose capacity. In short, our view is that they do not, but this point may well be tested in due course, not least by reference to the position that prevails in England and Wales where an advance decision to refuse the medical treatment which it is proposed will be administered will serve – in general – as a bar to the grant of an authorisation under Sch A1 to the MCA 2005.

The criminal justice system

The provisions of the Bill relating to the criminal law had not at the time of writing yet advanced to a position where they can be put out for consultation, but the current consultation document provides an indication of the direction of travel. It is clear that the Department of Justice is making a sustained attempt to introduce a fully capacity-based approach to care,

treatment and personal welfare in respect of persons subject to the criminal justice system:

- removing the equivalent to s 135 MHA 1983 allowing police to remove individuals to a place of safety upon the basis of mental disorder, instead making the operation of this power contingent upon the individual lacking the material capacity and that removal being necessary to prevent serious harm to themselves or another and it being in their best interests;
- at remand, sentencing or following a finding of unfitness to plead (a test which will, itself, be revised to be based upon capacity), making court powers to impose particular healthcare disposals on offenders contingent on that individual's capacity (and – where they lack capacity – upon their best interests);
- the operation of prison powers by which the Department of Justice can transfer prisoners for in-patient treatment in a hospital.

It is very clear from the consultation document that these proposals are predicated on a radically different model of the treatment of those with mental disorder at all stages of their involvement with the criminal justice system. With respect to mentally disordered offenders, and whilst the Department of Justice acknowledges the need to strike an appropriate balance between respecting an individual's autonomy whilst providing adequate protection against risk, the Bill poses particular challenges in respect of risky but undetainable individuals. It is undoubtedly the case that forensic psychiatry will be one of the professional groups who will feel the effects of the Bill most acutely. How the process is taken forward by the Department of Justice remains to be seen, but this area will no doubt be one of the most sensitive and controversial.

CRPD compliance?

The model set down in the draft Northern Irish Bill is one that other UK jurisdictions may wish to pay attention to, not least as the process of engagement begins with the Committee on the Rights of Persons with Disabilities ('CRPD'). No doubt the Bill will feature in deliberations in the run-up to the consideration of the UK by that committee in the course of 2015–6. In this section, we offer a few observations as to the extent to which the Bill complies with the provisions of the CRPD. In so doing, we are acutely conscious of the debate that is currently raging as to exactly what the CRPD requires (as to which, see the article by Lucy Series at [2014] Eld LJ 62 and also the position paper prepared by the Essex Autonomy Project (EAP) available at: http://autonomy.essex.ac.uk/uncrpd-report).

While the MCA 2005 is limited in specifying support for P in making a decision, the Northern Ireland Bill ('NI Bill')requires (for significant interventions) that there is documentation of the support that has been given, and involvement of others likely to be of help in the decision-making process. As such it is more obviously compliant with the CPRD than the MCA 2005. However, both are in contrast with the Assisted Decision-Making (Capacity) Bill in the Republic of Ireland ('ROI Bill')(see the article by P Rickard-Clarke at [2014] Eld LJ 78) which has the explicitly stated aim of CRPD compliance and contains much greater detail of support in decision-making arrangements (albeit without taking on the ambitious task of seeking to encompass mental health as well).

The NI Bill uses best interests as the basis on which to intervene in the affairs of those that lack capacity (clause 6). We understand that this has been deliberately framed using the same term as in the English legislation so that benefit can be drawn from the body of case-law building up in under the MCA 2005. However, the term 'best interests' is, to put it mildly, a loaded one in light of the current debate as to whether best interests decision-making is forbidden by virtue of Art 12 of the CRPD. Again the draft Bill is a contrast with the ROI Bill, which is more obviously CRPD compliant, using 'will and preferences' as the basis for intervention (whether, though, the ROI Bill itself complies with the CRPD as interpreted by the Committee is questionable because even that Bill does not provide for will and preferences to be determinative in all cases).

