Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Department of Justice
www.dojni.gov.uk

Draft Mental Capacity Bill (NI)

Consultation Summary Report

January 2015

CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION (Chapter 1)

- On 27th May 2014, the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Justice (DoJ) published for consultation, the core civil provisions of a new draft Mental Capacity Bill ("the draft Bill") along with policy proposals for those subject to the criminal justice system.

- The consultation period ran for 14 weeks and closed on 2nd September. A total of 121 responses have been received from a wide range of stakeholders including voluntary and community groups, professional bodies, service providers, carers and service users.

ANALYSIS OF RESPONSES – OVERVIEW (Chapter 2)

- The consultation has confirmed previously expressed support for the development of a **single legislative framework** as recommended by the Bamford Review. A small number of respondents did, however, express concern about the removal of separate mental health legislation.

- Both Departments welcome this overall support but, like many of the respondents, do not underestimate the size of the task ahead. Existing culture and practice will need to change significantly if the aims and objectives of the Bill are to be realised.

ANALYSIS OF RESPONSES – CIVIL PROVISIONS (Chapter 3)

- Where responses focussed specifically on draft clauses, there was a broad measure of support for the direction of travel, particularly in relation to:
  - The **principles** based approach.
  - Provisions requiring individuals to be given all practicable help and **support** to exercise their capacity to make their own decisions where they can.

- Provisions enabling people to put in place future decision making arrangements (such as a new **Lasting Power of Attorney**) to make not only financial decisions on their behalf but also health and welfare decisions should they lack capacity to do so themselves at some point in the future.
- The requirement to put in place **significant additional safeguards** where the intervention proposed (in the life of a person lacking capacity) is serious.
- The introduction of a new **offence of ill treatment or neglect** of a person lacking capacity.

- The statutory recognition of effective **advance decisions to refuse medical treatment** was broadly supported. However, a key message coming through was that clear guidance on what currently constitutes an 'effective advance decision' is required, with opinion divided on whether this should be fixed in statute or elaborated on further in the Code of Practice. The Department has carefully considered the arguments for and against fixing the rules around advance decisions in the draft Bill, but remains of the view that it is best to allow the courts to continue to develop these rules in light of the Bill.

- Another key area that featured in responses was compatibility with the **UN Convention on the Rights of Persons with Disabilities** (UNCRPD). This is an emerging area of law and the Department will continue to monitor developments in this area. It should be kept in mind that no other existing or proposed legislation of a similar type seeks to address the discrimination inherent in having separate mental health legislation. This is at the heart of the Bill and is an aim entirely in keeping with the UNCRPD.

- It is clear from the responses received that overall, the civil provisions adopt the right approach. Therefore, no major policy changes are being proposed as a result of the consultation. That said, there are a number of modifications to the framework that the Department could see merit in making or considering further in light of the consultation. These will be the subject of detailed discussions with Legislative Counsel. They include:

- Amending the title of the legislation (in response to comments made about the inclusion of the word *'mental'* being stigmatising).
- Reviewing the wording of clauses that set out the principles and the definition of 'lacks capacity' to address any potential for misinterpretation and to take account of the findings of the House of Lords Post Legislative Scrutiny of the English Mental Capacity Act 2005.
- Amending the best interests clause to give more prominence to the views and wishes of the person on behalf of whom a decision is being made when determining their best interests.
- Amending the deprivation of liberty clauses as a result of the recent case law relating to deprivation of liberty including the Supreme Court decision in *Cheshire West* in March 2014.
- Reviewing the provision of information clauses to ensure it is clear that certain information must be given to a person when detained under Part 2 of the Bill and discharged from that detention.
- Exploring the option of regional commissioning in respect of independent advocacy.
- Reviewing the right of review provisions to ensure that the rights of those who lack capacity to apply to the Review Tribunal are fully respected.
- Reviewing provisions around research projects to ensure that research involving a serious intervention can only be undertaken where it is in the person's best interests.

- As part of that work, DHSSPS will discuss with DoJ and the NI Courts and Tribunals Service issues raised relating to the review of interventions by the Tribunal and the new Office of the Public Guardian. Discussions will also continue with the Department of Finance and Personnel (DFP) around the civil law provisions in the Bill which fall within DFP's remit.

ANALYSIS OF RESPONSES – CRIMINAL JUSTICE PROPOSALS (Chapter 4)

- Broadly speaking, the DoJ's decision to adopt a capacity-based approach to treatment within the criminal justice system received support from consultees. However this was often qualified by the recognition that sufficient training,

resourcing and increased awareness would be required in order to support this change.

- Of the 25 respondents that commented directly on the DoJ's proposals for **places of safety**, over half raised concerns about the continued use of Emergency Departments and Police Stations as places of safety, including their use for those aged under 16. However support was expressed for the DoJ's proposal that a police station should only be used as a place of safety as a measure of last resort, provided that the power is carefully monitored and reviewed. A number of responses stressed the need for continued work around handover arrangements between the police and healthcare staff at Emergency Departments and the requirement to provide clear guidance for staff in a Code of Practice.

- The need to safely manage patients in order to ensure public protection was a recurring theme from those who commented on the proposed **court disposals**. The need for a **protection order** was generally accepted by respondents, however there were concerns raised about how it would operate in practice; the resource implications it would create, and its compatibility with the European Convention on Human Rights.

- Consultation responses raised concerns that proposals for recasting the **hospital order** to take account of an individual's capacity to make decisions about treatment created a risk to public safety, as it was felt that the approach may not be robust enough to allow individuals who posed a significant level of risk to be detained if they had capacity to make decisions about treatment and so refused. The DoJ has reconsidered its approach and has liaised closely with stakeholders during its ongoing work. The DoJ now proposes introducing an order, to be known as a **Public Protection Order**, which will be available in circumstances where an individual is convicted of an offence punishable with imprisonment or determined to be unfit to plead but to have done the act with which he or she was charged. It is proposed that the Order will be based around the need to detain the individual because of the risk posed to other people.

- DoJ considers that the public protection order is a criminal court disposal, not a substitute decision, and it would be wrong for a criminal court's power of detention to depend on whether the accused has or lacks capacity in relation to detention. It also appears to the DoJ that capacity to make decisions about treatment is not a relevant consideration in determining whether an individual should be detained for the purposes of ensuring public safety. In addressing any public protection issues, the DoJ still wishes to adhere to the Bamford Principle that an individual who has capacity to make decisions about treatment will have any decision to refuse treatment respected.

- Consultees were generally supportive of the proposals in the consultation paper to retain the power to **transfer prisoners to hospital**. Comments made by some respondents included concern over the length of time it currently takes in transferring a prisoner from prison to hospital. Comments were also expressed that the DoJ's proposals might result in a significant increase in the numbers of prisoners transferred to hospital. Consultees also raised the issue of resources, pointing out that it is imperative that appropriate resources are in place to accept the detained individual for treatment or examination.

CHILDREN & YOUNG PEOPLE (Chapter 5)

- Concerns were raised about the **exclusion of under 16s** from the scope of the draft Bill. However, the Department's position on this issue has not changed because the considerations around children are different and there is already a decision making framework for them.

- The Department acknowledges the continuing concern expressed during the consultation in respect of the retention of the Mental Health (NI) Order 1986 for under 16s but reiterates both that this retention is not intended to be permanent and that the Department is committed to building on the safeguards already provided for in the Order.

- There was general support for the options put forward regarding additional safeguards for under 16s falling within the remit of the Mental Health (NI) Order 1986. Comments made in relation to these proposals will be carefully

considered and will inform final instructions to Legislative Counsel. Further suggestions were made during the consultation in addition to the options put forward in the consultation paper. These suggestions have been assessed and, at this stage, subject to further discussions with colleagues, stakeholders and Legislative Counsel, the Department can see merit in taking forward the following:

- Exploring how the Trust authorisation safeguard in the Bill might be reflected in the processes involved in authorising detention for treatment under the current provisions of the Mental Health (NI) Order 1986.
- Making provision in the Mental Health (NI) Order 1986 for a right to independent advocacy for all persons aged under 18 admitted to a hospital for the assessment or treatment of mental disorder.
- Amending the definition of mental disorder to remove the current exclusions.
- Exploring further the option of applications to displace the nearest relative being submitted to the Tribunal rather than the County Court.
- Exploring further issues around independence where consent and a second opinion is required for ECT and that consent is provided by the HSC Trust as the person with parental responsibility.
- Reviewing the offence of ill treatment in light of the new offence of ill treatment or wilful neglect in the Bill.

IMPLEMENTATION (Chapter 6)

- The theme most widely commented upon during the consultation was the need for early and properly resourced implementation. Responses relating to the implementation of the Bill commented on the need for funding, training, awareness raising and most importantly, the Codes of Practice to understand the Bill and the roles of professionals involved.

NEXT STEPS (Chapter 7)

- Both Departments aim to be in a position to seek Executive approval in March 2015 to introduce the draft Bill to the NI Assembly.

CHAPTER 1: INTRODUCTION

The Draft Mental Capacity Bill

1.1 On 27 May 2014, the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Justice (DoJ) published for consultation, the core civil provisions of a new draft Mental Capacity Bill ("the draft Bill") along with policy proposals for those subject to the criminal justice system.

1.2 The draft Bill is intended to give effect to a major recommendation of the *Bamford Review of Mental Health and Learning Disability (Northern Ireland).* It will introduce, for the first time anywhere, a single legislative framework governing situations in which a decision needs to be made in relation to the care, treatment (for a physical or mental illness) or personal welfare of persons aged 16 or over, who lack capacity to make decisions for themselves.

1.3 The aim of the consultation process was to seek views on how the draft clauses might be strengthened prior to the Bill's introduction into the Assembly.

Consultation Process

1.4 The consultation period was launched by Health and Justice Ministers (by written statement to the NI Assembly) on 27th May 2014 and formally ended on 2nd September 2014.

1.5 Consultation documents were published on the DHSSPS and DoJ websites. An Easy Read version was published on 27th June 2014. The consultation document was also made available in audio format following a specific request.

1.6 To raise awareness of the consultation, a wide range of key stakeholders were contacted with over 500 letters/emails distributed to the relevant statutory, independent, voluntary and community sector organisations and political representatives. Two press releases were also issued to all media

outlets: one on 27th May to coincide with the consultation launch; and one on 16th June announcing five public meetings in Ballymena, Armagh, Belfast, Derry/Londonderry, and Newcastle. Approximately 87 people attended those meetings in total.

1.7 In addition, DHSSPS wrote to key stakeholders represented on its Departmental Reference Group (membership attached at Appendix C) and invited applications for support, to hold further meetings to engage directly with those likely to be affected by the legislation.

1.8 On foot of this invite and other requests, DHSSPS attended approximately 40 additional meetings and focus groups during the consultation period delivering tailored presentations, listening to feedback, and on occasion, facilitating discussion. DoJ attended these meetings, where appropriate, to speak to the criminal justice policy, as well attending a number of additional meetings specifically focused on criminal justice. Details of these events are attached at Appendix A.

1.9 Both Departments wish to thank all of the individuals and organisations who worked with the Bill teams to raise awareness and encourage key stakeholders (including providers, voluntary and community groups, and people using services and carers) to participate in this very important consultation.

1.10 The Departments are also pleased that this engagement has continued after the close of the consultation period, particularly with children and young people. Both DHSSPS and DoJ Bill teams have developed a comic which has been used to help explain the key aspects of the Bill at a number of meetings with children and young people. Details of these meetings are also included in Appendix A and a copy of the comic has also been published on Departmental websites.

Consultation Responses

1.11 There were 121 responses received in total. Individuals and organisations who submitted a response have been listed at Appendix B.

1.12 This is considered to be a significant response and reflective of the considerable interest in the Bill among stakeholders and the public. Both Departments are very grateful for the significant contribution made and would like to thank respondents for taking the time to respond, particularly as the consultation was held over the summer period.

1.13 Respondents focused largely on the themes covered in the consultation document in their submissions. Comments have therefore been analysed following the same approach with a Departmental response highlighted at the end of thematic summaries (Chapters 2 – 5). Any comments on implementation issues, such as the Code of Practice and associated training, have been dealt with separately in Chapter 6.

CHAPTER 2: ANALYSIS OF RESPONSES – OVERVIEW

Single Legislative Framework

Chapter 1 of the consultation document refers

2.1 Approximately **40% of total responses** received took the opportunity to further comment on the decision taken by DHSSPS in 2009 to develop a single legislative framework for the introduction of mental capacity legislation and the reform of mental health legislation in Northern Ireland, as recommended by the Bamford Review.

2.2 There was a general consensus that this approach was the right way forward in order to help reduce the stigma often associated with separate mental health legislation and strengthen protections for people who lack capacity to make decisions for themselves.

2.3 Respondents who commented on the decision to extend mental capacity legislation to the criminal justice system were also broadly supportive of this proposal. Two-thirds of the consultation responses in respect of this particular issue were in favour of this approach, with the remaining responses expressing concern about the criminal justice proposals. Greater detail on this issue is contained within Chapter 4 of this document.

2.4 Below are some examples of comments made:

"Our members were keen to stress that it is right that government have taken steps to implement the Bamford Review's call for unified legislation, for the whole population." **(NI Council for Voluntary Action)**

"For too long we have had one piece of legislation for those diagnosed with a mental illness and one for the rest of our population; this is unacceptable. We approve of the Bill and commend the Departments' commitment to delivering the Bamford vision." **(Aware Defeat Depression)**

"A positive effect of the proposed new law will be removal of the interface between the MHO [Mental Health Order] and the common law framework dealing with incapacity and best interests." **(Belfast HSC Trust)**

"While we support the implementation of the Mental Capacity Bill we do not support the removal of the Mental Health Legislation." **(Regional Forensics Group)**

"We welcome the approach of this Bill in providing a singular legislative basis for all agencies involved in keeping the public safe, ensuring those members of our society with mental health needs are afforded the appropriate level of support/care and that an expedient and effective judicial process is maintained where relevant." **(Police Service of NI)**

Departmental Response

2.5 The consultation response has confirmed previously expressed support for the development of a single legislative framework. Both Departments welcome this but, like many of the respondents, do not underestimate the size of the task ahead. Existing culture and practice will need to change significantly if the aims and objectives of the Bill are to be realised. Initial work on the Code of Practice has already begun to exemplify how the legislation is intended to work on the ground. Stakeholder input to that work will be essential. (Chapter 6 refers).

Title of Legislation

2.6 Approximately **15% of total responses** received specifically commented on the title of the draft Bill. The general consensus was that the inclusion of the word *'mental'* is stigmatising and should be removed. Respondents felt that it was important for the title to adequately reflect the purpose of the legislation and suggested the following alternatives:

- *Capacity Bill*
- *Capacity for Personal Decision Making Bill*
- *Individual Decision Making Bill*
- *Best Interests Bill*
- *Supported Decision Making and Capacity Bill*

2.7 Below are some examples of comments made:

"Suggest... a more all-encompassing and accurate term."
(HSC Clinical Education Centre)

"It was felt that the word 'right' might augment the title of the Bill." **(VOCAL)**

"The word mental continues to have pejorative connotations."
(British Psychological Society)

"Titles of documents represent where their emphasis, values etc lie. We strongly believe that the emphasis should be on systems of support to enable the person to make informed decision and/or informed refusals." **(Irish Advocacy Network)**

Departmental Response

2.8 Both Departments can see considerable merit in amending the title of the draft Bill and have noted the alternative suggestions provided. A final decision on the title will be taken when drafting is complete and following further discussions with Legislative Counsel.

CHAPTER 3: ANALYSIS OF RESPONSES – CIVIL PROVISIONS

Principles

Paragraphs 2.6 – 2.9 of the consultation document refer

3.1 Approximately **45% of total responses** received commented on the principles in clause 1 of the draft Bill. The key points raised were:

- The principles based approach respects the dignity and human rights of the individual and is the right way forward.
- The presumption of capacity is a positive development and fundamental to respecting individual autonomy. There were concerns, however, at the findings of the House of Lords Post Legislative Scrutiny of the English Mental Capacity Act 2005, which found evidence of this principle being applied perversely.
- The support principle (and in particular the steps that must be taken to ensure compliance) is a significant improvement upon the English Mental Capacity Act 2005 and in line with the UN Convention on the Rights of Persons with Disabilities (UNCRPD).
- The phrase '*unwise decision*' should be defined.
- It is right to state that unfair assumptions cannot be made about whether a person lacks capacity. This principle should be strengthened by adding '*disorder or disability'* of the person alongside '*condition*' (clause 6 refers).
- Acting in the best interests of a person who lacks capacity is a concept already well established under common law. However, concerns were raised about the use of the term '*best interests'* in the context of the UNCRPD, with '*will and preferences'* put forward as an alternative.
- Clause 1 does not explicitly reference the Bamford Review's principles of *Autonomy*, *Justice*, *Benefit* and *Least Harm*.
- The 'least restrictive alternative' (currently a key part of the best interests checklist) should be a principle in its own right. There should also be a principle of Reciprocity.

- It is important to be mindful of the need to balance principles and the tensions that may result in practice.

3.2 Below are some examples of comments made:

"The (House of Lords Select) Committee stated that whilst the Mental Capacity Act 2005 was considered to be both a significant and progressive piece of legislation with relevant principles, they felt that in relation to the presumption of capacity within the Act… (it) is widely misunderstood. At times it is used to justify non-intervention by health or social care services, either erroneously or, in some cases, deliberately." **(Children's Law Centre)**

"Insufficient effect is given to the incorporation of the 'justice' principle… Whilst the overall approach of capacity-based legislation (which includes mental health) is progressive in terms of non-discrimination, the Bill also effectively creates a new potential ground for discrimination in practice: namely, 'having been found to lack capacity'. The proposals do not offer any remedy for discrimination on this ground and the disability discrimination legislation would not currently be adequate to cover all potential cases." **(Victim Support NI)**

"It is worth noting that the Bamford Review did not suggest that the principle of 'benefit' be transposed directly into the legislation and that it made use of the concept of 'best interests' in articulating the meaning of the principle of 'benefit'. There is great value in retaining the current concept of best interests as it differs from benefit. There are many situations where multiple options would all be of benefit to P, but only one option can be in P's best interests. 'Benefit' would not serve as a criterion to choose between options where all of those options provide benefit to P." **(Law Centre NI)**

Departmental Response

3.3 The Department has initiated, in consultation with Legislative Counsel, a review of clause 1 of the Bill in light of the consultation response and outcomes of the House of Lords Report on the English Mental Capacity Act 2005. The purpose of this review is not to alter the intended effect of the principles in clause 1 but rather to address any potential for confusion or misunderstanding around what the presumption of capacity and the other principles actually mean.

3.4 For example, it is important that a person who is thinking about carrying out an intervention in reliance on someone's consent does not misinterpret clause

1(1) as requiring them to assume that the person has capacity to consent. Rather what it seeks to achieve is the placing of the onus on a person intending to carry out an intervention under the Bill to have properly established that capacity is really lacking. This is so that no one finds him/herself in the position where they feel they are being asked to prove they have capacity to make the decision. It is not so as to prevent or obviate the need for proper checks to be made where there are doubts about a person's capacity to make a decision. Proceeding on the basis of a mere assumption that the person has capacity to consent could end in liability if in fact the person lacks capacity.

3.5 The Explanatory Notes to the Bill will explain key changes made as a result of the Department's review of clause 1. The Code of Practice will further exemplify how the principles are intended to operate when decisions are being made under the Bill.

3.6 In response to the points made during the consultation about the Bamford principles, the Department would emphasise that, whilst not directly transposed into the draft Bill, the Bamford principles have acted as a reference point throughout the drafting process. On this issue, the Department would also like to make the following points:

- Respect for personal autonomy is a recurring theme in the draft Bill.
- The best interests principle achieves what the Department understands to have been the thinking behind the Bamford principle of benefit.
- Justice is a universal characteristic that applies to all Northern Ireland legislation.
- It would seem artificial to have a separate principle on least harm when consideration of what is in a person's best interests must necessarily involve consideration of any option available that is less restrictive of that person's rights.

All Practicable Help and Support

3.7 Approximately **30% of total responses** received commented specifically on the practical steps that must be taken to provide a person with all practicable help and support (as outlined in clause 4). The key points raised were:

- Clause 4 is a critical component of the draft Bill. It is a significant improvement on the English Mental Capacity Act 2005 which includes a support principle but doesn't elaborate further on the steps that are expected to be taken to ensure compliance with it. However, more detail is required in the primary legislation in addition to the Code of Practice.
- The phrase *'all practicable help and support'* should be defined to ensure equitable regional delivery.
- Measures taken to support a person should be documented including reasons why any were ineffective.
- The names of *'others'* likely to help P needs to be identified. For example, carers, nominated persons, advocates and speech and language therapists should contribute to the determination of capacity. '*Likely to help'* should also be explained and it should be made clear that it is not appropriate to involve anyone in supporting P where there is a risk of undue influence.
- There should be more emphasis on supported decision making rather than substitute decision making.
- There needs to be an examination of the different models of support being utilised in different countries such as the Republic of Ireland.

