





# The history and development of the MCA (NI) 2016

## Professor Roy McClelland





# BJPsych Bulletin

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## Mental Capacity Act (Northern Ireland) 2016

Gerard Lynch <sup>(a1)</sup> <sup>(a2)</sup>, Catherine Taggart <sup>(a2)</sup> and Philip Campbell <sup>(a3)</sup> 



Health and Social Care  
(Control of Data  
Processing) Act  
(Northern Ireland) 2016



Health and Social Care  
(Control of Data  
Processing) Act  
(Northern Ireland) 2016



Mental Capacity Act  
(Northern Ireland) 2016

CHAPTER 18



# History and Development of the MCA (NI) 2016

- Beginnings



**Medizin in Recht und Ethik**

**Band 33**

**Hans-Georg Koch/Stella Reiter-Theil/  
Hanfried Helmchen (eds.)**

**Informed Consent in  
Psychiatry**

**European Perspectives of Ethics,  
Law and Clinical Practice**



**NOMOS**

The inquiry condemned the 1983 Mental Health Act, the most recent legislation governing mental health in England and Wales, as obsolete and called for it to be replaced.<sup>1</sup> Again Dr *Berghmans* reports on a Dutch survey of public opinion in which one in six are dissatisfied with current legislation. There are many other anecdotal comments from the report writers pointing to public and professional dissatisfaction with various aspects of the operationalisation of consent, the withholding of consent, the overriding of patients' decisions by healthcare workers, the lack of guidelines and quality control on assessment of competence and patient participation in research.

## II. Treatment and consent

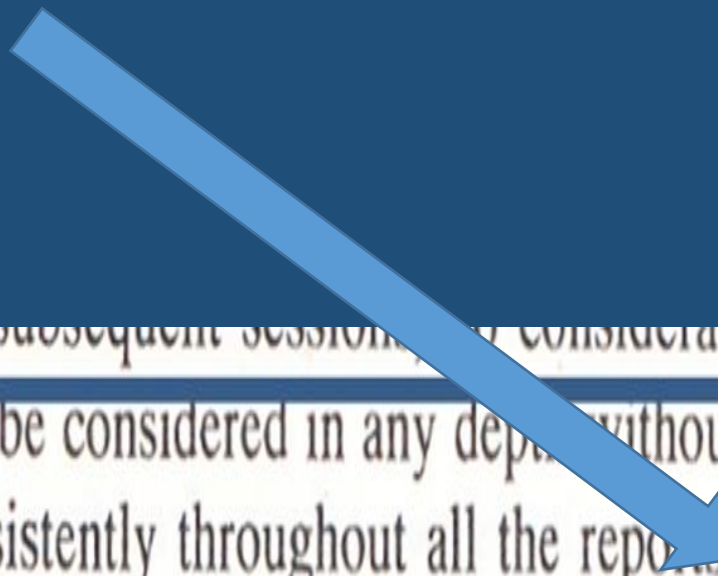
### 1. Definitions

The UK Department of Health (1990) has proposed a definition of consent which is the voluntary and continuing permission of a patient to receive a particular treatment, based on adequate knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives.

The Italian Medical Deontological Code defines three different kinds of consent:

- a) Implicit consent where caring and treatment does not imply particular risk for the patient.
- b) Explicit consent where caring and treatment carries special risks, where consent can never be assumed and must be explicitly given, usually in writing.
- c) Presumed consent where a patient is unaware or cannot understand the nature of their situation and there is a serious risk.