Also relevant to the CRPD is the capacity test itself. It is arguable that the

framing of the capacity test in the draft Bill goes further than does the MCA 2005 towards eliminating its discriminatory effect upon those with disabilities by emphasising that it does not matter whether functional incapacity in relation to a specific issue is caused by a disorder or disability or otherwise than by a disorder or disability (clause 2(3)). However, there is an argument that any functional test is discriminatory according to the terms of the CRPD itself (see, in this regard, the EAP position paper referred to above).

It is also arguable that the fact that the NI Bill, by making 'impairment' the basis for compulsory intervention, falls foul of the requirement in Art 14(1)(b) of the CRPD that 'the existence of a disability shall in no case justify a deprivation of liberty' (Art 14(1)(b)). No matter the extent to which the draft legislation attempts to de-link the impairment causing the incapacity from an underlying disability, it may well be the case that this is, in fact, impossible, and – ultimately – a person's lack of capacity and hence their disability – is being used as a reason to restrict their liberty (P Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 *The Modern Law Review* 752, at p 763). If so, then it may be that the NI Bill is incompatible in this regard with the CPRD. Further, very complex issues will then arise as to how the UK Government is to square its obligations under the CPRD with those under Art 5(1)(e) of the European Convention on Human Rights, which expressly makes deprivation of liberty contingent upon the establishment of unsoundness of mind (see, for a discussion of some of the issues involved: P Fennell and U Khaliq, 'Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English law' (2011) 6 *European Human Rights Law Review* 662–674).

We will wait with very considerable interest to see how those charged with taking forward the draft Bill and the Northern Ireland Assembly seek to address these questions. On the one hand it is in some ways unfortunate that the ground is (or seems to be) shifting as to the requirements of the CRPD at exactly the point when the legislation is being finalised. On the other hand, the fact that the legislation will be progressing through the Assembly during the course of the UK's engagement with the Committee on the Rights of Persons with Disabilities provides an opportunity to engage in a real – and hopefully constructive – dialogue with that Committee in the context of a proposal to enact legislation that is so clearly intended to seek to end discrimination in care, treatment and detention, a goal that is entirely in line with the aims of the CRPD.

Elderly people

For those who are incapacitous and acquiesce to treatment, the current position in Northern Ireland is similar to that in England and Wales prior to the enactment of the MCA 2005. The new legislation will bring NI into line with the rest of the UK by introducing a capacity statute and addressing the 'Bournewood gap'. Currently questions regarding such individuals are dealt with under the common law, but often only arise when a person actively refuses treatment. The Bill will bring a large number of people, many of them elderly, under its remit where currently there is no clear protection to secure them against unlawful deprivations of liberty.

This has significant implications for professionals working with elderly people, and others who lack capacity, who will have to become familiar with the new law and principles of capacity assessment. This will apply particularly to social workers, and also general hospital staff, psychologists and care workers. This will require a comprehensive training programme – not just for new assessors, but for all health and social care staff who need to have a working knowledge of the Bill. At a time of crisis in health service funding this could be a concern because of competing demands for time and resources, but it cannot be ignored if the new law is to function effectively. The example of the MCA 2005 is instructive – the recent House of Lords post-legislative scrutiny report is clear that poor understanding of the Act and its underlying principles has led to difficulties in implementation and arguably a failure of the MCA to achieve its aims.

Conclusion

The draft Bill has a long way to go before its eventual enactment. If it survives in its current form it will be a paradigm shift in the law relating to mental health and capacity in Northern Ireland. Already there are some clear difficulties, but also opportunities, to be grappled with / grasped by those who are taking the Bill forward. How the legislative process unfolds – and in particular the process of engagement with the provisions of the CRPD and the putting of flesh upon the bones of the draft primary legislation – will be interesting. The ongoing development of the draft Bill in Northern Ireland (and similarly that of the ROI Bill) will, and should, be watched with interest from the other side of the Irish Sea.