3.8 Below are some examples of comments made:

"This aspect of the Bill may have the greatest potential to improve the promotion of the autonomy of people whose decision making may be impaired... to have it in law is an excellent development." **(NI Association of Social Workers)**

"We consider that s4 'Supporting person to make decision' is a critical component within the legislation; and that strengthening its provisions linked to the Code of Practice will fundamentally enhance respect, protection and promotion of human rights of individuals with mental health problems." **(NI Association for Mental Health)**

"We recommend... creating a positive duty to provide assistance to people who experience significant difficulties in being involved when decisions are being made about their life, to enable them to understand and make their own decisions." **(Mencap)**

"The provision of substituted decision-making unless all practicable help and support has been given is insufficient to provide for the positive rights necessary for supported decision-making.... the CRPD Committee has called for substituted decision-making to be 'replaced' by supported decision-making." **(Centre for Disability Law and Policy, NUI Galway)**

Departmental Response

3.9 Notwithstanding the overall support for clause 4 (which sets out the sorts of steps to be taken to comply with the principle that all practicable help and support be given to a person to enable them to make a decision), it is clear that further detail is required to exemplify how this might be realised in practice. The Code of Practice will provide that detail, informed by engagement with key stakeholders.

3.10 This is a significant clause that aligns fully with the autonomy principle and promotes a key message that by far the best outcome is for decisions to be taken on the basis of informed consent by the person themselves. However, it is the Department's view that, to posit that it can never be the case that a decision might need to be made on someone else's behalf, does not reflect the reality of everyday life and, in certain circumstances, could well operate against a person's best interests. However, this is an emerging area of law and the Department will continue to monitor developments relating to the UNCRPD. It should also be kept in mind that no other existing or proposed legislation of a similar type seeks to address the discrimination inherent in having separate mental health legislation. This is at the heart of the Bill and is an aim entirely in keeping with the UNCRPD.

Future Decision Making Arrangements

Paragraphs 2.10 – 2.17 of the consultation document refer

Lasting Powers of Attorney

3.11 Approximately **40% of total responses** received commented on Lasting Powers of Attorney (LPA). The key points raised were:

- The majority welcomed the introduction of LPAs and in particular the extension of decisions to include care, treatment and personal welfare (in addition to property and affairs).
- This approach will bring Northern Ireland into line with the rest of the UK but there are lessons to be learned from the introduction of LPAs in England and Wales (in terms of implementation).
- It is considered important that Attorneys must comply with the principles.
- Further guidance is required on the appointment and registration process.
- Consideration should be given to situations where P changes his/her mind, their relationship with the Attorney alters, the Attorney no longer wishes to act, or the Attorney's capacity diminishes. There should also be mechanisms in place to ensure LPAs are up to date and correlate with P's current views and circumstances and to deal with disputes.
- There should be additional safeguards to protect P where there is a potential conflict of interest between the management of his/her finances and health/well-being.
- Further clarity is required on how LPAs interact with the different roles of nominated persons, independent advocates and advance decisions.
- Other issues were noted to ensure effective implementation including the need for adequate resources and effective publicity to maximise the uptake of LPAs with simple and inexpensive forms and processes. Chapter 6 refers.

3.12 Below are some examples of comments made:

"The proposal to introduce lasting powers of attorney for financial and health and welfare matters, along the same lines as happened in England and Wales under the Mental Capacity Act is long overdue and should be included." **(Individual response)**

"We recommend that the Bill includes a legal duty upon Health and Social Care Trusts to promote the uptake of future planning mechanisms." **(Bamford Monitoring Group)**

"This is something that carers feel very strongly about and we welcome these additional powers… we are pleased to see also that the draft Bill will respect any EPA that was put in place prior to the Bill coming into operation." **(Carers NI)**

"The Society would favour the retention of the EPA regime however it can see benefits to the introduction of the LPA regime, whether that is alongside the EPA or as a complete replacement for it. The Society sees no reason why the two regimes cannot co-exist by giving clients the choice of the Rolls Royce or Mini." **(Law Society of NI)**

Departmental Response

3.13 The consultation exercise has confirmed that there is broad support for the introduction of a new system of Lasting Powers of Attorney. Further work on the operation of the new system, particularly around the appointment and registration processes, will be undertaken in consultation with key stakeholders. Interface issues (i.e. how LPAs relate to other key roles under the Bill) will be addressed in the Code of Practice. However, a key point is that an attorney appointed under a LPA has been given the power to make the decision that needs to made by the donor. The Bill confers no such power on nominated persons and independent advocates, for example.

Advance decisions

3.14 Approximately **45% of total responses** received commented on advance decisions to refuse medical treatment. While the majority welcomed the statutory recognition provided in clause 10, the general consensus was that further clarification is needed to explain what constitutes an *'effective advance decision'*. Opinion was divided on how that clarification should be provided.

3.15 Approximately half of those who responded specifically requested additional clauses in the draft Bill itself:

"The current draft of the Mental Capacity Bill acknowledges Advance Decisions whilst relying on common law for their enforceability; this seems likely to create confusion both for members of the public who would like to plan ahead for their future care in the event of a loss of capacity; and for healthcare professionals who may be faced with an Advance Decision and unsure as to its legal status." **(Compassion in Dying)**

"The Law Centre welcomes the statutory recognition given to advance decisions to remove treatment; however we believe that more detail should be given within the Bill over what constitutes a valid advance decision, rather than leaving it to the common law to determine." **(Law Centre NI)**

3.16 The remaining half either made no suggestions or identified the Code of Practice and guidance as appropriate vehicles, with some acknowledgement that case law, practice and wider societal debates are still developing:

"We acknowledge that the law in relation to advance decisions is still evolving and agree that it may be premature to fix it in statute at this point." **(NIASW Training Programme)**

"NIPEC understands the position of the Department in relation to this evolving area of law; however, it would be helpful if the Code of Practice set out expressly the conditions under which advance decisions may be complied with or challenged." **(NI Practice & Education Council for Nursing & Midwifery)**

3.17 Key areas noted as requiring further clarification include:

- What is a valid and effective advance decision?
- Is there a threshold at which an advance decision can be overridden to provide life-sustaining treatment or pending a court decision?
- Who supports P to make an advance decision and ensure it is followed? How will it be ensured that P had capacity at the time of making the advance decision and was not under undue influence or duress?
- There needs to be a statutory duty on services to promote and facilitate advance decisions. P should also be formally reminded to review his/her advance decision regularly in case views change over time.
- How will an effective advance decision be obtained and shared with relevant decision makers? Will a 24 hour database be available?
- How will advance decisions work in the context of LPAs and what are the implications of advance decisions refusing treatment of mental disorder?
- Other issues were noted to ensure effective implementation including the need for a public and professional awareness and education initiative to encourage widespread use. Chapter 6 refers.

Departmental Response

3.18 The Department has carefully considered the arguments for and against fixing the rules around what is a valid and effective advance decision in the Bill but has, on balance, decided not to change its policy position on this issue. The Department therefore remains of the view that it is best to allow the courts to continue to develop these rules in light of the Bill.

3.19 The Department agrees, however, that clear guidance on what currently constitutes a valid and effective advance decision is required. The Explanatory Notes to the Bill will refer to the current law on this and further explanation will be provided in the Code of Practice to exemplify the role advance decisions will have in decision making on a practical level.

Lack of Capacity

Paragraphs 2.18 – 2.22 of the consultation document refer

3.20 Approximately **30% of total responses** received commented on the associated definitions. The key points raised in relation to the definition of *'lacks capacity'* (in clause 2) were:

- Does the inclusion of a diagnostic threshold mean that people with disabilities will be discriminated against (contrary to Article 12 of the UNCRPD)?
- Clause 2(3) (*'it does not matter whether the impairment or disturbance is caused by a disorder or disability or otherwise than by a disorder or disability'*) clarifies that the provisions of the Bill could apply to everyone as required by the UNCRPD.
- The issue and time specific nature of capacity makes it clear that there cannot be a 'blanket' label of incapacity. There were however, concerns with this approach in terms of time and cost.
- The issue and time specific nature of capacity does not recognise the nature and degree of mental disorder.
- Further detail is required on how the draft Bill might apply where someone's capacity fluctuates.
- Consideration of the functional elements of the capacity test before the diagnostic part is essential. There is evidence that the separation of the detail of the functional test into a subsequent and separate clause (as under the English Mental Capacity Act 2005) has led to some practices that would not be in keeping with the approach intended by that Act. Thought might be given to how the drafting of the similar provision in the Bill could put this beyond question.
- Other issues were noted to ensure effective implementation including the need for the Code of Practice to provide examples of an impairment of, or disturbance in the functioning of, the mind or brain. Chapter 6 refers.

3.21 The key points raised in relation to the definition of *'unable to make a decision'* (in clause 3) were:

- Opinion was divided on the inclusion of a person's ability to '*appreciate'* the relevance of information. On the one hand, it was considered a reasonable addition, particularly in the case of a person whose insight is distorted by their illness. On the other, it was noted as a novel concept and a step beyond the English Mental Capacity Act 2005.
- It will be important that persons with significant communication difficulties are not assumed incapable of making a decision when they could, with the right support, fully participate in the decision making process. The requirement to provide P with information appropriate to his/her *'circumstances'* is vague and should be elaborated on (clause 3(4) refers).
- Speech and Language Therapists should have a role in supporting communication.
- Other issues were noted to ensure effective implementation including the need for the Code of Practice to include practical examples and inform action where fluctuating capacity is evident (especially in Emergency Departments). Chapter 6 refers.

3.22 Below are some examples of comments made:

"If having a diagnostic limb is considered necessary (without it, there is a risk that merely indecisive people could be found to lack capacity), it may need to be reframed to ensure that a person is considered to lack capacity only where they are unable to make a decision because of the impairment or disturbance of the mind or brain." **(Law Society of NI)**

"We would suggest the term 'lack of appreciation/insight' needs to be further defined as to its specific nature and limitations." **(Federation of Experts by Experience)**

"Learning disability... should not be confused with a definition of lacking mental capacity." **(The Active Group)**

"There needs to be a clear statement in legislation that a full independent assessment of receptive language ability should be made for individuals with complex communication disability prior to the determination of capacity." **(Royal College of Speech and Language Therapists)**

Departmental Response

3.23 The Department will discuss with Legislative Counsel a number of suggestions made in relation to the drafting of clauses 2 and 3 that support the overall policy intentions behind the Bill. In particular, the Department is keen to ensure that the significance of the 'causative nexus' between the impairment of, or disturbance in the functioning of, the mind or brain and the inability to make a decision is not lost, as emphasised in recent case law in England and Wales on the equivalent provisions in the Mental Capacity Act. However, it is the Department's view that no change in substance to these clauses is considered necessary at this stage given the overall support repeated in this consultation exercise for the capacity based approach to the Bill.

3.24 This means that the Department's current view is that the diagnostic element of the test should be retained. However, the Department will continue to monitor the ongoing debate around substitute decision making regimes and compliance with the UNCRPD (and indeed the European Convention on Human Rights). This will involve further discussions with colleagues in the Ministry of Justice responsible for the Mental Capacity Act 2005.

3.25 It also means that the appreciation element of the test will be retained. On this particular issue, the Department would wish to make two key points. First, it is entirely correct to say that its inclusion in clause 3 will allow for things, such as lack of insight, delusional or distorted thinking to be taken into account when assessing someone's ability to make a decision. However, this does not seem unreasonable given that the test will apply to everyone in society – a key requirement of the Bamford Review fulfilled in this new framework. Nor, if viewed in the context of the overall objectives of the Bill, should its inclusion be considered to be detrimental to any one particular group of people. This is because falling within the scope of the Bill requires more to be done than is currently required under the law to support people to make decisions for themselves and only where it can be justified and all the required safeguards in the Bill have been met, can an intervention relating to a person's care, treatment or personal welfare proceed.

Protection from Liability

Paragraphs 2.23 – 2.27 of the consultation document refer

3.26 Approximately **20% of total responses** received commented on the protection from liability clause. The key points raised were:

- Clause 8 is important and necessary. It is an improvement on the English Mental Capacity Act 2005 as it requires additional protections to be put in place for serious interventions before the protection from liability can be relied upon.
- It is important that the protection from liability does not cover negligent acts.
- The language used appears to place greater emphasis on protecting the decision maker rather than the person who lacks capacity.
- More emphasis is needed on supporting staff involved in making and examining decisions made and there should be greater clarity around joint decision making.
- A move away from statutory powers to intervene (as currently under the Mental Health (NI) Order 1986) could potentially lead to a culture of defensive practice resulting in staff spending more time on paperwork than on direct service user engagement.
- Clear processes and documentation will be required where cases involve acts of omission, joint decision making or fluctuating capacity.
- There will be significant resource implications in terms of staff training around the implications of this clause.

3.27 Below are some examples of comments made:

"It is important for people intervening in someone's life to be protected from liability and we are happy to see that this protection is conditional on a clear set of steps outlined in the Bill being followed... This is important ... and will hopefully lead to a change in the culture of healthcare decision making." **(Carers NI)**

"Does this Bill affect our ability to make decisions we have been making for our loved one?" **(Positive Futures event, written feedback)**

"Consideration should be given to offering officials in financial institutions with protection from liability, similar to that offered by section 8, when they are acting in the best interests of persons who appear to be lacking capacity and… refuse to do an act when requested by P." **(Danske Bank)**

"There is a noticeable focus on protection from liability rather than positive obligation and professional duty and responsibility to act… RQIA suggests that the Codes of Practice are definitive in the description of professional accountability in terms of duty to care for an individual." **(Regulation and Quality Improvement Authority)**

Departmental Response

3.28 This new legal framework hinges around Clause 8. It is largely technical, aiming as it does, to put into statute the current common law doctrine of necessity which only permits a decision to be made on behalf of someone who lacks capacity to make it themselves if it is in their best interests.

3.29 It is important to be clear that it will provide legal protection to a very wide group of people (professionals and non-professionals alike) who work with, or care for, people unable to make a decision, but only if they comply with the principles and safeguards that are designed to protect those who lack capacity and go beyond current legal requirements. The majority of the clauses in the Bill are concerned with these principles and safeguards.

3.30 The Department does not, therefore, accept that the inclusion of this clause means that there is undue focus on the protection of the decision maker; rather it is seeking to clarify the existing law. Nor does the Department accept that its inclusion means that less time will be spent on service user engagement as this would be in direct conflict with the clearly stated, underpinning aims and objectives of the Bill as reflected in the principles and already explained above.

3.31 The Department does, however, agree with comments made during the consultation that it is essential for anyone caring for, or working with people to whom this Bill might apply, to know exactly what the Bill and this clause in particular means for them, and how it relates to other duties such as their duty of care. For many, it will not change the legal basis upon which they currently

act; for others, it will (for example those currently working under the provisions of the Mental Health (NI) Order 1986).

3.32 The Code of Practice will be the main vehicle for addressing this and will inform the training of all affected but the following key points are worth emphasising here so that it is clear what clause 8, and the rest of the Bill, does and what it does not do:

- It enables certain interventions to be carried out where a person lacks capacity in relation to a matter in respect of which a decision needs to be made.
- It prevents an intervention going ahead *on the ground of lack of capacity* without proper steps having been taken to establish that capacity is really lacking.
- Nothing *in clause 8 or in the rest of the Bill* allows an intervention to be carried out in respect of another person on the ground that the person consents.

General Safeguards

Paragraphs 2.28 – 2.38 of the consultation document refer

Reasonable belief that P lacks capacity

3.33 Approximately **10% of total responses** received commented on the need to take reasonable steps to establish if P lacks capacity before intervening (and reasonable belief when intervening) in order to avail of the protection from liability in clause 8. Key points raised were:

- The inclusion of a clearly articulated formal assessment of capacity raises the question of whether there is a process for 'informal' assessments of capacity and if/how this can be defined.
- *'Reasonable belief'* and '*reasonable steps'* should be defined.
- There is a need for clear guidance and training particularly in community and primary care settings and in cases where capacity is fluctuating.

3.34 Below are some examples of comments made:

"The legislation requires more detailed examples of routine and serious acts and the subsequent different processes and documentation required." **(College of Occupational Therapists)**

"Given the universality of the requirement to take reasonable steps to establish whether P lacks capacity and the application of principles to a broad range of formal and informal carers, significant guidance on and gradation of tests will need to be included in Regulations and Guidance." **(HSC Board & Public Health Agency)**

Departmental Response

3.35 The Bill is fundamentally a framework for decision making. As such, it has to be flexible enough to allow it to operate in the full range of circumstances in which it might apply. This includes every day decisions like washing and dressing, right up to the most serious decisions that a person might make around where they live or whether to have a particular treatment for a mental or physical condition that might have a serious effect on them. It also includes

emergency decisions. Therefore it would not be appropriate or, indeed, effective to include additional procedural detail on the face of the Bill.

3.36 The framing of this safeguard in terms of *'reasonable steps'* aims to achieve the required flexibility. What is reasonable will very much depend on, for example, the circumstances prevailing at the time, the decision that needs to be made, the seriousness of that decision and the status of the person making the decision. To be more prescriptive, by for example defining *'reasonable'* for this purpose, would affect the operability of the framework and prevent necessary interventions being made, possibly resulting in greater harm to the person the framework aims to support and protect.

Best Interests

3.37 Approximately **35% of total responses** received commented on the need to have a reasonable belief that the intervention is in the person's best interests in order to avail of the protection from liability in clause 8. The key points raised were:

- Clause 6 is a welcome addition although *'best interests'* has to date been perceived as paternalistic and is not in keeping with the language used in Article 12 of the UNCRPD which refers to *'will and preferences'*.
- There should be a timescale for determining whether it is likely the person will regain capacity.
- An interpretation of what is meant by *'help'* and *'encouragement'* is required to ensure uniformity of approach. The use of *'encourage, help and support'* was suggested as an alternative.
- P's involvement in the decision making process is limited by the use of language such as, *'as far as reasonably ascertainable'*. The need to take account of the person's past and present wishes and feelings should be given more prominence.
- A statutory requirement to consult with nominated persons and anyone engaged in caring for P is a step forward and recognises that carers are best placed to determine the best interests of the person they care for. The

weight given to the views of carers, nominated persons and independent advocates needs to be made clearer. Any Enduring Power of Attorney should also be included within this list.

- There should be a duty to record actions taken and decisions made along with a mechanism for resolving disputes.
- Opinion was divided on the inclusion of a requirement to have regard to whether failure to act is likely to result in harm to other persons with resulting harm to P. While on the one hand it was welcomed, to others it was considered a novel concept and a step beyond the English Mental Capacity Act 2005, without the benefit of jurisprudence to guide professionals.
- There needs to be an interpretation of what is meant by harm and whether it includes psychological harm.
- It was suggested that assessing best interests should be a more formal process akin to the formal assessment of capacity.
- Other issues were noted to ensure effective implementation including the need for clear guidance on procedures and documentation including steps that must be taken to ensure P's participation; general awareness raising and training. Chapter 6 refers.

3.38 Below are some examples of comments made:

"... clarity on the role of choice of the individual versus "best interests" tests and protection from harm would need emphasised both in the Code of Practice and in the training of staff." ***(VOCAL)***

"If the Bill continues with its current substituted decision-making provisions, the Society recommends that the patient's wishes and feelings are given considerably greater weight in the determination of how that decision is made." **(Law Society of NI)**

"We recommend a shift towards best interpretation of a person's will and preferences" **(University of Ulster, School of Nursing)**

Departmental Response

3.39 As already stated, the Department will continue to monitor the ongoing debate concerning the UNCRPD but would reiterate the aim of the Bill in terms of seeking to address the discrimination inherent in separate mental health legislation, an aim entirely in keeping with the UNCRPD.

3.40 However, the Department agrees with many of the comments received during the consultation that there may, nonetheless, be scope to give the views and wishes of the person on behalf of whom a decision is being made, more prominence in the current construction of the determination of best interests in clause 6 of the Bill. This issue has already been discussed with Legislative Counsel and changes made to the Bill as a result will be explained in the Explanatory notes accompanying the Bill.

3.41 The Department also notes comments made during the consultation around the inclusion in clause 6 of the requirement to have regard to whether failure to act *'is likely to result in harm to other persons with resulting harm to P'.* While acknowledging that this goes further than the equivalent provision in the Mental Capacity Act 2005, it is the Department's view that this is a valid and reasonable factor for anyone charged with making a decision on anyone else's behalf to have regard to alongside all of the factors in clause 6, bearing in mind that the ultimate objective of the exercise is to determine whether what is being proposed is the best thing for P in the circumstances prevailing at the time.

3.42 In response to comments raised around the need for greater definition/specificity, like the *'reasonable belief of lacks capacity'* general safeguard, the best interests safeguard has also been framed in a flexible way so as to work in the wide range of situations in which the Bill might apply. The Department remains of the view that this is the correct approach, but accepts the need to provide clear guidance on how it is intended to operate in practice through the Code of Practice.