While consideration of the ethical principles and issues of evaluation are topics for subsequent sessions, no consideration of the problems of informed consent can be considered in any depth without touching on these issues. As noted quite consistently throughout all the reports, the high status of consent today and respect for the withholding of consent, relates in large part to the rise in the status of respect for autonomy. Within the healthcare arena the primary conflict is with the principle of beneficence. (It might reasonably be argued that this is all too often a false dichotomy driven by inadequacies in resource provision and the fundamental ethical appeal is to fairer distribution of national wealth). From an historical perspective it is interesting to note the universal shift in legislation across the EEA from the more paternalist 'best interests' argument to the dominance of patient rights, 'respect of autonomy.'



for subsequent sessions, in consideration of the problems of informed consent can be considered in any depth without touching on these issues. As noted quite consistently throughout all the reports, the high status of consent today and respect for the withholding of consent, relates in large part to the rise in the status of respect for autonomy. Within the healthcare arena the primary conflict is with the principle of beneficence. (It might reasonably be argued that this is all too

**“A man or woman of full age and sound understanding may choose to reject medical advice.... A decision to refuse medical treatment by a patient capable of making the decision does not have to be sensible, rational or well considered.”**

**Court of Appeal in Re T (Adult: Refusal of Treatment) 1993**

- **Understand and retain the information relevant to the decision in question;**
- **Believe that information;**
- **Weigh that information in the balance to arrive at a choice**

**Re C (Adult: Refusal of Treatment) 1994**





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EDITORIALS

## **Medical incapacity act†**

*A. S. Zigmund*

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*Psychiatric Bulletin* (1998), **22**, 657–658

“The Mental Health Act should be repealed”

“The College should, in conjunction with other  
Royal Colleges, campaign for a Medical Incapacity Act.”



*Dawson J, Szmukler G. (2006) Fusion of mental health and incapacity legislation. Br J Psychiatry 188:504-9*



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*McClelland R, Szmugler. G (2000) Consent and Capacity in Psychiatric Practice Revisited. Eu J Health Law 7:47-55*



*Dawson J, Szmukler G. (2006) Fusion of mental health and incapacity legislation. Br J Psychiatry 188:504-9*

*McClelland R, Szmugler. G (2000) Consent and Capacity in Psychiatric Practice Revisited. Eu J Health Law 7:47-55*

*Szmukler G, Daw, R & Dawson, J (2010) "A Model law fusing Incapacity and Mental Health Legislation" J Mental Health Law, pp. 11-24*



Report of the Expert Committee



November 1999

# Review of the Mental Health Act 1983



## Two fundamental principles:

- non-discrimination against those with a mental illness
- respect for patients' autonomy



## **Two fundamental principles:**

- **non-discrimination against those with a mental illness**
- **respect for patients' autonomy**

## **Leading to the conclusions:**

- **reconsideration of the grounds of involuntary treatment**
- **this must be connected with a patient's lack of capacity to make treatment decisions**

# History and Development of the MCA (NI) 2016

- Beginnings
- College recommendations on legislative reform



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NI SECTION ROYAL COLLEGE OF PSYCHIATRISTS  
MENTAL HEALTH LAW SUB-COMMITTEE

Review of Ethical Issues and Related Developments in Law in Relation to People with  
Mental Health Problems

“.....any serious review of mental health legislation must consider the relevance of *patient capacity/incapacity* in the context of any clinical decision to treat *in the absence of consent or patient refusal.*”

Roy McClelland September 2001

## RCPsych Recommendations on Legislative Reform

*First: “Principles, well established within healthcare, provide an essential backdrop to any review of mental health law. This included respect for a person’s autonomy”*

# RCPsych Recommendations on Legislative Reform

*First:* “Principles, well established within healthcare, provide an essential backdrop to any review of mental health law. This included respect for a person’s autonomy”

*Second:* “In any review of mental health law - capacity/incapacity considerations must occupy a central place in any proposed treatment intervention, especially in the absence of consent or where a person withholds their consent”

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Equality

# The Bamford Vision

*“a valuing of all who have mental health needs or a learning disability, including rights to full citizenship, equality of opportunity and self-determination”*

# 8<sup>th</sup> Bamford report Equality of Opportunity (2006)

*“because a person has a mental health problem or a learning disability does not of itself mean that he or she is incapable of exercising his or her rights”*

*“equal citizenship requires equality under the law”*

*“repeal of laws that apply to only one group of people”*

Rachel Perkins

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Context and timing

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A Single Legislative Framework