3.43 The Department would also reiterate some of the points made in the consultation paper about this safeguard and, in particular, the need to look closely at the substance of clause 6 in order to fully appreciate the intention behind it. It is far from a paternalistic tool and placing it in statute puts the question of what is required, going forward, to make a robust assessment of best interests beyond doubt.

Acts of Restraint

3.44 Approximately **25% of total responses** received commented on the restraint condition. The key points raised were:

- The restraint condition is an important safeguard.
- The Bill provides a welcome differentiation between restraint and deprivation of liberty.
- There needs to be definitions of *'proportionate'* and *'restraint'*. Alternative suggestions included *'restrictive interventions'* or *'restrictive practices'*.
- The need to clarify the implications of the restraint condition for different professional groups. It needs to be clear who will be authorised to carry out restraint. Roles and responsibilities need to be clear and there must be documented evidence.
- Further clarity is required on the risk of harm criterion and in particular whether this includes a risk of psychological harm and risk of harm to others.
- Other issues were noted to ensure effective implementation including the need for clear guidance on process and how incidents are recorded, along with evidence based scenarios to aid understanding. Chapter 6 refers.

3.45 Below are some examples of comments made:

"With regard to restraint in practice, there is a need for further clarification of its use, limitations, and implications... It is also noted that in the absence of clear definitions, different professions may have different thresholds for what is needed or required in some instances." **(Southern HSC Trust)**

"Providers and care workers will need to provide a clear and transparent record of how they concluded that any restraint was proportionate to the risk of harm." **(UK Homecare Association)**

"A statutory definition of restraint is needed and appropriate guidance and training are essential to comply with human rights standards." **(Age NI)**

Departmental Response

3.46 The restraint condition is an additional safeguard applicable to any act restraining a person who lacks capacity in respect of whether he or she should be restrained. Such acts are defined in clause 11 and anyone carrying out such acts must ensure the condition is met before doing it. The condition also applies to instructing or authorising someone else to restrain that person. *'Harm'* for the purposes of this clause means harm of any kind, physical or non-physical, and includes harm that might come to the person from him harming others.

3.47 The requirement of proportionality for acts of restraint is already a well established concept in relation to actions of the state that engage fundamental human rights enshrined in our domestic law since the enactment of the Human Rights Act in 1998. Nonetheless, the Department does not underestimate the implications of putting this requirement in statute and the importance of providing clear guidance in relation to it. This will be a key section in the Code of Practice explaining not only what the restraint condition entails on the ground but also how it relates to an act or acts that together amount to a deprivation of someone's liberty.

Additional Safeguards for Serious Interventions

Paragraphs 2.39 – 2.47 of the consultation document refer

Formal Assessment of Capacity

3.48 Approximately **35% of total responses** received commented on the formal assessment of capacity. The key points raised were:

- Clause 12 is an improvement on the English Mental Capacity Act 2005 which only requires a formal assessment for deprivations of liberty.
- The *'suitably qualified person'* should have knowledge and skills relevant to the intervention, particularly in relation to specific or complex health conditions. It should also be someone who has knowledge of how to communicate most effectively with P (other than the carer or advocate).
- Formal assessments of capacity should require multi-disciplinary contribution. The *'suitably qualified person'* should include professions other than the traditional medical role e.g. nursing (especially mental health nurses), midwifery, psychology, occupational therapy and social work.
- It is unclear whether the General Medical Services (GMS) contract will be changed to include capacity assessments.
- Speech and Language Therapists should have a role in supporting communication.
- Recommendations were made for alternative terminology, for example, 'Approved Capacity Professional' and 'Statement of Current Incapacity'.
- There is potential for a conflict of interest if the person proposing the intervention is also the person assessing capacity. Where this isn't the case, any difference of opinion will need to be addressed.
- The requirement to document support given (in the written statement of incapacity) is a positive development but could be made stronger by explicitly referencing the steps outlined in clause 4.
- The process must be evidenced and transparent with standardised, regional documentation.

- Documentation should be made available to P, the nominated person and the independent advocate should they wish to challenge the outcome. However, it is essential to have regard to the security of personal data to ensure compliance with the Data Protection Act 1998.
- There should be a clear process to follow where P either refuses to consent to the capacity assessment or where there is dispute over the outcome.
- How valid will documentation be, given that capacity can fluctuate? There should be a statutory maximum timescale for determining how long a capacity assessment can be relied upon.
- Other issues were noted to ensure effective implementation including the need for simple, standardised tools and documentation, adequate resources and training. Chapter 6 refers.

3.49 Below are some examples of comments made:

"The need for a formal assessment of capacity within a reasonable time by a suitably qualified person is idealistic in its wording and difficult to know how it would work in practice." **(Royal College of General Practitioners)**

"...welcomes the draft Bill's requirement for a 'statement of incapacity' to be in writing and to include detail of the actual assessment, who it was carried out by and when... However it is important that these formal assessments of capacity remain decision-specific." **(Carers NI)**

"...fears that the FCA [formal assessment of capacity] could become just another paper exercise." ***(Federation of Experts by Experience)***

Departmental Response

3.50 There is no equivalent of the formal assessment of capacity safeguard in the English Mental Capacity Act 2005 although, in practice, professional involvement is sought where, for example, there is a dispute or the decision has serious consequences. The Bill, therefore, puts into statute what is already good practice elsewhere and indeed, in many cases, here.

3.51 All suggestions put forward during the consultation period as to who should carry out the formal assessment of capacity where required under the Bill will inform the drafting of the relevant subordinate legislation and training plans

being developed in preparation for the implementation phase. As is the position in England and Wales, the Department is clear, however, that while the assessment of capacity can be carried out by someone other than the decision maker, responsibility for ensuring this safeguard is met and the final decision on capacity ultimately rests with the decision maker.

3.52 This is because when a formal assessment is required under the Bill, a belief that a person lacks capacity in relation to a matter will not be a reasonable one unless that formal assessment of capacity has been carried out. (For those concerned about the practicality of this safeguard given the wide scope of acts to which the Bill applies, it is worth noting at this point that it does not apply in all cases – clause 12 makes it clear that it applies where the matter is an act that is or is part of a serious intervention and the situation is not an emergency.) So, if the decision maker is not satisfied that this safeguard has been met, any belief he may have about the person's capacity will not be a reasonable one and he will not be protected from liability under clause 8 of the Bill.

3.53 It is also worth noting in response to comments about challenging capacity assessments that the reasonableness of any such belief may be affected by disagreements about a person's capacity or objections from the person or others involved in the decision making process. Ensuring that the person is supported and engaged where possible throughout the assessment process and that others are also involved as appropriate, will not only be essential to demonstrate compliance with the principles of the Bill but will also clearly help militate against disputes arising. However, where they do arise, internal procedures will be required to manage such situations. Further guidance on this will be contained in the Code of Practice. Ultimately, recourse to the High Court under Part 6 of the Bill will be available to decide on issues of capacity and ensure that any action taken is lawful.

Nominated Persons

3.54 Approximately **20% of total responses** received commented on the introduction of Nominated Persons. The key points raised were:

- The new framework of Nominated Persons is an important development in response to the findings of *JT v United Kingdom* [2000].
- There was particular support for the consequences that flow from a Nominated Person's objection to a serious intervention and their right to apply to the Review Tribunal to seek a review of an authorisation granted in respect of a person lacking capacity ("P").
- The Nominated Person should be in place to support P during a formal assessment of capacity.
- P should be able to appoint more than one Nominated Person. Consideration should also be given to a formal registration requirement and central database.
- The positioning of the primary carer at the top of the default list is an important statutory recognition of carers.
- Social as well as familial relationships should be included in the default list along with alternative arrangements where P is isolated from both.
- There is potential for a coercive relationship between the Nominated Person and P. A person who has been previously found guilty of ill-treatment or neglect, or removed as an attorney or deputy under the Bill, should be prevented from being appointed default Nominated Person.
- The requirement that the default Nominated Person should be ordinarily resident in the UK should be removed.
- Consideration should be given to a potential default Nominated Person who is employed by P as a personal assistant through direct payment.
- The need to clarify how the role of Nominated Persons interfaces with other provisions such as Independent Advocates, advance decisions and LPAs.
- It will be important that the Tribunal meets in a timely fashion to consider whether a Nominated Person is acting in P's best interests.

- Other issues were noted to ensure effective implementation including the need for general awareness raising, adequate resources and clear guidance outlining roles and responsibilities. Chapter 6 refers.

3.55 Below are some examples of comments made:

"We are concerned that this section…. would routinely require a patient's nominated person to be consulted where that nominated person could be only 16 or 17 years old. We are not sure this would provide appropriate safeguards for certain vulnerable people." **(Medical Protection Society)**

"If the nominated person was perceived to lack capacity… how would Trust personnel progress this issue?" **(Western HSC Trust)**

"Supports the recognition of P's carer as the primary default nominated person; this is an important statutory recognition of the critical role of carers." **(Action Mental Health)**

"We disagree that the nominated person's important objection should have to satisfy a reasonable test." **(Mind Yourself)**

"Concerns have been raised over what happens if P selects a nominated person and then once P no longer has capacity that nominated person dies, or decides they no longer want the role. Where does that leave P?" **(Bryson Charitable Group)**

Departmental Response

3.56 The Department notes that the key points made in relation to this new safeguard largely relate to practical issues rather than the policy intent for which there is overall support. Nonetheless, it is important to emphasise that this is one of several new safeguards that will come into play in respect of serious interventions and will therefore require further explanation in the Code of Practice. Prior to finalisation, the Department will test the current default list, and the displacement provisions in particular, against specific scenarios raised in the consultation responses to ensure that any perverse results are avoided.

Second Opinions

Paragraphs 2.48 – 2.51 of the consultation document refer

3.57 Approximately **25% of total responses** received commented on the second opinion safeguard. The key points raised were:

- The requirement to obtain a second opinion is already well established in practice (under the Mental Health (NI) Order 1986).
- A second opinion for the administration of ECT is welcomed however its specific inclusion is at odds with the overall aim to ensure parity in the treatment of physical and mental health. There are other treatments more serious than ECT that should be specified.
- There needs to be further clarity on what treatments would fall within *'treatment with serious consequences'.*
- The proposed review of medication continued beyond three months is to be cautiously welcomed with concerns at a practical level, particularly in care homes and community settings.
- The three month period within which treatment can be administered without a second opinion is too long.
- There should be a statutory maximum timescale for determining how long a second opinion can be relied upon.
- There needs to be clarity around the appointment process of 'appropriate medical practitioners' who should be independent and ideally from another HSC Trust area.
- It may not always be appropriate for a medical practitioner to provide the second opinion, for example treatment could be delivered by psychologists. There may also be scope for nurse specialists to review medication based on best practice guidelines. Consideration should also be given to building in flexibility where the 'appropriate medical practitioner' is required to consult other professionals.
- An additional provision should be inserted to clarify that second opinion doctors must comply with clause 6 in determining the person's best

interests. This would then require him/her to consult with 'relevant others' in addition to persons principally concerned with the person's treatment.

- Consideration should be given to other areas where a second opinion could be required such as, where the person, or nominated person objects; and formal assessments of capacity.
- Other issues were noted to ensure effective implementation including the need for additional definitions, practical examples and timeframes involved within the Code of Practice. Regulations will need to provide clear descriptions of medications, qualifications and experience of the appropriate medical practitioner, processes and documentation involved including the regulatory role for the RQIA. The significant impact on resources was also noted. Chapter 6 refers.

3.58 Below are some examples of comments made:

"There is considerable ambiguity as to the treatments covered... Further regulations or guidance are needed to provide greater clarity for when a second opinion will be required under this section." **(Medical Protection Society)**

"It is not sufficient to seek second opinions from individuals in the same field as the intervener." **(Association for Real Change)**

"Whilst a review of routine medical treatment every 3 months for people in a care home is good practice, the requirement for a second opinion seems neither practical nor necessary. It would certainly be labour intensive and would require additional resources." **(British Medical Association)**

"This requirement will clearly result in more monitoring by RQIA in that it will involve an increased requirement for provision of second opinions in areas where second opinions are not currently provided." **(Regulation and Quality Improvement Authority)**

Departmental Response

3.59 This is an existing safeguard under the Mental Health (NI) Order 1986 for ECT. It is the Department's intention to continue to apply this safeguard to ECT. That being the case, it would seem counter-intuitive and potentially

misleading not to specify it as a treatment requiring a second opinion in the Bill itself.

3.60 Given the aims of the Bill, it is also right in the Department's view, to provide the option of extending this safeguard to other equally serious treatments, including treatments for a physical illness. Using subordinate legislation (regulations) for this purpose provides greater flexibility to respond to developments in the future. Further consultation will be necessary prior to the making of these regulations.

3.61 It is hoped that this further consultation will also inform whether the Bill is right to restrict the making of second opinions to medical practitioners or whether this should be opened up to other professions as some consultation responses suggested. Ultimately, this will depend on the kinds of treatment likely to be specified.

3.62 It is also worth clarifying that, as the purpose of the second opinion is to check that the proposed treatment is in the person's best interests, the steps in clause 6 apply equally to the person providing the second opinion as they do to the person proposing the treatment. This includes the requirement to consult, where practicable and appropriate, with anyone involved in caring for the person. Again, however, it is ultimately the responsibility of the person proposing the treatment to ensure that the second opinion has been obtained where the Bill requires it because otherwise, as the relevant clauses make explicit, the protection from liability offered by clause 8 will not apply. And, even if the second opinion has been obtained, this does not mean the treatment can proceed unless all the safeguards applicable to the treatment have also been met. The Code of Practice will provide practical examples and also address issues such as ensuring independence.

Authorisation for certain Serious Interventions

Paragraphs 2.52 – 2.75 of the consultation document refer

Authorisation process

3.63 Approximately **35% of total responses** received commented specifically on the authorisation process. The key points raised were:

- Trust Panels are cautiously welcomed as an additional safeguard (at the highest level) with concerns about deliverability in the context of significant financial constraints.
- An overarching regional framework was recommended to ensure equity and consistency across Trusts.
- The role of ASW as applicant for authorisation was welcomed but there were concerns that giving care homes or hospitals the option to designate a responsible person to act as applicant could lead to involvement of less trained staff and in particular, non HSC staff. On the other hand, this was identified as a potential role for other professions such as nursing.
- *'Care Plan'* should be defined and *'medical'* report should be replaced with *'clinical'* report so that other professions such as psychologists, nurses and midwives could take on this role. Similarly Healthcare Professional should be replaced with Health and Social Care Professional.
- Professionals who submit a report should be involved in the process and given the opportunity to present their own evidence.
- There should be a multidisciplinary approach to Trust Panels including at least one professional with expertise in the question at hand and the involvement of an ASW, service users and carers. Circumstances which would require an oral hearing and whether P will have a right to be legally represented should also be clarified.
- It is unclear if all decisions, regardless of care setting, will need to be sanctioned by a panel constituted by HSC representatives.
- The Trust panel should not be able to authorise an intervention if the application received did not specifically relate to it.

- It is unclear whether every hospital admission must be authorised via schedule 2 (short term detention for examination). In relation to the latter, examination of P should be *'immediately'* on admission (as under the Mental Health (NI) Order 1986).
- The speed at which panels will convene is unclear. The proposed timescale of 7 working days could result in undue delays in treatment. It is unclear as to what intervention will occur in the intervening period.
- Further guidance is needed on clauses relating to extensions of authorisations.
- Other issues were noted to ensure effective implementation including the need for adequate resources, clear guidelines around the composition of panels and practical outworking in the Code of Practice. Chapter 6 refers.

3.64 Below are some examples of comments made:

"Further consideration will need to be given to how in practice the Trust panel will work to ensure the balance between supporting defensible professional judgements whilst not being a rubber stamp and not creating a burdensome process." **(Office of Social Services)**

"This process may become a severe drain on clinical resources to an administrative process which has historically not been required."
(Royal College of Psychiatrists)

"Careful consideration needs to be given to how streamlined/simplified such a safeguard is in relatively common scenarios to prevent undue delays."
(British Geriatrics Society)

"Social workers were appointed to act within the Mental Health Order in order to provide an independent, objective and holistic assessment as a balance to the more medical model perspectives. We would suggest that this remains even more important within the proposed legislation."
(NI Social Care Council)

"The duty to give information is an important provision in upholding the right of the patient under Article 5(2) to information. That duty should be clearly spelt out on the face of the statute, rather than being left to regulations." **(Individual Response)**

Compulsory treatment with serious consequences

3.65 Approximately **5% of total responses** received commented specifically on the compulsory treatment with serious consequences provisions. The key points raised were:

- Drafting issues were raised in relation to the definition of *'serious intervention'* and definition of *'treatment with serious consequences'*.
- The need to include *'risk of serious psychological harm to P and others'* while being mindful that this could potentially increase compulsory treatment and detention.
- How the wishes of an individual will be obtained needs to be further considered.
- *'Prevention of serious harm'* will require clearly defined guidance and a clear definition.
- In relation to the *'prevention of serious physical harm to others'* any behaviour which predates the lack of capacity should be excluded.
- Every authorisation should meet the prevention of serious harm condition, not just when the nominated person objects.
- Further clarity is needed on when compulsory treatment with serious consequences should be revoked.
- Other issues were noted to ensure effective implementation including the need for additional guidance in the Code of Practice to clarify different roles and responsibilities. Chapter 6 refers.
- It should also be noted that comments on this theme have been captured within other areas of this summary document (such as Authorisations and Deprivation of Liberty sections).

3.66 Below are some examples of comments made:

"Compulsory Treatment with Serious Consequences. The provisions in this regard appear to be appropriate. However, we are not satisfied with the definition of "serious intervention". This misuses the term "serious" and makes no attempt to define such harm. Such lack of clarity will cause confusion in practice." **(Regional Forensics Group)**

"…query why the report for the authorisation process for compulsory treatment with serious consequences must be a medical report; the person may have little contact with medics and other professionals may be more involved in the care plan delivery." **(College of Occupational Therapists)**

"…meeting the prevention of serious harm conditions should be a precondition of every schedule 1 authorisation for provision to P of treatment with serious consequences (whether the nominated person objects, P resists or P is already subject to another measure under the Bill)." **(Law Centre NI)**

"…failing to meaningfully define what level of harm is "serious" would place great difficulty in interpreting the prevention of serious harm condition. In addition to this the failure to recognise serious psychological harm to others is anachronistic and not consistent with criminal justice legislation. We would submit that a Mental Capacity Bill which fails to recognise serious psychological harm is failing victims of such harm." **(Royal College of Psychiatrists)**

Deprivation of Liberty

3.67 Approximately **35% of total responses** received commented on the deprivation of liberty clauses. The key points raised were:

- Additional safeguards for persons deprived of their liberty is an important development and addresses the 'bournewood gap' in response to the findings of *HL v United Kingdom* [2004].
- Recognition that this is a problematic area as case law is rapidly evolving.
- There are lessons to learn from the implementation of the Deprivation of Liberty Safeguards in England and Wales, as evidenced in the House of Lords Post Legislative scrutiny of the English Mental Capacity Act 2005.
- The need to consider deprivation of liberty in settings beyond hospital and care homes in light of the recent Supreme Court ruling *P v Cheshire West and Chester Council and another (Respondents); P and Q v Surrey Council [2014].* For example, supported living.
- The requirement for any deprivation of liberty outside a hospital or care home to be authorised by the High Court should be reconsidered as it may not be the most cost effective measure and could result in considerable

delay. It was suggested that only matters of dispute should be referred to the High Court.

- Equally, concerns over the practicality of seeking authorisation for what is likely to be a large number of cases.
- The need to consider defining *'deprivation of liberty'* along the lines of the acid test provided in the aforementioned case.
- Consider whether the criterion of *'impairment of, or disturbance in the functioning of, the mind or brain'* (instead of *'mental disorder'*) is compliant with the European Convention on Human Rights.
- The process of conveyance needs to be clearer with roles and responsibilities explained.
- Further clarity is needed on when a deprivation of liberty intervention should be revoked and who should be informed.
- Other issues were noted to ensure effective implementation including the need for transitional arrangements, adequate resources, clear processes, definitions, roles and responsibilities within the Code of Practice. Also noted was the need for robust monitoring arrangements. Chapter 6 refers.

3.68 Below are some examples of comments made:

"Recent case law has made it clear that there is a DOL even if deprivation is with the person's compliance or lack of objection to their placement, if the purpose of placement is benign or the extent to which it enables them to live a relatively normal life for someone with their level of disability is objectively successful. This will mean that a process of authorisation will be required for a great many patients in Trust-run and independent residential settings and indeed community settings where community residence requirements are imposed under this bill. While all would accept that the draft Bill must deal with primary legal principles there will need to be a measure of pragmatism; a "big bang" approach on a fixed date would be potentially unworkable." **(British Medical Association)**

The evidence from the House of Lords Select committee report on the Mental Capacity Act in England and Wales gives weight to the considerable concerns about the application of legislation in relation to deprivation of liberty. It is imperative that the learning established from other areas in the UK is used to inform the regulation and codes of practice to ensure that that DOL is only used in the most robust cases and for the shortest period possible." **(Disability Action)**

"The Commission notes that under the draft Bill the term "unsound mind" or mental disorder is generally not used, in its place references to a lack of capacity have been included. The Commission notes that this is broadly considered a positive development. However the Commission advises the Departments to assure themselves that the proposed reform is in compliance with the ECHR." **(NI Human Rights Commission)**

Attendance Requirements

3.69 Approximately **10% of total responses** received commented on attendance requirements. The key points raised were:

- Detail required regarding process and practical application and in particular, how compulsory attendance will be enforced where P objects.
- Clarity needed about changes to current arrangements under the Mental Health (NI) Order 1986. Who will these provisions apply to (for example, can this be applied in circumstances of physical and/or mental health)?
- Other issues were noted to ensure effective implementation including the need for adequate resources and clear processes with practical examples of the various types of interventions in the Code of Practice. Chapter 6 refers.

3.70 Below are some examples of comments made:

"The provision that failure to impose the requirement would be more likely than not to result in the person not receiving the treatment is necessary and proportionate." **(Regional Forensic Group)**

"The threshold for attendance requirements is high and skewed towards medical interventions. In circumstances where the individual's impaired capacity is due to long term conditions their priority need may be social welfare interventions rather than medical." **(HSC Board & Public Health Agency)**

"We are positively against Community Treatment Orders or similar." **(Mindwise)**

"Does the Bill intend to... compel individuals to attend for other treatments e.g. Day Hospital, Occupational therapy, psychology, CPN. This would be concerning as attendance does not mean engagement or a therapeutic relationship and as such is not recovery-focused or likely to achieve any

desirable clinical outcome other than supervision." **(Mental Health Occupational Therapist Manager's Forum)**

Community Residence Requirements

3.71 Approximately **15% of total responses** received commented on community residence requirements. The key points raised were:

- Detail required regarding process and practical application. *'Training, education or occupation or treatment'* requires interpretation.
- There needs to be clarity on who these provisions will apply to and how they will be enforced if P is not compliant. This needs to be stronger than Guardianship under the Mental Health (NI) Order 1986.
- There should be a requirement for P to allow health *and social care* staff access to P at a place where P is living.
- Opinion was divided on the risk of harm criterion (as with attendance requirements). On the one hand it was accepted, on the other, a risk of serious physical harm was suggested to avoid over-use.
- There was a similar concern in relation to paragraph 12 of schedule 1 (with potential for such measures to be misused as a coercive tool).
- Other issues were noted to ensure effective implementation including the need for practical examples of the various types of interventions and clarity around current funding arrangements for Guardianship. Chapter 6 refers.

3.72 Below are some examples of comments made:

"... concerned about the potential DoL [deprivation of liberty] inherent in this, the need for this to be proportionate and for it to be rigorously reviewed rather than becoming prolonged unnecessarily." **(Royal College of Psychiatrists)**

"Decisions regarding employment, training and education are highly personal and should not be mandatory." **(Law Centre NI)**

"Disability Action support individuals who feel they do not want to attend these day activities and feel that it is being forced upon them." **(Disability Action)**

Departmental Response (to authorisations for certain serious interventions)

3.73 As a matter of policy, the Department remains of the view, supported by the consultation, that authorisation is a necessary and proportionate safeguard that should be complied with in respect of the most serious interventions in a person's life, including deprivation of liberty. In this regard, it mirrors the requirement for authorisation in respect of a deprivation of liberty under Schedule 1A of the English Mental Capacity Act 2005 but in a way that avoids the complexities of the interface between the provisions of that Act and the English Mental Health Act (as heavily criticised by the recent House of Lords report).

3.74 Drafting issues raised in relation to key clauses in Chapter 4 of the Bill and its associated Schedules will be discussed with Legislative Counsel. Key clauses will also be reviewed to ensure sufficient flexibility is built in to deal with process related issues where possible. However, in this regard, it should be noted that regulations will further define terms such *as 'treatment with serious consequences'*. The Code of Practice will also be invaluable in terms of exemplifying the operation of the authorisation safeguard in these cases and where an emergency arises for which the Bill also makes provision. Consultation with stakeholders will inform those regulations and the Code.

3.75 The Department also acknowledges that the implications for the Bill of recent case law relating to deprivation of liberty, including the Supreme Court decision in *Cheshire West* in March 2014, requires further consideration. Changes are likely to be made to the deprivation of liberty clauses as a result. At this point, however, the Department is not persuaded of the merits of defining *'deprivation of liberty'* in the Bill, preferring instead to continue to follow the jurisprudence of the European Court of Human Rights and domestic case law. However, consideration will be given to where factors considered not relevant to a deprivation of liberty would be best reflected. Any change made to the draft Bill as a result of the Department's further consideration of recent developments will be explained in the Explanatory Notes. In addition, ECHR compliance issues raised during the consultation in relation to, among

other matters, the criteria for the authorisation of deprivation of liberty are currently being assessed.

3.76 It is also the Department's intention that the prevention of serious harm condition will be reviewed with Legislative Counsel in light of consultation responses to ensure it is proportionate and fair in all the circumstances requiring authorisation under the Bill and that it appropriately reflects the types of harm that might arise in these circumstances. Several points arise in this regard that are worth making here. First, it is the Department's strong view that it would make no sense at all to impose the prevention of serious harm condition in, for example, a situation where someone is resisting treatment with serious consequences on entirely irrational grounds. To do so could have the perverse effect of causing the person greater harm than would be the case if the treatment were to proceed. Also, it should be remembered that, even though an authorisation has been granted, for example in the case of a person who is resisting treatment with serious consequences, this does not mean the treatment can proceed unless all the other applicable safeguards have been met.

3.77 As to the types of harm that are relevant where the prevention of serious harm condition applies, it is perhaps worth clarifying that psychological harm to others is a relevant factor in so far as it may be serious enough to result in harm to the person, for example by exposing the person to criminal prosecution. To go further than this, however, in this part of the Bill would not seem to sit well with its basic purpose i.e. to allow a decision to be made that would have required the person's consent if they had capacity, provided certain safeguards are met. It should be remembered, however, that other legislation may provide alternative powers/duties to intervene in such situations where the Bill may not apply.

3.78 It is also the Department's intention to review the provision of information clauses to ensure it is clear that certain information must be given to a person when detained under Part 2 of the Bill and discharged from that detention.

Independent Advocacy

Paragraphs 2.76 – 2.79 of the consultation document refer

3.79 Approximately **45% of total responses** received commented on the inclusion of a statutory role for independent advocacy. The key points raised were:

- It is right that the Bill includes a statutory duty to appoint and consult an independent advocate where a compulsory serious intervention is proposed in relation to a person who lacks capacity.
- The advocate should be made available at the earliest possible stage (including prior to the capacity assessment) and not only for compulsory serious interventions.
- The term *'independent advocate'* should be clearly defined to avoid misinterpretation. *'Independent Mental Capacity Advocate'* was put forward as an alternative suggestion.
- Advocacy should be truly independent, commissioned regionally rather than directly by individual HSC Trusts.
- The weight given to the advocate's views as part of the best interests determination needs to be made clearer and advocates should be afforded adequate time to obtain relevant information.
- There should be effective procedures in place for when there are disagreements and the advocate should be added to the list of applicants who can appeal to the Review Tribunal.
- P (or the nominated person) should be able to trigger the services of an advocate of their choosing given that P has the right to decline the service.
- The advocate is best placed to explain their role when P is deciding whether or not to avail of the service (not the service provider); and to advise D (the person intervening) on whether P still lacks capacity having been given all practicable help and support.
- The status of the advocate is unclear where P has verbally declined the services of an advocate but refused to complete the written declaration. Furthermore where P does decline the service he/she should have the right to have that service reinstated.

- Other issues were noted to ensure effective implementation, including the need for dedicated resources, publicity and oversight (of which other parts of the UK can provide useful models). Regulations need to detail the relevant training, qualifications and experience required. Chapter 6 refers.

3.80 Below are some examples of comments made:

"It is... vital that those most likely to be challenged by the involvement of independent advocacy are not the people introducing the possibility of advocacy involvement to the person." **(The Advocacy Network NI)**

"The earlier the advocate is in place the more beneficial they can be to P." **(CAUSE)**

"Independent advocates and organizations working within the provisions of the proposed Bill should have to sign up to a recognized Code of Practice." **(Compass Advocacy Network)**

"Given the importance of advocacy in supporting people to exercise their rights to be involved in decision making, it is essential that the development and resourcing of independent advocacy is addressed as a matter of urgency in further development of the Bill." **(Alzheimer's Society)**

"We recommend that the Independent Advocacy Service be a single service for Northern Ireland and that it be available not only to those who lack capacity, but also to people who have capacity but who need support in making decisions." **(Citizens Advice Bureau)**

"...an advocacy role is to support someone in a decision making process, help them voice their opinions and represent their opinions. It is therefore a misunderstanding and misrepresentation of the role of the advocate to say the views of the independent advocate should be taken into account. To do so would signify a substituted decision making approach rather than a supported decision making approach." **(Disability Action)**

Departmental Response

3.81 The Department acknowledges the wide support for the independent advocate safeguard in the Bill and the need to engage further with relevant stakeholders to devise the detail of how the service should be commissioned, taking on board comments made during the consultation and experience elsewhere.

3.82 In particular, further consideration will be given to suggestions made about the option of regional commissioning and how best to give effect to the principle of independence which is already addressed in the Bill itself. This work will inform the content of the subordinate legislation to be made under the Bill and the development of the Code Practice.

3.83 The Code of Practice will also explain in more detail the statutory role and functions of the independent advocate under the Bill. Informed by the consultation, the Department intends to discuss these issues further with Legislative Counsel.

3.84 It is also acknowledged that further clarification will be required in the Code of Practice regarding the instruction process outlined in the Bill. For example, it is important that those working under the Bill are aware that there is nothing in the Bill stipulating that it must be the decision maker who explains the role of the independent advocate to P before instruction.

3.85 It will also be important, in light of this consultation, for the Code of Practice to elaborate on the wider role of advocacy, acknowledged in the Department's Policy Guide published in 2012, as a potential source of the type of support that may enable someone to make a decision that needs to be made and that, without support, they might otherwise struggle to make – the former being by far the better outcome and in keeping with the underpinning principles of the Bill.

Rights of Review

Paragraphs 2.80 – 2.82 of the consultation document refer

3.86 Approximately **25% of total responses** received commented on the inclusion of a statutory right of review. The key points raised were:

- The right to review is an important safeguard.
- A change of name from Mental Health Review Tribunal to Review Tribunal was noted as better reflecting the scope of the legislation.
- There should be a statutory duty on HSC Trusts to inform individuals about their right of access to the Tribunal.
- There should be mechanisms in place for P to challenge their detention during the 28 day 'assessment' period.
- The automatic right to an appeal should be reduced. It was suggested that the current referral period of two years should be reduced to one year.
- Consider revising the composition of the current Tribunal panel. For example, the medical member should be extended so that other professionals with relevant skills and expertise can be involved (e.g. occupational therapists, psychologists and social workers). Furthermore, professionals who submit a report should be involved in the review process and present their own evidence.
- The involvement of a consultant psychiatrist is essential when considering the detention of a patient in a psychiatric hospital.
- Reconsider the Tribunal's power to specify revocation of an intervention at a later date in light of *X's Application (No.2) [2009] NIQB 2*.
- The circumstances where it is considered P is incapable of deciding to exercise his/her right of review need further consideration.
- The need for a mechanism to appeal decisions made by the Tribunal.
- Other issues were noted to ensure effective implementation, including the need for Tribunals to be properly resourced so they can carry out their functions, meet and decide promptly. Members will also require adequate training and support and there should be adequate provision for representation through legal aid. Chapter 6 refers.

3.87 Below are some examples of comments made:

"*Persons with capacity issues may require the provision of special assistance to enable them to effectively participate in the proceedings.*" **(NI Human Rights Commission)**

"We recommend that there is representation of the voluntary and community sector on this panel to ensure objectivity." **(NIACRO)**

"We are … concerned that individuals, nor their family members or carers are not made aware of the right to review before the Tribunal and do not have the knowledge of how to make an application to the Tribunal." **(Bamford Monitoring Group)**

Departmental Response

3.88 This is another example of an existing safeguard under the current Mental Health (NI) Order 1986 being transposed into the Bill and extended to provide additional protections to people to whom no such statutory protections currently apply. This right of review will apply to anyone detained under the Bill, or subject to one of the other really serious interventions for which authorisation is required. Nominated persons also have the right to seek a review on their behalf.

3.89 Both DHSSPS and DoJ are aware of the extra burden that will be placed on the Tribunal as a result of the changes contained in the Bill. To that end, work is ongoing to ensure that the Tribunal is appropriately resourced.

3.90 As part of that work, the Department intends to discuss with the Department of Justice and the NI Courts and Tribunals Service issues raised during the consultation, including the time limits pertaining to reviews of authorisations for short-term detention under the Bill and the duty to refer cases to the Tribunal. The Department is also currently considering how best to ensure that the rights of those who lack capacity to apply to the Tribunal for a review are fully respected under this new framework. The Departments do not, however, accept any criticism regarding the independence of the current (or future) Tribunal.

Emergency Interventions

Paragraphs 2.83 – 2.84 of the consultation document refer

3.91 Approximately **10% of total responses** received commented on the provisions relating to emergency interventions. The key points raised were:

- Acknowledgement of the importance of emergency provisions however the processes to be followed required further explanation.
- Recognition that there will not always be time to ensure that the relevant safeguards are in place in an emergency as to do so could cause delays in treatment which could have a negative impact on the outcome for the individual.
- Reconsider the definition of *'emergency'* so that it is more tightly defined and not open to interpretation. The risk of harm criterion in (clause 65(2)) should read a risk of harm to P *or others.*
- Other issues were noted to ensure effective implementation, including the need for working examples in the Code of Practice to ensure clarity and consistency in practice, along with details of timeframes and associated documentation. Chapter 6 refers.

3.92 Below are some examples of comments made:

"(It) would be practically difficult for us to provide (additional safeguards for serious interventions) in the circumstances we frequently encounter where extreme urgency to protect life and limb is often required." **(NI Ambulance Service)**

"Significant concerns were raised at our consultation event that clause 65 will, at worst, provide a catch all 'opt out' clause from the legislation's safeguards." **(NI Association of Mental Health)**

"We do not condone its inclusion in respect of ss14 (1) (a) – electro-convulsive therapy, as we consider that this form of treatment which can have irreversible effects requires the most stringent regulation, and the highest safeguards." **(Bamford Monitoring Group)**

"The potential to include 'urgent' as well as 'emergency' into the legislation needs to be explored." **(The Society of Radiographers)**

"RCN members have, in general terms, welcomed the legislation's move away from an emphasis upon the traditional holding power towards a more sensitive range of interventions. However, they have also expressed concern that the current six hour holding power does at least provide a simple and widely understood framework for intervention and that a considerable amount of work will need to be undertaken in order to secure the confidence of nurses and other health and social care professionals in respect of this change of emphasis." **(Royal College of Nursing)**

Departmental Response

3.93 It is essential that this new legal framework provides for emergency situations, otherwise it would have negative outcomes for those it is designed to support and protect. It would be impossible, however, for the Bill to prescribe exactly what the outcome should be in every emergency likely to arise. Instead, the relevant provisions have to reflect the fact that the Bill is a framework for decision making, constructed around a legal defence made available provided certain safeguards are met.

3.94 This is why the question of whether a situation is an emergency requires the decision maker to, in effect, balance the risks involved in proceeding with or without the applicable additional safeguards being put in place. A reasonable belief that the person lacks capacity in relation to the intervention and that it is in their best interests is always required, even in an emergency.

3.95 The Department fully accepts, however, that those working under the Bill must be clear about what exactly they have to think about and do when faced with an emergency situation. The working up of examples will be a critical part of developing the Code of Practice.

Other decision making mechanisms

Paragraphs 2.85 – 2.89 of the consultation document refer

High court and Deputies

3.96 Approximately **10% of total responses** received commented on the provisions relating to the High Court and court appointed Deputies. The key points raised were:

- It is important that the High Court has declaratory and decision making powers and the ability to appoint Deputies as another decision making mechanism.
- Paragraphs 3.67 - 3.68 refer in relation to court authorisation of deprivation of liberty outside hospital and care homes.
- Other issues were noted to ensure effective implementation, including the need for adequate resources, publicity and legal aid. Chapter 6 refers.

3.97 Below are some examples of comments made:

"The Law Centre agrees with the Department's opinion that Northern Ireland is too small to justify the creation of a separate Court of Protection and is content for those powers to be retained within the High Court." **(Law Centre NI)**

"There appears to be an intention that suitable professional persons with the required training and experience may be Special Visitors and not just medically trained persons as in the present Order. I welcome this." **(Individual Response)**

"It is important that the appointment of Deputies is closely monitored to ensure that they are appropriate for the person, for example, the relationship with the person and if they have the ability to carry out the role. It is essential that any person appointed as a deputy clearly understands the role and the model of supported decision making, rather than substitute decision making." **(Disability Action)**

Departmental Response

3.98 The powers of the High Court (to make declarations regarding a person's capacity, to make decisions on behalf of a person who lacks capacity and to appoint court deputies) provide an alternative decision making mechanism to that set out in Part 2 of the Bill which, as mentioned above, is constructed around a legal defence provided certain safeguards are met.

3.99 The Department would fully acknowledge that the interface between these two mechanisms, and indeed the new system of Lasting Powers of Attorney, will require further explanation in the Code of Practice. It is clear, however, that the underpinning principles in Part 1 of the Bill apply to all three mechanisms. This is significant because it means that the requirements around supporting people to make decisions for themselves and making decisions in the best interests of the person apply as much to court appointed deputies and attorneys appointed under a lasting power of attorney as they do to anyone working under Part 2 of the Bill. Work is already underway to assess the implications of these changes on the NI Courts and Tribunals Service here.

Office of Public Guardian

Paragraph 2.90 of the consultation document refers

3.100 Approximately **15% of total responses** received commented on the proposed new Office of the Public Guardian (OPG). The key points raised were:

- The introduction of a new OPG is a positive step but it is unclear how the current Office of Care and Protection will change.
- It is right that the new OPG establishes and maintains a register of LPAs and deputies as well as dealing with disputes and complaints.
- Other issues were noted to ensure effective implementation, including the need for adequate resources to allow timely intervention in disputes. Chapter 6 refers.

3.101 Below are some examples of comments made:

"Transparency and scrutiny will be necessary to ensure that the OPG acts within the parameters of this proposed legislation." **(Age NI)**

"The registration of an LPA with the Office of Public Guardian provides some assurance and mechanism for the investigation of complaints or fraudulent activity." **(Volunteer Now)**

"Important that expertise is not lost in the new arrangements. We also have concerns over the dislocation of services in the transition period and how this may have a detrimental impact on the financial affairs of those older people who are incapacitated." **(Society of Trust and Estate Practitioners NI)**

Departmental Response

3.102 The new Office of the Public Guardian will have a pivotal role under the Bill. In essence, it will take on some of the existing functions of the Office of Care and Protection and some new functions created by the Bill. As noted in consultation responses, preparations for the setting up of this new Office need to begin as early as possible. Discussions are ongoing with the Department of Justice and the NI Courts and Tribunals Service with this in mind and to ensure, given the current significant financial constraints, that its functions are carried out efficiently and effectively.

Expenditure and Payment for Goods and Services

Paragraphs 2.91 – 2.93 of the consultation document refer

3.103 Approximately **10% of total responses** received specifically commented on provisions relating to expenditure and payment of necessary goods and services. The key points raised were:

- The provisions are accepted in principle but there will be challenges in practice which requires further consideration.
- There needs to be more emphasis on how a person can be supported to make decisions about their finances and safeguards to prevent exploitation.
- Other issues were noted to ensure effective implementation, including the need for the Code of Practice to explain the corporate responsibility of Trusts and to interpret what a 'reasonable price' means. Chapter 6 refers.

3.104 Below are some examples of comments made:

"The Codes of Practice must provide practical examples to ensure consistency in the application of this provision." ***(Regulation and Quality Improvement Authority)***

"There needs to be further guidance as to how a person can be supported to make decisions about different aspects of their finances." ***(Disability Action)***

Departmental Response

3.105 The principles in Part 1 of the Bill (and the safeguards in Part 2) apply equally to decisions around spending someone's cash to pay for necessary goods and services as they do to care or treatment decisions. The requirements around supporting people to make decisions for themselves and making decisions in their best interests therefore apply. The Department agrees fully that this should be expanded upon in the Code of Practice and examples provided of the type of support that could be given in such circumstances. This is also a good example of where it would be important for the interface between the Bill and adult safeguarding policy to be well understood.