THE BAMFORD REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY  
(NORTHERN IRELAND)

**A COMPREHENSIVE LEGISLATIVE  
FRAMEWORK**

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August 2007

9<sup>th</sup> Bamford Report

A Comprehensive Legislative Framework (2007)

*“Having one law for decisions about physical illness and another for mental illness is anomalous, confusing and unjust”*

# 9<sup>th</sup> Bamford Report

## A Comprehensive Legislative Framework (2007)

*“Having one law for decisions about physical illness and another for mental illness is anomalous, confusing and unjust”*

*“Northern Ireland should take steps to avoid the discrimination, confusion and gaps created by separately devising two statutory approaches but should rather look to creating a comprehensive legislative framework which would be truly principles based and non-discriminatory”*

## 9<sup>th</sup> Bamford Report

### A Comprehensive Legislative Framework (2007)

*“A rights based approach is proposed as the guiding principle for reform of legislation, which should respect the decisions of all who are assumed to have the capacity to make their own decisions. Grounds for interfering with a person’s autonomy should be based on impaired decision-making capacity”*

# 9<sup>th</sup> Bamford Report

## A Comprehensive Legislative Framework (2007)

*“A rights based approach is proposed as the guiding principle for reform of legislation, which should respect the decisions of all who are assumed to have the capacity to make their own decisions. Grounds for interfering with a person’s autonomy should be based on impaired decision-making capacity”*

*“from public protection as the priority towards safeguarding the rights and dignity of people with a mental disorder or a learning disability”*

## **Legislative Proposals - 5 key demands**

- **repeal of separate and discriminating mental health legislation**
- **a single legislative framework in which all health and welfare issues are considered equally**
- **principles supporting the dignity of the person should be explicitly stated in the legislation**
- **a presumption of decision-making capacity, with respect for decisions and provision of support to enable participation in a decision**
- **where an individual's capacity is impaired the best interests of the person should be protected and promoted**

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- The Departments' responses to Bamford

## The Department's policy consultation January 2009

“The Department took the view that the Bamford Review’s legislative proposals could be delivered through *separate mental health and mental capacity legislation* but with an overarching set of human rights based principles.” !!

Draft Mental Capacity Bill (NI) Consultation Document April 2014

**“The overwhelming view expressed in the responses to the 2009 consultation was that the Department should instead take the time to develop the single, comprehensive framework envisaged by the Bamford Review.**

“The overwhelming view expressed in the responses to that consultation was that the Department should instead take the time to develop the single, comprehensive framework envisaged by the Bamford Review.

*Consequently, it was decided in September 2009, that the Department would fuse together mental capacity and mental health law into a single Bill, a ground breaking approach not yet attempted in any other jurisdiction.”*

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  - UNCRPD article 12 compliance?

## General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities

*“compliance with Article 12 requires that States Parties abolish all substitute decision-making regimes”*



Essex Autonomy Project

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# ACHIEVING CRPD COMPLIANCE

IS THE MENTAL CAPACITY ACT OF ENGLAND AND WALES COMPATIBLE  
WITH THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH  
DISABILITIES? IF NOT, WHAT NEXT?

**AN ESSEX AUTONOMY PROJECT POSITION PAPER**

**REPORT SUBMITTED TO THE UK MINISTRY OF JUSTICE**

*22 SEPTEMBER 2014*

Essex Autonomy Project

## ACHIEVING CRPD COMPLIANCE

The Mental Capacity Act of England and Wales is not fully compliant with the United Nations Convention on the Rights of Persons with Disabilities, to which the UK is a signatory.

## ACHIEVING CRPD COMPLIANCE

The Mental Capacity Act of England and Wales is not fully compliant with the United Nations Convention on the Rights of Persons with Disabilities, to which the UK is a signatory.

The UN Committee on the Rights of Persons with Disabilities is *not correct* in its claim that compliance with the CRPD requires the abolition of substitute decision making and the best-interests decision-making framework.

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  - Children and young people

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- The MCA (NI) 2016



# Mental Capacity Act (Northern Ireland) 2016



**Law  
Commission**  
Reforming the law

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## **Mental Capacity and Deprivation of Liberty Summary**

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90. In our view, the “fusion” of mental health and mental capacity legislation potentially represents the future direction for mental health law reform in England and Wales. *The introduction of such “fusion law” in Northern Ireland provides an opportunity to review mental health law in England and Wales with a view to the possible introduction of mental capacity-based care and treatment for mental as well as physical disorders.* Our report urges the UK and Welsh Governments to take that opportunity. In the absence of fusion, we have sought to simplify the notoriously complex interface between the current DoLS and the Mental Health Act.

13 March 2017



# Civilitus mortuus – no longer?

Dr Tony Zigmond



# Ethics and mental health legislation

Dr Julian Sheather



# Autonomy and welfare



# Four main pressures



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# Resources



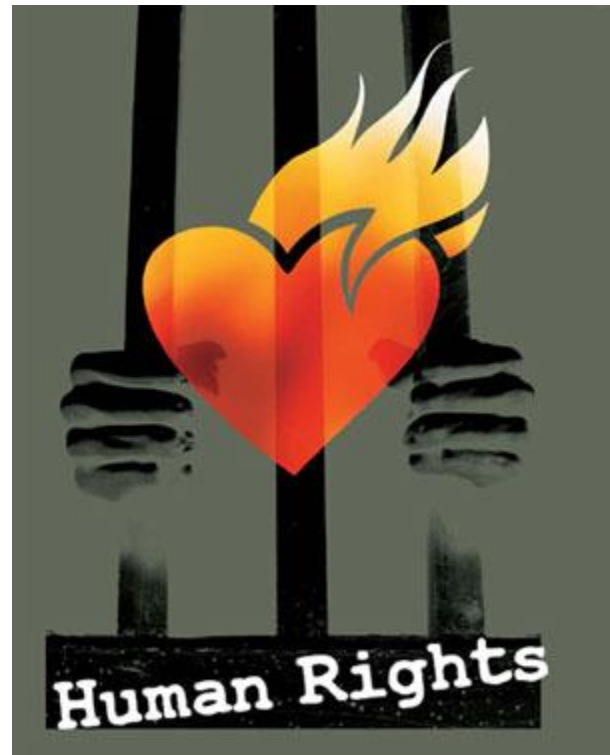
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# Those who use them



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# UNCRPD and other rights



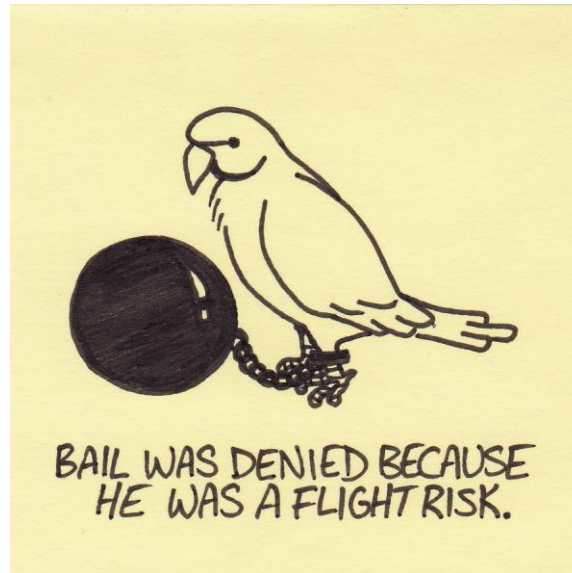
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# The autonomy question



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# Risk



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And finally



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# The Draft Code of Practice

Taryn McKeen



# **MENTAL CAPACITY ACT (NORTHERN IRELAND) 2016**

# **DRAFT CODE OF PRACTICE**

**Taryn McKeen**  
**DoH**  
**22 March 2018**

# BACKGROUND TO THE ACT

- Royal assent 9 May 2016 – Bill became the Act!
- Fuses mental health and mental capacity law – single legislative framework
- Parity of esteem for mental health