Research

Paragraphs 2.94 – 2.95 of the consultation document refer

3.106 Approximately **10% of total responses** received specifically commented on research. The key points raised were:

- General acceptance that there should be limited circumstances in which a person who lacks capacity may be involved in a research project and that safeguards should be in place.
- It is important that the researcher has the appropriate expertise in working with persons who lack capacity. Information on research must be collated and confidentiality ensured.
- Public interests should not trump the best interests of the individual.
- Research should not be permitted where it is not of benefit to P. This Part of the Bill should be linked to the best interests requirement in Part 2 and in doing so ensure that the individual participates as fully as possible in any decision to undertake research.
- Other issues were noted to ensure effective implementation, including the need for further guidance in the Code of Practice to, for example, clarify the role of 'R' and the Nominated Person. Chapter 6 refers.

.

3.107 Below are some examples of comments made:

"We feel that a number of the provisions are not compatible with the principles themselves. We do not believe that research should be permitted which is not deemed to be in P's best interests." **(Law Centre NI)**

"We note that the UK Research Governance Framework is to be updated during the passage of the Bill. This work will be led through England's Health Research Authority. We recommend the Bill Teams engage with this process." **(NI Association of Mental Health)**

"We note with interest that the provisions of this section of the Bill reflect the MCA approach which does not rely on the 'best interests' principle. It might be helpful to provide explanation within the Bill or in the Code of Practice given the strong statements elsewhere about 'best interests' as the underpinning foundation of the Bill." **(General Medical Council)**

Departmental Response

3.108 Part 2 and Part 8 of the Bill each provide a legal defence for certain acts that would require a person's consent if they had capacity to give it provided certain safeguards are met. Part 8 specifically applies to acts done as part of a research project. Part 2 applies to any act in connection with a person's care, treatment or personal welfare (which could include an act done as part of a research project).

3.109 Therefore, as currently drafted, it would be correct to say that Part 8 would provide a defence in circumstances where the defence in Part 2 would not be available because the treatment, for example, is not in the person's best interests. The Department agrees with comments made during the consultation that this requires further consideration, particularly where the research project involves an intervention that would be considered serious under Part 2 of the Bill. As a result, the Department intends to review Part 8 and make necessary amendments to it to ensure a more equitable approach is achieved in this regard.

Transfers between Jurisdictions

Paragraphs 2.96 – 2.98 of the consultation document refer

3.110 Approximately **15% of total responses** received specifically commented on transfers between jurisdictions. The key points raised were:

- It was generally agreed that provisions enabling the transfer of patients between jurisdictions continue to be required. It was however, questioned whether such transfers will be improved under the new legislation.
- Transfer arrangements with the Republic of Ireland should be addressed in this legislation.
- Cross jurisdictional transfers should include individuals subject to a community residence requirement.
- The individual being transferred should have a right to an independent advocate, and the right to continue family life.
- He/she must also be made aware of his/her right to apply to the Tribunal and the relevant timescales for applications within the receiving jurisdiction.
- Other issues were noted to ensure effective implementation, including the need for regulations and a Code of Practice to outline arrangements on how to facilitate transfers, address difficulties experienced with the current system and provide clarity around which jurisdiction's legislation a person is subject to. Chapter 6 refers.

3.111 Below are some examples of comments made:

"The Bill makes reference to provisions for the transfer of persons detained in hospital to a hospital in England, Wales or Scotland, but not the Republic of Ireland or other European Jurisdictions." **(Royal College of Psychiatrists)**

"Whilst it is sensible to facilitate the transfer of patients to other jurisdictions as appropriate, this should not be used as a substitute for the lack of services within Northern Ireland." **(Individual Response)**

"We recommend a duty is placed on the discharging/transferring Consultant to continue to review and monitor ongoing treatment while an individual is outside of Northern Ireland; and for periodic multidisciplinary review

meetings to be held involving the individual and his/her family, if appropriate." **(NI Association of Mental Health)**

"The group consider that the capacity based approach to hospital detention is so fundamentally different to the mental health approach used by all other jurisdictions that the future transfer of patients to specialist care outside of the region will become legally tortuous." **(Regional Forensic Group)**

Departmental Response

3.112 The Department remains of the view that provisions enabling the transfer of persons detained in hospital between jurisdictions within the UK continue to be necessary. Should it be possible in the future to make similar provision in relation to persons subject to community residence requirements, this can be done by subordinate legislation made under the Bill. It is not possible to do so in the Bill at present due to the lack of parity between measures of this kind in the different parts of the UK. It is also not possible for the Bill to change the law of the Republic of Ireland which would be required in order to legislate for transfers between Northern Ireland and the Republic of Ireland.

Offences

Paragraphs 2.99 – 2.101 of the consultation document refer

3.113 Approximately **20% of total responses** received specifically commented on the offences contained in the draft Bill. The key points raised were:

- The introduction of a new offence of ill treatment or wilful neglect is a positive development however there is a need to:
  - Define *'wilful neglect'* as it may be open to interpretation.
  - Consider including corporate responsibility for offences.
  - Ensure that the offence should also apply to a person who has been appointed under an active enduring power of attorney.
  - Consider raising the maximum sentence on summary conviction to 12 months (not 6 months as drafted) for parity with other UK jurisdictions.
  - Consider extending so that it is an offence to ill treat or neglect individuals who retain capacity.

- The offence of unlawful detention of a person lacking capacity is welcomed.
- Concern that offences of assisting persons to absent themselves without permission or breach residence requirements may result in criminalizing family, carers and friends who may be ill-advised but acting with good intention.
- Further consideration should be given to settings other than hospital and care homes.
- Consider inclusion of particular provisions from the Mental Health (NI) Order 1986 (as amended by the Sexual Offences (NI) Order 2008) in relation to sexual offences.
- In relation to the obstruction offence (clause 138), consider raising maximum obstruction sentence from 3 to 6 months on summary conviction and 2 years on indictment.
- Other issues were noted to ensure effective implementation, including the need for regulations and the Code of Practice along with a communication and training strategy. Chapter 6 refers.

3.114 Below are some examples of comments made:

"The introduction of a new offence for the ill-treatment or neglect of a person who lacks, or is presumed to, lack capacity, is welcomed. However, it's necessary to ensure the persons, family and staff involved are aware of what qualifies as ill-treatment or neglect, and to provide an easily accessible process for reporting concerns. For paid staff, there should be a requirement to report any concerns and consideration should be given to a 'whistle-blowing' policy, to ensure transparency and increase trust." **(NOW Group)**

"The Draft Bill does not allow for a prosecution on indictment. Whilst hopefully a rarely needed sanction the legislation should permit a prosecution, in the most serious of circumstances... to proceed by way of indictment. The impact of obstructing a live inquiry and investigation could have serious safeguarding implications and this should be reflected within the draft legislation." **(Commissioner for Older People for NI)**

Departmental Response

3.115 The Bill includes a range of new and updated criminal offences designed to protect those who fall under its scope. The Department remains of the view, supported by the consultation, that these offences are necessary and that the penalties (informed by advice from the Department of Justice) are proportionate but will keep the latter under review pending further discussion with those who raised specific issues about this during the consultation. The sexual offences in the existing Mental Health (NI) Order 1986 are already provided for in the Sexual Offences (NI) Order 2008.

3.116 It is worth noting that the offences in the Bill will not apply in isolation. New adult safeguarding arrangements are also currently being developed by the Department. Explaining the interface between these new safeguarding arrangements and the Bill generally will be an important aspect of the work involved in developing the Code of Practice.

Excluded Decisions

Paragraphs 2.102 – 2.104 of the consultation document refer

3.117 Approximately **10% of total responses** received specifically commented on those decisions which are excluded from the scope of the Bill. The key points raised were:

- The exclusion of certain decisions from the legislation was noted as was the clarification that the Bill does not affect the law on murder, manslaughter and assisted suicide.
- Further clarity is needed on why the Bill does not address decisions in relation to family relationships like consenting to sexual relations.
- Reference should be made to civil partnerships in clauses 149-150 (re dissolution). Consider also the inclusion of judicial separation.

3.118 Below are some examples of comments made:

"List of exclusions seems appropriate." **(HSC Board & Public Health Agency)**

"Some decisions relating to intimate relationships, particularly where sexual contact is involved, may have far reaching implications for patients lacking the capacity to consent to such relationships... People without capacity can be vulnerable and exploited, and though of course maximum choice and autonomy is important, leaving someone open to serious exploitation would be a failure of duty of care." **(Royal College of Psychiatrists)**

"Mental disorder is, by nature, dynamic and can change in a short time. This is why mental health legislation recognises both the nature and degree of mental illness but the dynamism of mental disorder is not recognised in the Draft Bill and this may mean in practice that the provisions of the Bill will not be sufficient to ensure public safety." **(Regional Forensics Group)**

Departmental Response

3.119 Due to the proposed revocation of the Mental Health (NI) Order 1986 as it applies to those aged 16 and over, it is not necessary to exclude from the scope of the Bill matters currently governed by that legislation. This is consistent with the Bamford vision and the aims of the Bill, supported by the majority view expressed during the consultation, in terms of removing the

stigma associated with separate mental health legislation and bringing all treatment decisions under one set of rules in a single legislative framework.

3.120 However, there are some decisions that are just too personal and, if not excluded, could fall within the scope of the Bill. These are reflected in the list of excluded decisions. Taking into account views expressed during the consultation, the Department has concluded that these provisions are appropriate but will discuss the issues raised during consultation around civil partnerships and judicial separation with the Department of Finance and Personnel (as well as any other civil law provisions in the Bill falling within DFP's remit).

Direct Payments

Paragraphs 2.105 – 2.107 of the consultation document refer

3.121 Approximately **10% of total responses** received specifically commented on Direct Payments. The key points raised were:

- A large majority of the comments welcomed the proposed changes to Direct Payments.
- The importance of ensuring an individual does indeed lack capacity to manage their own payments (and the need for regular reviews).
- The importance of implementing a clear and robust process for identifying and monitoring the 'suitable person'.
- The importance of ensuring assessments at the point of transition when a child turns 16 where they are already in receipt of a Direct Payment.
- The need for guidance for financial institutions.
- One respondent disagreed with the replacing of the Controller (under the Mental Health (NI) Order 1986) with the Deputy.

3.122 Below are some examples of comments made:

"...strongly welcomes the amendment to the Carers and Direct Payments Act Northern Ireland (2002) outlined in the Draft Bill." **(CAUSE NI)**

"We welcome this provision and the intention to develop Regulations, noting the importance of criteria and scrutiny of the 'suitable person' particularly with regard to financial abuse." **(NI Association of Mental Health)**

"One of the measures we are pleased to see is the change to the Direct Payments scheme." **(Carers NI)**

Departmental Response

3.123 The Department acknowledges the need for clear guidance on how these changes will be implemented for various stakeholders. Direct Payments will be addressed within the Code of Practice which will be consulted on before publication. Service Users and Carers, as well as Voluntary and Community Organisations, will form part of this process to ensure that any effect of the

changes is clear, understandable, and properly implemented. The Code of Practice will also expand upon the importance of identifying the 'suitable person' and how this should be done.

3.124 The Department has issued comprehensive guidance to the HSC Board and Trusts on accounting and monitoring requirements for payments made under the Carers and Direct Payments Act (NI) 2002. Services purchased by direct payment recipients should be in accordance with agreed care plans and clients made aware of their responsibilities associated with Direct Payments before they agree to manage the associated processes. Direct Payment recipients' financial requirements and responsibilities are managed by HSC Trusts in accordance with Direct Payments Legislation and Guidance for Boards and Trusts (PDF 188KB) and Circular HSC (ECCU) 3/2009 Revised Guidance on Accounting and Monitoring Requirements for Payments made under the Carers and Direct Payments Act (NI) 2002 . This guidance will be updated to reflect any changes in line with the draft Bill.

3.125 The review of a client's care needs is a fundamental element of the care management process undertaken by HSC Trust Case Managers/Key Workers. As part of this review process for direct payment recipients the case manager/key worker should give consideration to whether the direct payment rate is correct and discuss issues relating to the administration of the direct payment. A review of needs and the services provided (including Direct Payments) should take place at the times or intervals specified in the care plan or at any other time deemed necessary. Whilst the review process is a formal arrangement, reviews should be conducted to suit the individual circumstances of recipients and their carers.

CHAPTER 4: ANALYSIS OF RESPONSES – CRIMINAL JUSTICE PROPOSALS

4.1 This chapter summarises the responses to the Department of Justice's ("the DoJ") policy proposals for extending mental capacity legislation to the criminal justice system. It also provides a departmental response to the issues raised. Our analysis has been structured in line with the categories set out in the original consultation document. Background information and detail of the policy proposals are also provided in order to set the analysis in context.

4.2 The summary of responses provided in this chapter is reflective of the written responses submitted to the consultation, as well as the feedback received by the DoJ at meetings both during and after the consultation period.

General Criminal Justice Comments

Background

4.3 Alongside the Department of Health, Social Services and Public Safety (DHSSPS), the DoJ also accepted the conclusions of the Bamford Review, and agreed to the extension of mental capacity legislation to the criminal justice system in Northern Ireland.

Proposals

4.4 In order to achieve this aim, in its consultation document the DoJ proposed the following three key positions:

I. **A fully capacity-based approach to care, treatment and personal welfare in respect of persons subject to the criminal justice system**. In line with the Bamford Review recommendations, the DoJ proposed that treatment in the criminal justice system would be delivered in accordance with capacity principles or on the basis of valid consent;

II. **The removal of potentially stigmatising references in legislation to "mental disorder."** Also in keeping with the recommendations of the Bamford Review, the Departments' proposals were designed to be

”illness-neutral” rather than making direct, stigmatising references to mental disorder; and

III. **Reflecting those positions in criminal justice legislation.** At the time of consultation it was being considered whether the Bill could be used as a vehicle to insert provisions into existing criminal justice legislation or to simply deliver it substantively in the Bill in its own right.

Response to consultation

The capacity-based approach

4.5 Broadly speaking, the Department’s decision to adopt a capacity-based approach to treatment within the criminal justice system received support from consultees. Of the 9 respondents who commented directly on this issue, 6 were supportive and welcomed the underlying principle of no compulsory treatment for those who have capacity to make a decision about medical treatment. The NI Mental Health Occupational Therapy Managers Forum felt that the criminal justice population “should have equal access to the right treatment, in the right setting and at the right time as any other citizen in society”, a view which was concurred with by the other responses.

4.6 Others however expressed concern, with the Northern Health and Social Care Trust stating that “mental health could be criminalised” by the inclusion of the criminal justice system in the capacity framework. Another respondent, the Regional Forensic Group (Mental Health & Learning Disability), supported the introduction of capacity-based legislation but did not support the removal of mental health legislation and did not believe that ‘the nature of mental disorder can be safely managed through the use of capacity based legislation alone’.

4.7 Consultees’ support for the adoption of a mental capacity approach within the criminal justice system was often qualified by the recognition that sufficient training and increased awareness would be required in order to support this change. In addition, whilst there was broad support for the policy direction outlined within the consultation document, several consultees expressed disappointment that draft criminal justice clauses were not available.

Removal of references to “mental disorder”

4.8 Again, there was broad support for the removal of the term ‘mental disorder’ from criminal justice healthcare legislation. Several consultees welcomed this development in favour of an “illness-neutral” approach, due to the belief that language used around mental health issues should be non-stigmatising. However, the Regional Forensic Group (Mental Health & Learning Disability) stated that “it is not the provision of appropriate mental health legislation that is stigmatising but the reaction of the general public to mental health issues”.

Reflecting those positions in criminal justice legislation

4.9 The Law Centre strongly expressed a preference “for as much of the legislative proposals to be contained within the main body of the Mental Capacity Bill as possible, rather than using it as a vehicle to amend existing criminal justice legislation”. NICCY suggested that “if the legislation is genuinely seeking to reduce stigma, any legislation changes should be undertaken through the draft Bill”. However, as highlighted above, there were some contrasting concerns expressed about the inclusion of the criminal justice proposals within the capacity framework.

Departmental Response

The capacity-based approach

4.10 The DoJ accepts the principle of no treatment without consent. Any treatment for a person who cannot consent to treatment will be in line with Part 2 of the Bill, or for under 16s, in line with amendments to the Mental Health (Northern Ireland) Order 1986 (‘the 1986 Order’) which DHSSPS proposes.

Removal of references to ‘mental disorder’

4.11 The DoJ will endeavour to ensure that provisions are illness neutral. However, there may be instances where this approach may not be possible, due to the need to comply with the European Convention on Human Rights (ECHR).

Reflecting those positions in criminal justice legislation

4.12 The legislative changes proposed by the DoJ will be introduced through the Mental Capacity Bill.

Police and the Place of Safety

Background

4.13 Article 130 of the 1986 Order empowers a police officer to remove an individual from a public place and convey them to a designated 'place of safety', if that individual appears to be suffering from a mental disorder and to be in need of immediate care or control. Article 129 defines a place of safety as "any hospital, of which the managing Board or HSC Trust is willing temporarily to receive persons' removed under Article 130, any police station, or any other suitable place". In practice, when exercising the power afforded to them under Article 130, the police will remove an individual to a hospital's Emergency Department or, if more appropriate, a police station.

Proposals

4.14 The DoJ proposed the creation of a place of safety power in the Mental Capacity Bill, developed in accordance with mental capacity principles. Therefore, the power would still be exercisable where a constable encounters an individual in a public place who appears to be in immediate need of care or control.

4.15 However, any reference to "mental disorder" would be removed from the proposed new power and instead it would have to appear to the Constable that "the person is unable to make a decision because of an impairment or disturbance in the mind or brain as to whether he needs to go to a place of safety". The criteria for exercising the power would also require a police officer to take account of mental capacity principles such as an individual's best interests, and to consider whether or not the removal of an individual to a place of safety is necessary to prevent serious harm to the person or serious physical harm to others.

4.16 The DoJ further outlined its proposals for the places of safety power within the consultation document as follows:

- Application of the power irrespective of age;
- Preservation of the existing definition of a place of safety, with the added caveat that a police station should only be used if no other suitable place is available;
- A duty for a constable to inform certain persons of the individual's removal to a place of safety – a family member or a relevant HSC Trust for example;
- Any treatment or care provided to an individual at a place of safety would be on the basis of capacitous consent or arrangements under the Bill;
- Retention of the 48 hour time limit for detention at a place of safety, with provision to amend this period by way of secondary legislation; and
- The creation of a further separate power to transfer an individual from one place of safety to another within that 48 hour period.

Response to consultation

Definition of a place of safety: concerns about venues

4.17 Of the 25 respondents that commented directly on the Department's proposals for places of safety, over half raised concerns about the continued use of Emergency Departments and police stations as places of safety.

4.18 FEBE felt that "not enough alternatives [are] being considered in the community as places of safety", whereas an individual consultee expressed the view that the current venues "are inadequate and stigmatising". Emergency Departments were variously described as "very detrimental", "unsafe" and "stressful". Similarly, one respondent, NOW, suggested that the use of a police station could "criminalise mental illness". A number of respondents (Include Youth, Parenting NI, NICCY, and the Children's Law Centre) also expressed the view that police stations should not be considered as places of safety for young people and, in particular, those aged under 16.

4.19 However, some support was expressed for the Department's proposal that a police station should only be used as a place of safety as a measure of last

resort, provided that the power should be carefully monitored and reviewed. In addition, the Royal College of Psychiatrists was supportive of the use of police stations as places of safety because persons are often removed to a place of safety due to "placing themselves or others at risk" and "custody suites are designed to manage aggressive behaviours and would allow a meaningful assessment of such a person's needs".

4.20 Examples of alternative places of safety were also suggested, with the NI Mental Health OT Forum referring to "section 136 suites" developed following the introduction of Mental Capacity legislation in England and Wales and the Northern Ireland Policing Board referring to the Mental Health Unit at Royal Bolton Hospital which has been used as a place of safety. Both locations have been introduced as alternative venues which allow an individual that has been removed to a place of safety access to healthcare in a hospital facility without having to attend a busy Emergency Department.

Statistics

4.21 The Children's Law Centre stated that an obligation should be placed on the PSNI, in statute, to record statistics on the use of place of safety powers, specifically in relation to children and young people. It was also suggested by the NI Human Rights Commission that the use of a police station as a place of safety "should be monitored and figures published as to how often police stations are used for this purpose going forward".

Operational issues

4.22 A number of responses stressed the need for continued work around handover arrangements between the police and healthcare staff at Emergency Departments, and the requirement to provide clear guidance for staff in the Code of Practice. The issues raised in connection with this issue were best summarised by the Northern Health and Social Care Trust's response, which stated that the "joint protocol setting out roles of PSNI, NIAS & Trusts needs to be clear within the Code of Practise to ensure the difficulties experienced in relation to retention and conveyance have been addressed".