# OVERVIEW OF THE ACT

- For care, treatment or personal welfare of a person aged 16 or over, who lacks capacity
- Revokes **Mental Health (NI) Order 1986** for persons aged 16+
- Extremely wide – covers all programmes of care!
- Requires a **Code of Practice**

# THE CODE OF PRACTICE

- Purpose is to help those who work with persons who lack, or may lack, capacity.
- The code explains:
  - what concepts mean;
  - what should be done;
  - when it should be done; and
  - the process of doing it.
- Purpose of Code is not to explain why the Act is the way it is.

# 5 PRINCIPLES

1. Person cannot be treated as lacking capacity unless it has been established that they lack capacity in relation to the matter in question
2. Respect for decisions even if unwise
3. No unjustified assumptions based on age or condition
4. Must always act in person's best interests
5. Support must be provided

# 5<sup>th</sup> PRINCIPLE - SUPPORT

- Supporting a person to make a decision requires certain steps to be taken:
  - *Providing relevant information*
  - *Getting the time and location right*
  - *Involving those likely to help, so far as practicable*

Capacity is **time** and  
**decision specific!**

# PROTECTION FROM LIABILITY

- Provides “D” with protection from liability, because no valid consent = potential crime (such as assault, wounding or false imprisonment) or civil wrong
- D is the person **doing** the act – doctor, nurse etc. *Not the person making the decision!*
- Defence applies to all acts in connection with P’s care, treatment or personal welfare

***But only if certain safeguards have been met!!!***

# SAFEGUARDS

General safeguards applicable to all acts where P lacks capacity:

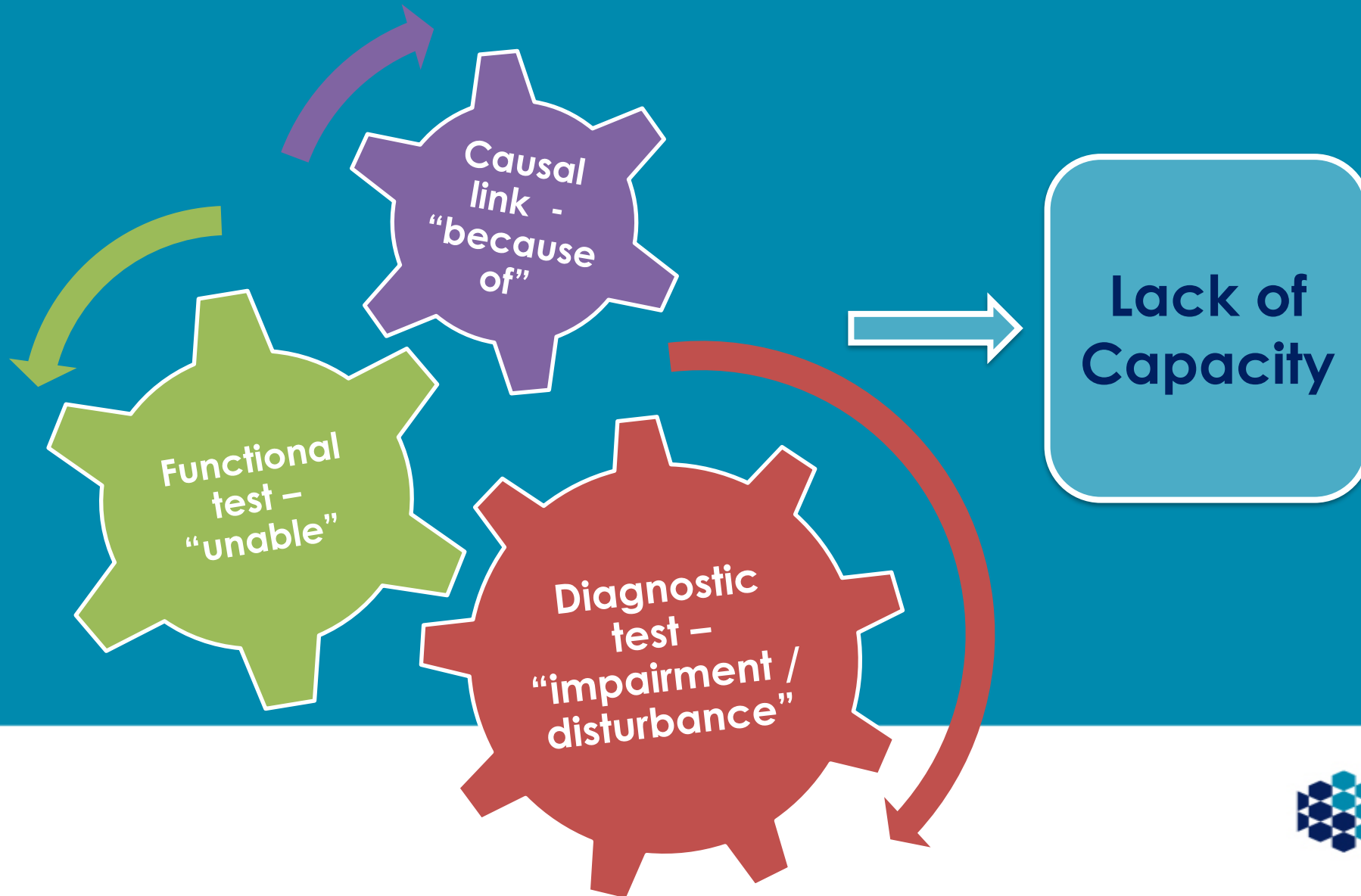
- Reasonable belief that P lacks capacity
- Reasonable belief that the act is in P's best interests