Role of police officers

4.23 Two respondents commented on the role undertaken by police officers in relation to places of safety. The Royal College of Nursing highlighted that "the police are not nurses" and should not be making the decision to remove an individual to a place of safety without access to "clinical expertise" supported by a "nursing assessment". The Regional Forensic Group (Mental Health & Learning Disability) queried how a police officer could be expected to "reach a decision that "the person is unable to make a decision because of an impairment or disturbance in the mind or brain,"" and further stated that this expectation is "unrealistically demanding".

Under - 16s

4.24 NIAMH and the Children's Law Centre expressed concern at the retention of the Mental Health Order for children who are detained for assessment/treatment. Include Youth raised concerns that "under 16s will not be afforded the new protections and safeguards" available to those individuals aged 16 and over that will be treated in accordance with the Mental Capacity Bill. NIAMH labelled the retention of the 1986 Order for those children and young people aged under 16 "discriminatory".

Length of detention

4.25 Several consultees commented on the department's proposal to retain the 48 hour time limit for detention at a place of safety. NIACRO suggested that detention should be for the "shortest period of time possible". Include Youth, the Children's Law Centre and Parenting NI were more explicit, suggesting that the time limit for detention should be reduced from 48 to 24 hours, in line with Article 37b of the United Nations Convention on the Rights of the Child (UNCRC).

Departmental Response

Definition of a place of safety: concerns about venues

4.26 The proposed definition of a place of safety within our proposals – a hospital or a police station – is reflective of the service provision currently available. However, the place of safety legislation in the Mental Capacity Bill will be

"future-proofed" to include a power for the DoJ to amend the definition of place of safety by way of secondary legislation, in the event that alternative facilities or locations become available in the future.

Statistics

4.27 The DoJ recognises the importance of collecting statistics on the use of the place of safety power in order to capture its impact and use. Therefore, there will be a requirement within the legislation for the PSNI to record statistics in relation to the use of this power.

Operational issues

4.28 The DoJ has liaised with appropriate contacts during the development of these proposals to ensure that they are operationally viable, and this consultation will continue during the drafting of the code of practice to ensure that the roles and responsibilities of staff tasked with using the place of safety power are clearly understood.

Role of police officers

4.29 The DoJ accepts that police officers are not best placed to carry out detailed assessments of an individual's health in the same way as qualified healthcare professionals, and recognises that training will have to be provided to officers in respect of the revisions proposed for this power, as well as in relation to the introduction of capacity-based legislation in general.

4.30 Therefore, the proposed place of safety power is constructed in such a way that officers will not be required to carry out a full capacity assessment. Instead, in order to exercise the power the officer will have to reasonably believe that the individual is in need of immediate care and control. The constable must also reasonably believe that:

- failure to remove the person would create a risk of serious harm to the person or serious physical harm to other persons;
- that the person's removal is a proportionate response to the likelihood and seriousness of that harm;

- that due to an impairment or disturbance in the functioning of the mind or brain the person cannot make a decision about being removed to a place of safety; and
- removing the person to a place of safety would be in his or her best interests.

4.31 There will not be any requirement for officers to exercise any degree of clinical judgment when using the power. Instead, an officer will have to have a "reasonable belief" that the criteria for the use of the power apply. In assessing whether the officer was justified in having such a reasonable belief, consideration will be given to the place and circumstances in which the need to exercise the power arises, as well as the availability or lack thereof of clinical or social work advice.

Under 16s

4.32 The Department's proposals for a new place of safety power will apply to everyone, regardless of age. The place of safety power has been deliberately structured in this manner, in recognition of the fact that it can prove difficult for police officers to ascertain an individual's age in situations where a place of safety power might be used.

4.33 However, any treatment delivered in a healthcare or police station setting will be delivered in accordance with relevant law. For those aged 16 and over, treatment can be delivered with the individual's consent, or if the individual is unable to consent the Mental Capacity Bill will apply. For anyone under the age of 16, where consent to treatment cannot be obtained, the 1986 Order may determine how they receive treatment.

Length of detention

4.34 The DoJ acknowledges the concerns about the current and proposed 48 hour time limit for detention under a place of safety power. During consultation with health and justice stakeholders, support has been expressed for the retention of the 48 hour time limit, and the DoJ intends on proceeding on this basis.

4.35 It is important to highlight that 48 hours would be the very outside time limit for detention and, as is currently the case, it is expected that detention under the place of safety power would end before the expiry of this time limit.

4.36 However, setting the upper limit for detention at 48 hours provides flexibility for both the police and the health service in complex cases where handover may take some time. To provide an additional safeguard, under the Department's proposals, the 48 hour time limit would begin at the point of removal from the public place rather than, as is currently the case under the 1986 Order, once the individual arrives at the place of safety. The DoJ is also proposing a power to amend the time limit by way of secondary legislation in the future, should the need arise.

Courts

Background and proposals

4.37 The consultation document looked at four particular areas relating to courts. These areas were remand; sentencing; unfitness to plead; and community based disposals in unfitness cases.

Remand

4.38 Currently, courts have powers under the 1986 Order to remand a person to hospital for a report on his or her mental condition or for medical treatment. The consultation paper proposed that the two remand powers would be required in the future, however, any examination or treatment of the individual would have to take place with the individual's consent, or if the person lacks capacity to make decisions about whether he is examined or treatment, such examination or treatment must be in his best interests.

Sentencing

4.39 Under the 1986 Order, the court has power to order that an individual is admitted to hospital, either on an interim (short term) basis for up to 12 weeks with the possibility of renewal up to a period of 6 months, or on a longer term basis. It is also possible to make a restriction order, which has the effect of

restricting therapeutic leave from hospital, transfer between hospitals and allows for a variation in access to the Mental Health Review Tribunal, compared with access to the Tribunal for individuals who are subject to a hospital order made without restriction. The consultation paper proposed the retention of the interim hospital and full hospital order disposals, together with creation of a hospital direction. The hospital direction, recommended by the Bamford Review, would allow the court when sentencing an individual to direct that an individual is admitted to hospital prior to him or her serving the prison sentence.

Unfitness to plead

4.40 Before commencing the hearing of a criminal trial, or during the course of that trial, the court must be satisfied that the accused person is competent and able to participate in the proceedings. If the person is unable to effectively participate in his trial, a determination of "unfitness to plead" can be made by the court. The test used to determine unfitness to plead is called the *Pritchard* test. In order to be fit to plead, the test requires an individual to be capable of carrying out six tasks: understanding the charges; deciding whether to plead guilty or not; exercising his or her right to challenge jurors; instructing solicitors and counsel; following the course of proceedings; and giving evidence in his or her own defence.

4.41 In 2012, the DoJ asked the Northern Ireland Law Commission to review the law on unfitness to plead. The Commission published its report in July 2013 which contained recommendations for the reform of the *Pritchard* test. The proposed new test that the Commission recommended was that in order to be unfit to plead, the accused must be shown, because of an impairment or disturbance in the functioning of his or her mind to be unable to:

- Understand the charges brought against him or her;
- Follow the course of the proceedings; and
- Make certain decisions that he or she is required to make in relation to the trial;
- deciding to plead guilty or not; and
- challenge jurors and instruct counsel.

4.42 As well as proposing to adopt these recommendations of the Commission in the consultation paper, the DoJ also proposed to adopt other recommendations of the Commission. It was proposed to extend the new test and associated court processes to the Magistrates' court and the Youth Courts.

Community based disposals

4.43 The consultation paper also considered the retention of the supervision and treatment order as a disposal in cases where the individual is unfit to plead, but has been found to have committed the act with which he or she has been charged. The consultation paper also suggested a replacement for a guardianship order, which is currently available as a disposal upon conviction or in cases where a person is unfit to plead, but is found to have committed the act with which he or she was charged. The community residence order, it was proposed, would require an individual who poses a low level of risk, to live at a particular location and may require him or her to attend particular places at particular times for healthcare, training, education or occupation.

4.44 The consultation paper also proposed the retention of the absolute discharge as a disposal which would be available to the court following a finding that a person who is unfit to plead has committed the act with which he or she has been charged.

Response to consultation

4.45 The consultation responses that were received provided views and comments on the issues raised by the DoJ in the consultation paper, as well as a number of other matters.

Remand

4.46 Of the 7 consultees who specifically commented on remands, the Royal College of Psychiatrists and Regional Forensic Group (Mental Health and Learning Disability) stated that the existing powers under the 1986 Order to remand an individual to hospital for examination or treatment are rarely used. The same two consultees also commented that they were concerned about

the "present situation where the Courts attempt to remand defendants to hospital without necessary regard to mental health services". These consultees also commented in relation to the requirement in the proposed criteria to consider whether the individual would consent to examination or treatment, or whether, if he could not so consent, that the examination or treatment was in his best interests, that in their clinical experience, the overwhelming majority of patients would consent to examination or treatment. However, these consultees added that these patients could not be safely managed "without the restrictions imposed by the present mental health legislation".

4.47 Other comments received in relation to the proposals for remands included advice from the NI Human Rights Commission that in order to be compliant with "International Human Rights law", the continued detention of an individual under the remand power should not be linked to completion of any medical treatment. Disability Action stated that the individual should have the right to apply to the court for termination of the remand. The Law Centre and Disability Action considered that it was important that examination should always take place before treatment was administered, and appropriate periods for examination of an individual's condition should be allowed.

4.48 The Children's Law Centre raised issues around the provision of healthcare facilities for young people who are under the age of 16. The British Psychological Society suggested that it should not just be medical practitioners that provide medical evidence for the court to consider when determining whether an individual should be remanded under the proposed powers. They suggested that, instead, "suitably qualified practitioners" should be identified in the legislation. Disability Action suggested that the role of an independent advocate is essential for the individual during the court process.

Hospital order

4.49 Only three consultees specifically commented on the proposals for hospital orders that were contained in the consultation document. The Royal College of Psychiatrists and Regional Forensic Group (Mental Health & Learning

Disability) asked whether the hospital order would continue in effect once the individual regains capacity to make a decision about medical treatment. These consultees went on to comment that people who had capacity to make decisions about treatment could refuse a hospital order, and these individuals were the "overwhelming majority by the time the case came to sentencing". The Royal College of Psychiatrists stated that such a refusal of treatment may mean that people with capacity to make decisions about treatment would remain in prison even if they had a serious mental illness. The Regional Forensic Group (Mental Health & Learning Disability) commented that a capacitous refusal of treatment and any ensuing unavailability of a hospital order would have "serious consequences".

4.50 In relation to the suggestion in the consultation document that possible criteria for the making of a hospital order could include consideration of whether a person could provide a capacitous consent to treatment, the Regional Forensic Group (Mental Health & Learning Disability) asked what would happen when that patient later withdrew his consent to treatment. They stated that, if this situation would result in discharge from hospital, this approach "places public safety at risk".

4.51 Two consultees made specific comments about the proposals for interim hospital orders which were contained in the consultation document. The Regional Forensic Group (Mental Health & Learning Disability) had no objections to the proposals, but it considered that the court order would not be used in practice. Disability Action welcomed the interim hospital order, as it was considered that the order took cognisance of people who experience fluctuating capacity. They stated that "individuals that we support often feel frustrated at the lack of recognition by professionals for fluctuating capacity and subsequently no due process to revoke certain treatments, assessments or placements on this basis".

Hospital Direction

4.52 Six consultees commented on the proposals contained in the consultation document in relation to hospital directions.

4.53 The Royal College of Psychiatrists and Regional Forensic Group (Mental Health & Learning Disability) stated that they had no objection to the proposals, but noted that where analogous legislation was available in other jurisdictions, the hospital direction was rarely used.

4.54 The Belfast Health and Social Care Trust and BMA commented that they welcomed the hybrid nature of the hospital direction, as it seemed to be a pragmatic solution to the need to protect the public from harm. Disability Action stated that the hospital direction was a good outcome in a scheme which was based on a mental capacity approach. They considered that the introduction of such a direction may help to demonstrate to the individual that their offence may still require time in prison if they refuse to take treatment for their illness. The Law Centre supported the creation of the hospital direction, stating that "given a capacity based approach, it will no longer be possible for it to be guaranteed that an individual would serve an entire hospital order sentence in hospital and this would appear to be an appropriate solution".

Restriction Order

4.55 Two consultees commented on restriction orders. The Royal College of Psychiatrists and Regional Forensic Group (Mental Health & Learning Disability) both stated that restriction orders "are the very cornerstone of forensic psychiatry in the management of dangerous mentally disordered offenders". Both consultees considered that the consultation document was not clear as to how the restriction order was in keeping with the capacity principles. As a result, the Regional Forensic Group (Mental Health & Learning Disability) stated that "This is an admission on the part of the Bill that mental disorder has a nature and degree and failing to acknowledge this places public safety at risk". The Royal College of Psychiatrists noted that "mental disorder has a nature and degree and recognition of this is important in treating the patient and protecting the public".

Unfitness to plead

4.56 Eleven consultees expressed views on the Department's proposals for reforming the law on unfitness to plead. There was support for the adoption of the recommendations of the Northern Ireland Law Commission, with the HSC Board & Public Health Agency stating that it was considered that a capacity test would enhance understanding and improve consistency and "may reduce the disjuncture between fitness to plead and participate in criminal proceedings and ability to give informed consent for treatment". Disability Action welcomed the proposal, noting the benefits of modernising the language within this area of law, which would avoid stigmatisation of certain individuals. However, support was not universal. The Royal College of Psychiatrists and Regional Forensic Group (Mental Health & Learning Disability) responded that they considered that the proposals were not beneficial to the accused, to the court or to medical practitioners and did not consider that the case for change had been made. The NI Human Rights Commission cautioned that it was important to ensure that any approach taken was compliant with the ECHR.

4.57 The College of Occupational Therapists and Disability Action noted their support for the proposal that evidence from experts other than medical practitioners should be considered by the court when assessing whether an individual is unfit to plead. Another consultee questioned the methods that would be used to communicate with an individual in order to determine whether he or she was unfit to plead. NIACRO queried whether a person who was unfit to plead would have been fit to be interviewed, arrested and charged with an offence.

4.58 The Royal College of Psychiatrists, Royal College of Nursing, Regional Forensic Group (Mental Health & Learning Disability) and PSNI commented on the proposals to extend the test of unfitness to plead to magistrates' court, including Youth Courts. The Royal College of Psychiatrists and the Regional Forensic Group (Mental Health & Learning Disability) welcomed the extension of the test for unfitness to plead to magistrates' courts, though noted that unfitness hearings are time and resource intensive. The Law Centre

considered that it was not inappropriate to extend the test of unfitness to plead to Youth Courts, given that the age of criminal responsibility in Northern Ireland is 10 years of age. The Children's Law Centre asked for clarification as to how the test for unfitness could be extended to apply to those under the age of 16, if the capacity test within the Bill was only applicable to those over the age of 16.

Protection Order

4.59 The need for a protection order was generally accepted by respondents, however there were concerns raised about how it would operate in practice; the resource implications it would create, and its compatibility with the ECHR. Several respondents also stated that it would be important to ensure that a protection order is subject to regular review. The PSNI pointed out the need for such an order, saying that without it, a lacuna could exist through which the safety of the public could be compromised, and that there is a need to legislate for those rare cases that challenge Government's ability to ensure the publics' safety and which have the potential to undermine confidence in the criminal justice system.

4.60 Several consultees also queried if a person subject to a protection order should be detained in a care-based environment if the purpose of such an order is one of public protection. The concern that a scarce resource of secure psychiatric beds may be blocked by court placements of patients who refuse treatment was also raised by two respondents. The BMA and the SE Health and Social Care Trust questioned the benefit of placing a person who is unfit to plead and unwilling to seek treatment in a therapeutic environment. The SE Health and Social Care Trust also questioned where such a facility would be located.

4.61 The HSC Board & Public Health Agency suggested that as an alternative model to the protection order, shared services where the custodial aspects were provided through a criminal justice agency, with care and treatment in-reaching from health and social care may be feasible, and that current

supported housing models may provide a useful template for such shared responsibilities between agencies.

4.62 The Belfast Health and Social Care Trust stated that the spirit of the 1986 Order recognised that where there was deprivation of liberty as a result of mental health legislation that the reciprocity in this arrangement was that the patient must be provided with care and specifically treatment. They believed that this principle does not appear to be recognised within the current draft and raises concerns about this clinically appropriate reciprocity.

4.63 The definition of "treatment" was raised by an individual respondent, citing a European Court of Human Rights judgment[1] that determined that treatment could be construed as any form of intervention requiring treatment, including supervision or management regimes in a care based setting. If a person is found unfit to plead but capacitous and refusing treatment, the respondent questioned if this would mean that the individual would not take part in any of the programmes or therapies on offer in a care based setting. If that were the case, it would be very difficult for health care staff to manage or care for the individual. The respondent also commented that if a protection order is introduced, it might have to include the possibility of the person being held in a prison setting in the event of refusing to comply with a management or treatment regime within a health care facility.

4.64 The Probation Board suggested that a restriction order could be used in conjunction with a protection order, to require an individual to reside in a specific place and attend for treatment.

4.65 The Royal College of Psychiatrists took the view that the inclusion of a protection order illustrates that capacity based legislation will not always work with mentally disordered offenders and that one cannot assume that the dangerousness of an individual would reduce without treatment.

[1] Hutchison Reid v. the UK, 2003

Supervision and treatment order

4.66 Two consultees made comments about the proposals contained in the consultation paper regarding supervision and treatment orders. The British Psychological Society stated that it was concerning that courts, in the consultee's opinion, viewed supervision and treatment orders as appropriate disposals in cases where there did not appear to be clearly defined treatment needs. The consultee also commented that in order for the disposal to be practically workable, some level of motivation for the individual to engage with healthcare services is needed. It was noted that in the event that an individual failed to engage, there is no mechanism for the case to be returned to the court. It was felt that the lack of such a mechanism had implications for the protection of the public but also with respect to the individual's assessed treatment needs remaining unmet.

4.67 The Regional Forensic Group (Mental Health & Learning Disability) noted that if the criteria for the supervision and treatment order required a valid consent to treatment, or a lack of capacity to consent to treatment, then the disposal would "suffer from the same shortcomings as the Inpatient Order". Also, this consultee noted that it was considered that no individual would volunteer to take treatment under this order, given that the only alternative open to the court is an absolute discharge. The consultee also added that it was considered that most people who would be subject to a supervision and treatment order would have capacity to consent to such an order.

Community residence order

4.68 Five consultees commented on the Department's proposal to replace the guardianship order, which is currently available as a disposal under the 1986 Order, with a community residence order.

4.69 Four consultees welcomed the replacement of the guardianship order with the community residence order. However, all four consultees qualified their welcome to a degree. The SE Health and Social Care Trust and Disability Action stated that they were concerned about the order being used to force any individual to attend training, occupation or education, which Disability

Action considered was a personal choice to be made by the individual. The Regional Forensic Group (Mental Health & Learning Disability) commented that if the criteria for the community residence order were based on consideration of an individual's capacity to make decisions, then the disposal "would present the same limitations as the other proposals". The HSC Board & Public Health Agency asked the DoJ to recognise the limitation of HSC social workers' powers to restrict the liberty of an individual (should this be required) to protect public safety, whilst another consultee commented that the DoJ should recognise that "the mentally disordered offender population is notoriously aversive regarding complying with compulsive practices imposed by statutory authorities and "policing" of such provisions would pose significant difficulty".

General comments

4.70 Seven consultees made general comments about the Departments proposals on court disposals. One consultee stated that the public safety aspects of disposals will require robust criminal justice input, noting that there would be resource and ethical issues if health and social care staff were expected to undertake criminal justice functions.

4.71 The Children's Law Centre commented that they were concerned about the effect of the proposals on 16 and 17 year olds, given that they considered that no appropriate in-patient facilities for this age group currently exist in Northern Ireland.

4.72 The Regional Forensic Group (Mental Health & Learning Disability) cautioned against the use of a capacity based approach, stating that "the use of capacity based legislation in sentencing fails to acknowledge that mental disorder has a nature and a degree. It is the nature of a mental disorder which has implications for public safety and which is not addressed by capacity legislation. Removal of mental health legislation will place public safety at risk." They also stated that the use of mental capacity legislation in the criminal justice arena was supported, but they "cannot support the removal of mental health legislation".

4.73 The NI Human Rights Commission advised that courts should have available to them a range of diversionary disposals to ensure that those convicted of a criminal offence, who have mental health problems, receive appropriate treatment to address offending behaviour.

4.74 The Children's Law Centre asked for clarification around sentencing powers and procedures for 16 and 17 year olds in the criminal justice system. They also highlighted the need to train those who work in the criminal justice system, including lawyers, judiciary, court, PSNI, PBNI, and YJA staff, about the needs of young people. They also queried how an individual who is under the age of 16 will be treated in the criminal justice system after he or she attains the age of 17.

Departmental response

Remand

4.75 While the DoJ accepts that the current remand powers are used infrequently, it is considered that these powers are nevertheless useful and should be retained. It is therefore proposed that the Bill will have power to remand to hospital for a medical report and to remand to hospital for medical treatment.

4.76 In order to address concerns that remands to hospital could be made without consideration of healthcare services, the Bill will provide that a court may not remand a person to hospital unless satisfied, on the written or oral evidence of a person representing the managing authority of the hospital, that arrangements have been put in place for the person's detention in hospital.

4.77 In order to address concerns about an individual being able to challenge a remand to hospital, it is proposed that, similar to the current provisions in the Mental Health (NI) Order 1986, a person remanded to hospital may obtain at their own expense a medical report on their condition and in order to apply to the court for the remand to be terminated.

Hospital Order (now renamed Public Protection Order)

4.78 A hospital order is aimed at those individuals who may lack the level of culpability for their actions that would be required to be present for a custodial sentence to be passed: for example, culpability may be reduced because of a mental disorder that he or she was suffering from at the time of the commission of the offence.

4.79 In the consultation paper, the DoJ had consulted on an approach for the making of a hospital order which took account of an individual's capacity to make decisions about treatment. This approach was devised to take account of the recommendations of the Bamford Review. However, consultation responses raised concerns that recasting the hospital order in this way created a risk to public safety, as it was felt that the approach may not be robust enough to allow individuals who posed a significant level of risk to be detained if they had capacity to make decisions about treatment and so refused.

4.80 The DoJ has reconsidered its approach and has liaised closely with stakeholders during its ongoing work. The DoJ now proposes introducing an order, to be known as a Public Protection Order, which will be available in circumstances where an individual is convicted of an offence punishable with imprisonment or determined to be unfit to plead but to have done the act with which he or she was charged. It is proposed that the Order will be based around the need to detain the individual because of the risk posed to other people.

4.81 DoJ considers that the public protection order is a criminal court disposal, not a substitute decision, and it would be wrong for a criminal court's power of detention to depend on whether the accused has or lacks capacity in relation to detention. It also appears to DoJ that capacity to make decisions about *treatment* is not a relevant consideration in determining whether an individual should be *detained* for the purposes of ensuring public safety.

4.82 In addressing any public protection issues, the DoJ still wishes to adhere to the Bamford Principle that an individual who has capacity to make decisions about treatment will have any decision to refuse treatment respected.

Hospital Direction

4.83 We are aware that in other jurisdictions where Hospital Directions exist (such as England and Wales) they are used infrequently. However, we consider the availability of a Hospital Direction under the Bill, which was a disposal that was recommended by the Bamford Review on Mental Health and Learning Disability, is a useful disposal to have available in cases where a court considers a person to be fully culpable for his or her offending thereby warranting a custodial sentence, but also happens to be so unwell that in-patient treatment is required in the immediate term.

Restriction Order

4.84 The DoJ regards the restriction order as an important tool in public protection and agrees with those consultees that expressed the view that they are vital in the management of certain offenders who pose a risk to others. It is therefore proposed that restrictions are retained within the Bill.

Unfitness to Plead

4.85 The DoJ stated in the consultation paper that the recommendations of the Northern Ireland Law Commission should be taken forward in the Mental Capacity Bill. However, the DoJ is aware of ongoing work in this area by the Law Commission of England & Wales, due to be published in spring 2015, which may assist in informing the Department's approach.

Protection Order

4.86 The DoJ recognises the difficulty that may be posed by those with capacity to make decisions about treatment and who refuse such treatment. We also recognise that there is a need to detain individuals of this description who may pose a risk to the public. We also acknowledge the concerns raised by some consultees regarding where this secure environment might be located and the effect this might have on resources. The DoJ is seeking further engagement

with stakeholders to ensure a suitable balance is struck between respecting an individual's autonomy to make decisions about medical treatment and ensuring public protection from those who may pose a risk as a result of their illness.

Supervision & Treatment Order

4.87 The DoJ recognises that are difficulties in dealing with an individual who breaches a supervision and treatment order, given that the order is made in relation to a person who has not been convicted of any criminal offence. However, returning a person to court who breaches the terms of an STO may not result in the court being able to make an alternative disposal, as the criteria for other disposals may not be met. The DoJ will continue to consider the options to address this difficulty.

General Comments

4.88 The DoJ will continue to work with stakeholders in the health and criminal justice systems to ensure that issues surrounding resources, responsibilities and other concerns are dealt with appropriately. It should be noted that a Code of Practice will be produced to accompany the Bill and this will provide further detail of the roles and responsibilities of various organisations.

Transfer of Prisoners

Background

4.89 Healthcare is provided for individuals who are detained in custody in the criminal justice system by the South Eastern Health and Social Care Trust. Most prisoners are able to avail of the treatment they require whilst being detained in a custodial environment like a prison, however detainees may also need to access healthcare outside of the prison. There are various ways of facilitating this access to healthcare: under the Prison Act (Northern Ireland) 1953 ("the 1953 Act"), Prison and Young Offenders Centres Rules (Northern Ireland) 1995 ("the 1995 Rules"), Juvenile Justice Centre Rules (Northern Ireland) 2008 and various provisions contained in the 1986 Order.

4.90 The 1986 Order creates powers for the DoJ to transfer prisoners to hospital for treatment. It is usual for the 1986 Order powers to be used for individuals who may need to be detained in hospital for some considerable time and for whom it is not practicable to use the powers contained in the 1953 Act or 1995 Rules.

Proposal

4.91 The DoJ wishes to retain powers to transfer offenders for in-patient treatment in appropriate circumstances. There also needs to be a mechanism to return offenders from hospital back to the custodial environment.

4.92 It was proposed in the consultation paper that a prisoner's capacity to make a decision about treatment will be taken into account when deciding on whether a transfer to hospital should take place, so that where they have capacity to make a decision regarding medical treatment, this will be respected. Where a prisoner lacks such capacity, decisions regarding treatment will be carried out in line with Part 2 of the Bill or, where the person is under 16, by Part II of the Mental Health (NI) Order 1986, as amended.

Responses to Consultation

Time taken to transfer to hospital

4.93 Three respondents raised concerns about the delay in the time it currently takes in transferring a prisoner from prison to hospital. Concern was raised by an individual respondent that should access to assessment and treatment in hospital be delayed by the courts or by paperwork, then the individual's recovery is compromised and "risk is increased". The College of Occupational Therapists also commented that the current process for moving someone from prison to hospital is lengthy, often lasting several weeks, during which time the person's symptoms and distress are exacerbated as they cannot receive treatment. They were not convinced that the Department's proposals on transfers would make this process any quicker.

Under 16s

4.94 Two respondents (the Children's Law Centre and Include Youth) sought clarification on what would happen to those people under 16 who need to be transferred to hospital. The lack of a juvenile forensic facility in Northern Ireland and the limits this places on the options for 16 and 17 years olds was raised as a concern by the Children's Law Centre.

Increase in number of transfers

4.95 The HSC Board/Public Health Agency raised concerns that the new transfer provisions will result in a significant increase in the volume of transfers to hospital. They were of the view that there needs to be an awareness of the capability and resource limitations with health and social care that affect the transport or transfer of dangerous individuals or those that present a flight risk between criminal justice and health care settings. They took the view that this responsibility should sit within criminal justice, rather than health and social care.

Capacity to make a decision regarding medical treatment

4.96 Concern was raised by the Regional Forensic Group (Mental Health & Learning Disability) that hospitals might be expected to detain a person who has capacity to make decisions about treatment and wished to leave. This consultee also stated that it was important to retain mental health legislation which recognised the nature and degree of mental disorder.

4.97 The South Eastern Health and Social Care Trust raised concern that the inclusion of a capacity element could result in prisoners demanding to transfer to a psychiatric unit as of right or conversely, prisoners with mental capacity to refuse treatment remaining in prison even though they have considerable mental health issues.

Resources

4.98 Disability Action requested clarification that a lack of hospital resources would not be a consideration for a prisoner requiring in-patient treatment in a timely

manner, and that it is imperative that appropriate resources are in place to accept the detained individual for treatment or examination.

4.99 The NI Mental Health Occupational Therapy Managers Forum stated that the inclusive nature of the Bill results in everyone's behaviour and capacity becoming a healthcare issue rather than just those with a defined formal diagnosis. This would have significant operational issues and competency issues for prison healthcare staff.

Departmental Response

Time taken to transfer to hospital

4.100 Under the 1986 Order, a transfer direction order is valid for 14 days, during which time the transfer to hospital must occur or else a fresh direction would be necessary. It is intended that this time limit will be retained in the Mental Capacity Bill. The DoJ recognises that further work is needed to ensure transfers to hospital are made in a timely manner.

4.101 The DoJ acknowledges that it is important that transfers to hospital are expedited as much as possible. The Bill, and the development of the associated Code of Practice, is an opportunity to look at our processes to ensure swift handling of transfer cases.

Under 16s

4.102 The Department's transfer provisions will apply to everyone within the criminal justice system, regardless of age.

4.103 However, any treatment delivered in a healthcare setting will be delivered in accordance with relevant legislation. For those aged 16 and over, treatment can be delivered with the individual's consent, or if the individual is unable to consent the Mental Capacity Bill will apply. For anyone under the age of 16, where consent to treatment cannot be obtained, the 1986 Order may determine how they receive treatment.

4.104 The DoJ acknowledges that the lack of child adolescent services in Northern Ireland is an issue, but it is important to ensure that legislation is flexible enough to accommodate increases in service provision.

Increase in the number of transfers

4.105 DoJ and DHSSPS are working together to determine the additional demands that the Bill will place on all relevant sections of the health and criminal justice sectors. This work will include detailed estimates of the additional costs which are generated by the operation of the provisions of the Bill.

Capacity to make a decision regarding medical treatment

4.106 The criteria regarding the issuing of a transfer direction will take into consideration how likely it is that an individual who has capacity to make decisions about treatment will consent to being treated. Any treatment provided to an individual who lacks capacity to make decisions about treatment will be in accordance with the safeguards contained in Part 2 of the Bill. For anyone under the age of 16, where consent to treatment cannot be obtained, the 1986 Order may determine how they receive treatment.

4.107 However, the respecting of such a decision is not the only criteria in deciding whether a TDO should be issued. There must be a medical need to treat the prisoner in hospital for their disorder and treatment must also be available, so there will be no transfer to hospital simply because a prisoner requests in patient treatment.

4.108 The provisions regarding the ending of a transfer will be clearly set out in the Bill. It is not the intention of the DoJ that hospitals will have to continue to detain a transferred prisoner in hospital where they have capacity to make decisions about treatment and withdraw consent to treatment.

Resources

4.109 As mentioned above, both departments are working on establishing the extent of the additional demands that the Bill will place on all relevant sections of the health and criminal justice sectors. This work will include estimating and

costing the additional resources required, including any necessary additional training of staff in the health care and criminal justice sectors.

Young People (aged 16-17 years)

Paragraphs 3.3 – 3.7 of the consultation document refer

5.1 Approximately **15% of total responses** received commented specifically on provisions relating to young people. The key points raised were:

- It is important that 16 and 17 year olds who fall within the remit of the draft Bill are afforded additional protections.
- Clarity in relation to the refusal of treatment will be important.
- Further detail on education provision for this age group and on age appropriate accommodation is required.
- Consider shortening the automatic referral to the Tribunal for this age group (clause 48). Also ensure that when a child turns 18 this does not result in a delay in their case being heard by the Tribunal.
- Detail the type of support that should be offered to 16 and 17 year olds.
- Transitional arrangements and guidance for what should happen when a child reaches the age of 16 or 18 will be important, as will the need to provide clear guidance on how the Bill will interact with other legislation such as the Children (NI) Order 1995.
- The extension of the disregard provision to include periods of detention for treatment (as for under 16s) should also apply to 16 and 17 year olds.
- It was felt that all children and young people, regardless of age or whether they are detained or voluntary patients, should be able to request the services of an advocate to assist them in the decision making process.
- The definition of mental disorder in clause 159 should be removed.

5.2 Below are some examples of **comments** made:

"Welcome the proposed aligned project to link the Bill with the Children Order and relevant common law to ensure that the complexities of the legislation are suitably linked to offer enhanced protection for 16 and 17 year olds." **(Volunteer Now)**

"There continues to be concern about proposals to apply Mental Capacity principles and thresholds to 16 and 17 year olds. There is considerable scope for risk to the safety of children, undermining of parental authority, and contradictory statutory duties when there is HSC is acting as Corporate Parent. Applying the principles, duties and safeguards of mental capacity in the context of Children Order requirements will be challenging." **(HSC Board & Public Health Agency)**

"…a 17 year old who is formally detained and who has their 18th birthday during the first year of their detention will not have their case referred to the Review Tribunal until 2 years have passed. This is a flaw in this safeguard and must be addressed." **(Children's Law Centre)**

Departmental Response

5.3 It is important to be clear that, in respect of young people aged 16 and 17, the Bill is intended to apply alongside, rather than displace, other legislation such as the Children (NI) Order 1995. This is in recognition of the fact that such persons are still children under the law. The proposed additional safeguards for this group around age appropriate accommodation, rights of review and access to education are also intended to reflect this fact. The Department remains committed to working with key stakeholders to get these additional safeguards right. This work will continue, informed by comments made during the consultation, in coming months and any changes made to the draft Bill as a result will be explained in the Explanatory Notes to the Bill. The Code of Practice will provide further detail to assist those working under the Bill and the existing legal framework that applies to children and young people.

Children (under the age of 16)

Paragraphs 3.8 - 3.14 of the consultation document refer

5.4 Approximately **35% of total responses** received commented on the proposed way forward for children under the age of 16. Views expressed have been summarised as follows:

a) those respondents who specifically stated that the draft Mental Capacity Bill should apply to under 16s

5.5 Of those responses, approximately half appeared to be of this view, the reasons for which can be posited as being primarily twofold –

"Exclusion of children aged under 16 from the Bill will mean that... under 16s will not be able to access the protections and safeguards contained in the new Bill, which will be afforded to those over 16..." **(Children's Law Centre)**

"The Bamford report noted... While most people would agree that parents be substitute decision-makers for children up to the age of 10 or 12, consideration might be given to a rebuttable presumption of capacity between 12 and 16." **(Children in Northern Ireland)**

5.6 In relation to the latter comment, there was some discussion (although not a general consensus) around alternative age limits. Some contended that the Bill should apply to those aged 12 and above. Some were of the view that 13 and above would be appropriate, while others identified 14 as a suitable cut off point.

5.7 It should also be noted that, while these responses were replete with requests for the Bill to be applied to under 16s, there was very little consideration of what this would actually mean in practice or, more importantly, for society as a whole. The role of parents in making decisions for their children (which would be significantly eroded if such a Bill were to apply to under 16s) received limited if any coverage.

b) those respondents who agreed that the draft Mental Capacity Bill cannot apply to under 16s

5.8 It is estimated that approximately a quarter of respondents (who commented on this section of the consultation paper) agreed with the Department that the Bill cannot apply to children under the age of 16.

5.9 Below are some examples of comments made:

"The Law Centre is not yet convinced that the rights and best interests of children under 16 would be best served by their inclusion in the draft Mental Capacity Bill... We do not think that appropriate legislation is most likely to be achieved by simply extending a law developed for adults." **(Law Centre NI)**

"... the intention of this exclusion is positive, to ensure children's rights are better protected....." **(NI Association of Approved Social Workers)**

"... allows for a full debate with regard to emerging capacity and how the needs of this group can be better met within legislation." **(NI Social Care Council)**

c) those respondents who did not comment specifically on the scope of the Bill but expressed concerns that any delay to the proposed separate project could have an adverse impact on under 16s

5.10 Remaining responses (approximately a quarter) were disappointed at the lack of progress made on the separate project and as a result expressed concern at the retention of the Mental Health (NI) Order 1986 as an interim measure (discussed further below).

5.11 It is also fair to say that this was a key message also conveyed by respondents falling within categories a) and b) above.

Departmental Response

5.12 The Department fully recognises the strongly held views of some stakeholders who have continued to voice their opposition to the proposed age threshold in the Bill during this consultation exercise. The considerable time and effort

applied by those concerned in making their responses and attending many events over the summer period is also acknowledged. It is important to note, however, that this is not an issue upon which there was a consensus of opinion during the consultation. Differing views were expressed and, ultimately, having carefully considered all of the consultation responses, it remains the Department's view that there is no clear, robust evidence base upon which to conclude that the extension of the Bill to children would result in them being better protected under the law.

5.13 The Department's position is clear: the Bill is a decision making framework for adults and, as it stands, it is simply not appropriate for children. As the Department has consistently argued, there is already a decision making framework in place for children: a framework that has safeguarding children at its core and that recognises the importance that society places on the role of parents when it comes to making decisions in respect of children. The Bill will not affect that framework as it applies to under 16s, nor at this point has the Department the authority to make any changes to it, other than to enhance the existing safeguards in the Mental Health (NI) Order 1986 (discussed further below).

Proposed Amendments to the Mental Health (NI) Order 1986

5.14 Approximately **30% of total responses** received commented on the options put forward by the Department to enhance safeguards for children under the age of 16 detained in hospital for assessment and/or treatment of mental disorder (under the Mental Health (NI) Order 1986).

Insertion of a Best Interests principle

5.15 Over half of those respondents commented on and strongly agreed with this proposal. The key issues raised were:

- To ensure compliance with the UNCRC and UNCRPD, any best interests clause must provide that the best interests of the child shall be a primary consideration; that the child's views should be taken into account; and that

every effort should be made to ensure the child is supported to express their views, if they wish to do so.

- The child's participation should not be limited in assessing what is in their best interests (by use of terms such as *'where practicable and appropriate'*) rather it should be an integral part of the assessment with the provision of appropriate advice and information and consultation with persons with parental responsibility.
- To ensure conformity with the Children (NI) Order 1995.

Insertion of a duty to consult with an Independent Advocate

5.16 All of those respondents commented on and strongly agreed with this proposal. The key issues raised were:

- Advocacy should be available to voluntary and detained patients.
- There should be advocacy support as early as possible.
- Children should be able to request an advocate of their choice.
- Independent advocates should be appropriately trained.
- More information is required in terms of how services will be commissioned and implemented (chapter 6 refers).

Extension of Disregard Provision

5.17 Approximately half of those respondents commented on and strongly agreed with this proposal. In addition, some recommended retrospective application to include all persons who have been detained as a child under the Mental Health (NI) Order 1986.

Insertion of a provision requiring consent and a second opinion for ECT

5.18 A small number of those respondents commented on this proposal and gave a cautious welcome. Significant concerns were raised about the use of ECT on children with a recommendation made to reflect NICE guidance.

Amendment of Nearest Relative Provisions

5.19 Approximately half of those respondents commented on and agreed with this proposal with some acknowledgment that this approach should ensure

compliance with the European Court of Human Rights' judgment in the case of *JT v UK 2000*. The key issues raised were:

- Children should be allowed to choose a person not on the current statutory list as their nearest relative if deemed suitable/willing to act.
- Children should be able to apply to the Tribunal for the displacement of an unsuitable nearest relative (rather than the county court) as this would be quicker and align with provision made for those over 16 in the draft Bill.
- The displacement of a nearest relative should not systematically follow the statutory default list. The term, '*any other person deemed suitable by the Review Tribunal*' should be inserted into the default list.
- A 'looked after child' should be able to displace the Trust as their nearest relative in favour of a more suitable person of their choosing.

Duty on hospital managers in respect of age appropriate accommodation

5.20 The majority of those responses commented on this proposal which was, in theory, welcomed. There were however, requests for an enhanced commitment from the Department that no child will be detained on an adult psychiatric ward. The key issues raised were:

- Further clarity is needed around the definition and location of *'age appropriate'* accommodation.
- The term *'suitable'* is open to interpretation.
- What are the procedures hospital managers will be expected to follow in order to fulfil this duty?
- Further detail is needed in respect of alternative procedures in the event that no child in-patient facilities are available.
- There should be a mechanism to allow children to challenge instances where they are not placed in appropriate accommodation.
- It is difficult to see how this will translate into practice, given the significant resource issues already in existence.

Consideration of access to education provisions

5.21 Approximately half of those respondents welcomed this statement but expressed concern at the lack of detail and legislative commitment provided. The key issues raised were:

- Provisions must allow children detained in hospital (and upon discharge) to have equal access to the level of education that their peers receive in the community to ensure compliance with the UNCRC, the UNCRPD and the Bamford Review.
- Children and young people with special educational and/or health needs must be accommodated within any provisions.
- Further clarity is needed on what level of educational services will be provided.