# DEFINING “LACKS CAPACITY”

A person lacks capacity in relation to a matter if, at the material time, he or she is:

*“unable to make a decision for himself or herself about the matter, because of an impairment of, or a disturbance in the functioning of, the mind or brain.”*

# THREE STAGE TEST



# “UNABLE TO MAKE DECISION” – FUNCTIONAL TEST

- Unable to **understand** information;
- Unable to **retain** information;
- Unable to **appreciate relevance** of information and **use and weigh** it; OR
- Unable to **communicate** decision.

# “IMPAIRMENT OR DISTURBANCE” – DIAGNOSTIC TEST

## **EXAMPLES:**

- Alcohol or drugs
- Infection
- Learning disability
- Mental ill health
- Delirium
- Stroke
- Dementia
- Acquired Brain Injury
- Accident leading to unconsciousness

REMEMBER: NEED A CAUSAL LINK!

*Must be unable to make the decision **BECAUSE OF** an impairment or disturbance in the functioning of the mind or brain!*

# BEST INTERESTS

- No unjustified assumptions
- All relevant circumstances
- Likely to regain capacity?
- Participation by P
- Special regard to P's past and present wishes, feelings, beliefs and values
- Consult "relevant people" where practicable and appropriate
- Consider less restrictive options
- Likelihood of harm if fail to act

# BEST INTERESTS – EXAMPLE

## **Rodney\*:**

- 58 year old man, had a stroke 2 years ago
- unable to walk, has limited speech
- depressed and alcohol dependent
- Presents to local ED following a fall
- Clinical assessment - HDU for dialysis
- Rodney says “No, home”
- registered nurse assesses capacity - concludes that he is unable to make decision - does not appreciate relevance of information regarding refusal of treatment

- *nurse speaks to daughter - father previously indicated that he would not want prolonged medical treatment*
- *Conclusion: admission to HDU not in Rodney's best interests - contradicts previously stated wishes*
- *Rodney asked to consider admission to general ward for a few days for antibiotic treatment*
- *determined he lacks capacity re this decision*
- *daughter states that father would consent to time limited hospital stay, if he had capacity*
- *treatment plan agreed, Rodney admitted to hospital for a few days before returning home – in his best interests.*

# SERIOUS INTERVENTIONS

- Major surgery;
- Something that causes P serious and prolonged pain, serious and prolonged distress or has serious and prolonged side effects for P;
- Something that affects seriously the options P will have in the future or has a serious impact on day to day life, if prolonged and demonstrable; **or**
- in any way has serious consequences for P as long as not temporary.

***NB. If intervention includes examination, procedure or therapy, then it is a treatment with serious consequences.***

# Deprivation of Liberty (DoL)

- Under continuous supervision and control;
- Not free to leave; AND
- Care arrangements attributed to State.

Examples:

- care home with keypad entry/exit and resident does not have code;
- Locked hospital ward;
- Acute ward where patient is bed bound but would be prevented from leaving if they had the ability to;
- Day care centre where patient is not allowed to leave.

## Attendance Requirement (AR)

Requirement to attend certain place at certain times for treatment with serious consequences

May be a less restrictive option than a DoL

## Community Residence Requirement (CRR)

Requirement to live in a particular place, as stipulated by the HSC Trust

May also include a requirement to allow access by an HSC professional, or to attend for training, education occupation or treatment (not serious)

# ADDITIONAL SAFEGUARDS

Formal assessment of capacity

Nominated Person

Authorisation

Second opinion certificate (ECT only)



# FORMAL ASSESSMENT OF CAPACITY

- Needed for all “serious interventions”
- Must include written “statement of incapacity”
- Must be made by suitably qualified person with specialist training and relevant experience:
  - *Medical practitioner;*
  - *Nurse or midwife;*
  - *Social worker;*
  - *Occupational therapist;*
  - *Speech and language therapist;*
  - *Dentist; or*
  - *Practitioner psychologist.*

# NOMINATED PERSON

- Must be consulted for all “serious interventions”
- Appointed by P, **if P has capacity to do so**
- If not, default list – P’s primary carer at top
- Tribunal can appoint or replace NP
- Not decision maker but can object – if object to treatment with serious consequences then need further safeguard of authorisation

# AUTHORISATION

## *When is authorisation necessary?*

- Detention amounting to **Deprivation of Liberty**
- Treatment with serious consequences, **where NP reasonably objects**
- **Attendance Requirement**
- **Community Residence Requirement**

# TYPES OF AUTHORISATION

## 1. Trust Panel – for DoL, CRR, AR, treatment with serious consequences where NP objects:

- Application can be made by anyone who can make formal assessment of capacity
- Decision made within 7 days
- Set paperwork required, incl. formal assessment of capacity, best interests determination, NP consultation, medical report and care plan
- Can last for 6 months initially, and can then be extended

## 2. Report – for short-term detention in hospital:

- Must include some element of examination
- Lasts for max 28 days – initial 14, can be extended by 14

***NB. No requirement for short-term detention before “full” panel authorisation.***

# CRITERIA FOR AUTHORISATION

- Different ones needed for different interventions, e.g.:
  - *Prevention of Serious Harm condition (POSH)* – needed for DoL and treatment with serious consequences where NP has reasonably objected
  - *Prevention of Harm condition (POH)* – needed for CRR
  - *Receipt of Treatment condition* – needed for AR

# EMERGENCIES

- D does not need to comply with most additional safeguards if situation is an “emergency”
- **BUT** – must put general safeguards in place: reasonable belief of lack of capacity and best interests
- Test – D has a reasonable belief that to delay acting until safeguard in place would create an unacceptable risk of harm to P

# SCENARIO BOOKLET

- Have developed a scenario book as supplement to Code – many real life examples provided by stakeholders;
- Will not form part of official Code, but Departmental guidance;
- Longer scenarios, 1-3 pages, to provide insight into the case, why decisions were taken and the processes that took place.

# WHAT NEXT?

- Hoping to consult on Code and regulations later this year.
- Subject to funding, hoping to proceed with developing training packages.
- Require a working Assembly to commence Act and regulations, and approve Code.

*Thank you!*



**DoH**

[www.health-ni.gov.uk](http://www.health-ni.gov.uk)