5.22 As noted in the consultation document and at consultation events, the list of safeguards proposed by the Department was not intended to be exhaustive. Other key suggestions put forward by respondents included:

"Children and young people whether they are voluntary patients or detained patients, who continue to come within the remit of the Mental Health Order should experience the same safeguards as those who are over 16 years of age." **(Mencap)**

"In hospital settings, access to advocacy should be available equally to voluntary and detained patients." **(NI Commissioner for Children and Young People)**

"With the exception of the presumption of capacity... the other principles of the Mental Capacity Bill should apply." **(Law Centre NI)**

"Some young people in the group thought that personality disorder should be included within the legislation." **(VOYPIC User Feedback Group)**

"Allow under 16s the ability to apply to the Tribunal during the assessment period and a tribunal should be constituted within the assessment period, rather than after 6 weeks as is the case currently." **(Children's Law Centre)**

"Currently the 1986 Order only permits a young person to apply to the Mental Health Review Tribunal once every 6 months... CLC wants to see this

restriction being removed and the inclusion of a provision to allow for multiple applications to be made." **(Children's Law Centre)**

"Article 73 of the 1986 Order relates to the automatic referral mechanism to the Mental Health Review Tribunal. This should be amended to ensure that applications are made in time to allow the Tribunal to hear the case within one year." **(Children's Law Centre)**

"There merely being a duty to consult with an advocate for under 16s, rather than a duty to provide advocates for under 16s was not a strong enough safeguard. It was also felt that advocacy should be available for voluntary patients as well as for detained patients." **(youth@clc)**

"It is vital that the Bill makes provision for how the transition from one legal framework to another work." **(Start 360)**

"Deprivation of liberty safeguards should apply to all regardless of age." **(Parenting NI)**

"Consideration should also be given to the immediate introduction of robust regional policies and guidelines in relation to the use of restrictive practice in hospital and the community, where the criteria for detention under the Mental Health Order is not met but where there are significant restrictions on the child's liberty to ensure their safety. Future legislation should also deal with this issue." **(Belfast HSC Trust)**

"Article 121... needs to be amended to mirror the offence of ill treatment or neglect." **(Children's Law Centre)**

"Detention and compulsory treatment of under 16s should require authorisation by the Trust Panel." **(Law Centre NI)**

"The language of the Order should be carefully reviewed to ensure that it adheres to Bamford's vision to eliminate the stigma surrounding mental health issues." **(NI Commissioner for Children and Young People)**

"We could have a situation where under 16s are more easily detained than their adult counterparts, as their lack of capacity will not have to be demonstrated." **(Include Youth)**

"Better connections should be made with families, who often have the best knowledge of the person and their feelings. Their thoughts and feelings should be listened to." **(Youthnet)**

"Under the proposed Mental Capacity Bill when considering detention in a hospital setting it will be necessary to assess an individual's capacity and only once a lack of capacity has been established will it then be possible to apply the test for formal detention in a hospital setting. Under the Mental Health (Northern Ireland) Order 1986, there is no requirement to establish a lack of capacity before applying the test for formal detention. In CLC's view it will therefore be easier to formally detain under 16s than those over the age of 16." **(Children's Law Centre)**

Departmental Response

5.23 The Department acknowledges the continuing concern expressed during the consultation in respect of the retention of the Mental Health (NI) Order 1986 for under 16s but reiterates both that this retention is not intended to be permanent and that the Department is committed to building on the safeguards already provided for in the Order.

5.24 In that context, the Department notes the general support for the options regarding additional safeguards put forward in Section 3 of the consultation paper. Comments made in relation to these will be carefully considered and will inform final instructions to Legislative Counsel on the amendments to be made to the Mental Health (NI) Order 1986. It is intended that these amendments will be carried in the Bill and fully explained in the Explanatory Notes.

5.25 The Department is also grateful for the further suggestions made during the consultation in addition to the options put forward in the consultation paper. These suggestions have been assessed and, at this stage, subject to further discussions with colleagues, stakeholders and Legislative Counsel, the Department can see merit in taking forward the following:

- Exploring how the Trust authorisation safeguard in the Bill might be reflected in the processes involved in authorising detention for treatment under the current provisions of the Mental Health (NI) Order 1986;

- Making provision in the Mental Health (NI) Order 1986 in relation to independent advocacy for all persons aged under 18 admitted to a hospital for the assessment or treatment of mental disorder;
- Amending the definition of mental disorder to remove the current exclusions;
- Exploring further the option of applications to displace the nearest relative being submitted to the Tribunal rather than the County Court;
- Exploring further issues around independence where consent and a second opinion is required for ECT and that consent is provided by the HSC Trust as the person with parental responsibility; and
- Reviewing the offence of ill treatment in light of the new offence of ill treatment or wilful neglect in the Bill.

5.26 It is hoped that the ongoing constructive engagement with key stakeholders on this important aspect of the Bill will continue in coming months as the Department works towards finalising its proposals for the amendment of the Mental Health (NI) Order 1986 for under 16s. Beyond that, the Department fully acknowledges the need for clear guidance on the implications of the changes to the Order and of the Bill more widely, in particular, on the transition arrangements for those approaching the age of 16.

CHAPTER 6: IMPLEMENTATION

6.1 Approximately **60% of total responses** received commented on the implementation of the Bill. There were general comments that the Bill will require a shift in culture in the health and social care sector and that clear planning and strategies for implementation are required:

> *The Bill will mean a "change in culture for the delivery of Health and Social Care"* **(Western HSC Trust Adult Mental Health & Learning Disability Services)**

6.2 A number of respondents stressed the importance of:

- A clear plan and solid framework to ensure that the human rights of those who lack capacity are accounted for.
- Implementation planning not only for health care professionals, but also for the general public. The plan must also be well communicated to both the professionals and the general public to ensure awareness of the Bill and the importance it will have for everyone in Northern Ireland.

6.3 There were also comments that lessons should be learned from the implementation of the Mental Capacity Act 2005 in England and Wales. It was the view of a number of the respondents that a single implementation body should be commissioned to take charge and oversee the implementation, including the rollout of the Code of Practice, mitigation of conflict and raising of public awareness. This would be in line with the House of Lords report[2] into the Mental Capacity Act in England and Wales, which recommended such an implementation body.

6.4 The responses received in relation to implementation can be divided into five areas; resources, training, regulations, Code of Practice and services.

[2] http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf

Resources

6.5 About half of the responses in relation to implementation commented on the need for sufficient resources, in terms of finance and staff. Many of the comments stressed the importance that necessary resources are in place before the commencement of the Bill and a number of questions were raised about whether there would be sufficient numbers of staff to complete the number of capacity assessments that will be required, as this will lead to an increase in staffing costs.

6.6 There were concerns from a number of respondents that the safeguards in the Bill are overly bureaucratic, will increase the workload for clinical staff, and that without, for example, a simple-to-use toolkit or similar measure, the tasks of providing all practicable help and support, completing capacity assessments and adhering to the safeguards would be an undue burden on staff and will make it difficult to implement the Bill effectively and efficiently.

> *"The Bill identifies a number of key individuals 'to provide all practicable help'. This is likely to be resource intensive i.e. the use of legal advocate, nominated persons, lasting power of attorney, ASWs, tribunals and panels. We would raise the concern as to how individuals can operate outside of normal working hours."* **(Western HSC Trust Adult Mental Health & Learning Disability Services)**

6.7 There were also a number of comments in relation to the resourcing of particular aspects of the Bill. For example, the Bill provides for a new statutory right to advocacy in certain conditions. There were concerns as to who would provide resources, both in term of finances and staff, for this.

6.8 There were also concerns that the costs of the Trust Panels had not been examined and there must be further detail on the remit of the Trust Panels in relation to persons not directly within the care of the Trusts, for example those in care homes. This and other issues in the Bill may also lead to higher legal costs as various aspects of the Bill are tested in court and as more declaratory judgments are required.

Training

6.9 More than half of the responses in relation to implementation commented on the need for training. Most stated that training is fundamentally important for the implementation of the Bill.

> *"The delivery of the vision outlined in the draft legislation will require substantive investment, particularly in relation to training and development."* (**Royal College of Nursing)**

6.10 A number of respondents stated that training is required for most people involved in the care and treatment of persons who lack capacity and needs to be delivered across all types of health providers. Some stated that to implement the Bill successfully, the full support from professions is required, and the key to achieving this is successful and proper training that is tailored to the person to whom it is being delivered.

6.11 It was noted that the quality of training is very important. To achieve this, dedicated training resources need to be available with suitable resources depending on what level the training is aimed at. This does not only need to be during the implementation phase of the Bill, but continuous during the life of the Bill. Dedicated training for the new roles created in the Bill is also required. For example the new statutory advocates need to have clear training with a good support network to ensure that the statutory functions are carried out properly.

> *"There will be a significant training requirement on the interpretation of the legislation and associated documentation for all those involved in a patient's care in a Primary Care setting."* (**HSC Board & Public Health Agency)**

6.12 Some responses stated that to achieve this, lessons should be learned from the training regime in England and Wales during the implementation of the Mental Capacity Act 2005. Similarly some commented that the House of Lords report into the implementation of the Mental Capacity Act should be considered when a training programme is set up in Northern Ireland.

6.13 The respondees also asked some questions of the Department:

- Are the implementation time frames realistic bearing in mind the extensive training required?
- Who will deliver training?
- Who will fund training?

Regulations

6.14 A number of responses included comments in relation to the regulations for which the Bill makes provision. There was some criticism that it is difficult to understand the Bill without also having the regulations as they regulate significant aspects of the day-to-day workings of the Bill.

6.15 Other comments on the regulations stressed the importance of the inclusion of service users in the process of making regulations and the requirement for regulations to define significant aspects of the Bill, for example serious interventions and the role of advocates. There were also comments that the regulations need to be consulted on before they come into operation.

Code of Practice

6.16 More than half of the responses relating to the implementation of the Bill commented on the Code of Practice. There was a general consensus that the Code is important to understand the Bill and the roles of professionals.

6.17 There was some criticism that the Code had not been developed in tandem with the Bill and it was noted by many respondents that the Code needs to be published as soon as possible and no later than at the same time as the Bill. There were also calls to publish the Code in advance of the commencement of the Bill to ensure sufficient time for training and implementation planning.

6.18 A significant number of comments related to the creation of the Code. There were some calls for the Code to be created by healthcare professionals. There were also many comments expressing the view that the Code should be created in cooperation with a large group of interested parties, including

case workers, healthcare professionals, non-government organisations and service users.

"The Code of Practice will be required to set out clearly what is defined as 'reasonable, practicable, or appropriate' in terms of decision making around care episodes within a context of capacity being 'issue and time specific." (**NI Practice and Education Council for Nursing and Midwifery)**

6.19 A number of comments indicated that the Code should be consulted on before publication. There were also wishes for the Code to define standards and forms to ensure efficient work practice, and that it needs to include a glossary of terms. Some comments also stated that the Code needs regular reviews and updates.

Services

6.20 A number of respondents commented on existing services and questioned how the implementation of the Bill would affect current and future services. This included comments that service provisions will need to be considered when the Bill is implemented, and a wish for streamlined templates and guidance to ensure implementation of the Bill does not put undue restraints on services and to ensure that they can cope with the extra demand the Bill will create.

"Services in general may well struggle with the person's right to make unwise decisions, especially where risk is involved, leading to people's right being restricted." (**British Psychological Society)**

6.21 Two specific questions were asked in relation to how services will cope when the Bill is implemented:

- Who will provide oversight of the services in relation to the Bill?
- How is infrastructure going to be supported to allow the Bill to work?

Departmental Response

6.22 The Departments acknowledge that the Bill will create a major shift in how healthcare and social care are delivered. It will require a significant change in

culture across the health and justice systems, with huge implementation challenges.

6.23 The Departments are committed to thorough, well planned implementation of the Bill. Project management structures have been put in place. A project board oversees developments, and a project manager and staff have been appointed to work across both Departments to prepare for implementation.

6.24 The project consists of a number of work streams, in addition to completion of the Bill. These are:

- Drafting and enacting an Order in Council (once the Bill is enacted) to provide for inter-jurisdictional patient transfers within the UK.
- Drafting and enacting the various sets of Regulations that will be required to fully implement the Bill. It is envisaged that drafting will start in early 2015, and they will be consulted on in due course.
- Drafting of Codes of Practice. A working group has been formed to draft Codes of Practice, and this work will be quality-assured by a Reference Group, which will consist of representatives from relevant statutory and voluntary bodies. It is envisaged that there will be a general Code to provide guidance on how the new law will work in practice. In addition, it is likely that there will be a range of Codes which will provide practical guidance for professionals working in a number of health and justice settings. The codes will be consulted upon during their development. It should be noted, however that the Codes cannot be finalised until the Regulations have been passed by the Assembly. Substantial work and consultation can, however, take place now, and it has already commenced.
- Determining the likely costs of the new legislation, and how these will be met. The Departments are giving this work a very high priority, prior to introduction of the Bill.
- Assessing the equality, human rights and regulatory impacts of the legislation.
- Assessing the training and awareness raising needs across the health and justice sectors, and more generally for the public, and, in conjunction with

relevant staff, planning how this will be delivered, without adversely impacting on services.

- Producing guidance and engaging with health and social care and justice staff, and stakeholders, to ensure the law works in practice.
- Planning for delivery, including assessing potential changes to paperwork and IT systems; providing for any workforce changes which might be required on foot of the new law; developing independent advocacy services; establishing the Office of the Public Guardian; establishing regulation and inspection services required under the new law; and arranging for transitional measures to be put in place, for when the new law comes into operation, and the Mental Health (NI) Order 1986 is repealed in respect of people aged 16 and over.

6.25 Individually, these work streams would be a significant challenge. Together, they will require major effort and resources across the health and justice systems, and the Departments recognise this.

6.26 Further, the Departments acknowledge the pressing need to learn from previous experience in other jurisdictions. For example, lessons from the House of Lords report on the implementation of the Mental Capacity Act 2005 are being taken on board. One practical outworking of this is the priority and effort being given to the development of the Codes of Practice, with a commitment that these will be consulted on and published, at least in draft, well before the local Act is commenced. This will help to inform preparation, training and awareness raising.

6.27 One of the recommendations of the House of Lords report on the Mental Capacity Act 2005 was that an independent body should have been established to monitor implementation of the legislation. Several consultees suggested that such a body should be formed in Northern Ireland, to oversee implementation here. The Departments are considering this as an option. Whilst an independent body would be useful in providing an oversight function, there are a number of issues which need to be further explored with stakeholders, including:

- How would such a body be staffed?
- How could its independence be established and maintained?
- Would it create a new layer of bureaucracy?
- How would it be resourced, particularly in a time of financial pressure?

The Departments will continue to give consideration to this proposal.

6.28 The Codes of Practice and many of the necessary Regulations will be drafted during 2015, with a view to consultation towards the end of 2015. There are some sequencing factors to consider here. The Codes cannot be finalised until the Regulations have completed their Assembly passage. The Regulations cannot be made and laid until the relevant powers in the primary legislation have been commenced. As such, it will be the second half of 2016 at the earliest before the Codes will be published in their final form.

6.29 That is not to say that significant work cannot be done now, but it provides an indication of how the Departments will be managing their work. Similarly, early work on scoping and preparing for delivery of training has already started, but the content of training courses will be dependent on what the Codes of Practice and Regulations say.

6.30 The Departments are therefore keeping an open mind on the “Go Live” date for the new mental capacity legislation.

CHAPTER 7: NEXT STEPS

7.1 Detailed discussions will now take place with Legislative Counsel to consider necessary drafting amendments in light of the consultation responses received. Comments made in relation to other key elements of the project (such as the Code of Practice, training etc.) will also be taken on board. However, the first priority for DHSSPS/DoJ Bill Teams is to now finalise a draft Bill capable of introduction to the NI Assembly.

7.2 Both Departments aim to be in a position to seek Executive approval in March 2015 to introduce the draft Bill.

7.3 Once again we would like to thank all of those who have contributed to the development of this legislation. The views shared have been extremely useful and we hope that this engagement will continue as we embark on the next phase of this important area of legislative reform.

APPENDICIES

Appendix A

Consultation Events

Details of the 5 public consultation events across Northern Ireland (all attended by both DHSSPS & DOJ):

Location	Date	Event type	No. of attendees
NHSCT – Ballymoney – Adair Arms Hotel	25 June	Presentation & information session	7
SHSCT – Armagh – Market Place Theatre & Arts Centre	2 July	Presentation & information session	8
BHSCT – Belfast – The Mount	25 July	Presentation & information session	34
WHSCT – L'Derry – Millennium Forum	29 July	Presentation & information session	19
SEHSCT – Newcastle – Glenada Holiday & Conference Centre	6 Aug	Presentation & information session	19

Details of additional meetings / events attended:

Event / Group	Date	Event Type	Departmental representation
ASW Training & Development, BHSCT	12 June	Presentation and Information Session	DHSSPS
British Psychological Society	19 June	Presentation at Cross-divisional group meeting	DHSSPS
Commissioner for Older People for NI	19 June	Presentation and Information Session	DHSSPS & DOJ
DHSSPS	23 June	Medical Leaders Forum – Presentation at meeting	DHSSPS
All Party Group on Learning Disability	24 June	Presentation	DHSSPS & DOJ
Advocacy Network NI	26 June	Presentation at ANNI CoP launch	DHSSPS & DOJ
New 2 Forensic Support Group Meeting	26 June	Presentation and Information Session	DHSSPS
Stratagem NI & Alzheimer's Society	1 July	Attendance only at event on Mental Capacity in an Ageing Society	DHSSPS
Law Society of NI	1 July	Meeting & Information session	DHSSPS & DOJ
Chambré Public Affairs & Disability Action	3 July	Presentation at conference - *A Draft Mental Capacity Bill for NI: reducing stigma, empowering the individual*	DHSSPS & DOJ
Bamford Monitoring Group (PCC)	4 July	Presentation at meeting	DHSSPS
Northern HSC Trust Directors	22 July	Presentation and Information Session	DHSSPS

Northern HSC Trust service user event	22 July	Presentation & Meeting with service users	DHSSPS
Royal College of Nursing	24 July	Presentation and Information Session	DHSSPS & DOJ
Lord Chief Justice	30 July	Presentation and Information Session	DHSSPS & DOJ
The Active Group	31 July	Presentation at Group meeting	DHSSPS & DOJ
Regulation and Quality Improvement Authority	1 Aug	Presentation and Information Session	DHSSPS & DOJ
Cedar Foundation	1 Aug	Presentation to User Forum	DHSSPS
NI Practice & Education Council for Nursing & Midwifery	4 Aug	Presentation at workshop event	DHSSPS
NI Council for Voluntary Action	5 Aug	Presentation and Information Session	DHSSPS & DOJ
Royal College of Speech & Language Therapists	5 Aug	Presentation and Information Session	DHSSPS & DOJ
South Eastern HSC staff	6 Aug	Presentation and Information Session	DHSSPS & DOJ
Positive Futures - Service user/carer meeting	6 Aug	Presentation and Information Session	DHSSPS
Mencap - Service user engagement	7 Aug	Presentation and Information Session	DHSSPS
AgeNI – Meadowbank Residential Home	7 Aug	Presentation and Information Session	DHSSPS
Positive Futures - Service user/carer meeting	7 Aug	Presentation and Information Session	DHSSPS
NI Practice &	8 Aug	Presentation at workshop	DHSSPS

Education Council for Nursing & Midwifery		event	
NI Practice & Education Council for Nursing & Midwifery	11 Aug	Presentation at workshop event	DHSSPS
Mencap - Service user engagement	11 Aug	Presentation and Information Session	DHSSPS
Positive Futures	12 Aug	Presentation at Focus group event	DHSSPS
Positive Futures	13 Aug	Presentation at Focus group event	DHSSPS
Royal College of Psychiatrists	13 Aug	Presentation and Information Session	DHSSPS & DOJ
Children's Law Centre	13 Aug	Meeting to discuss draft Bill	DHSSPS & DOJ
Law Centre (NI) Event	14 Aug	Seminar and discussion	DHSSPS & DOJ
NI Practice & Education Council for Nursing & Midwifery	15 Aug	Presentation at workshop event	DHSSPS & DOJ
Mencap - Service user engagement	18 Aug	Presentation and Information Session	DHSSPS
General Medical Council	19 Aug	Information session	DHSSPS & DOJ
Cedar Foundation	20 Aug	Presentation to service user forum	DHSSPS
Advocacy Network NI	27 Aug	Presentation	DHSSPS
FEBE	2 Sept	Presentation and information session	DHSSPS & DOJ
CAUSE NI (arranged during consultation)	16 Sept	Information session	DHSSPS & DOJ
VOCAL (arranged during consultation)	23 Sept	Information session	DHSSPS

Details of additional meetings with children & young people (paragraph 1.10 refers):

Group	Date	Event Type	Departmental representation
Include Youth	5 Nov	Information Session	DHSSPS & DOJ
Iveagh Centre	6 Nov	Information Session	DHSSPS
Juvenile Justice Centre	1 Dec	Information Session	DOJ & DHSSPS

Appendix B

Respondees

Action Mental Health
Age Concern Causeway
Age NI
Alzheimer's Society
Advocacy Network NI
ARC
Ards Borough Council
Aware Defeat Depression
British Geriatrics Society
British Geriatrics Society (NI Branch)
Belfast HSC Trust
British Medical Association (NI)
Bamford Monitoring Group
British Psychological Society
Bryson Charitable Group
Carers NI
CAUSE NI
Clinical Education Centre
Centre for Disability Law and Policy, NUI Galway
Children in Northern Ireland
Citizens Advice
Children's Law Centre
Compass Advocacy Network
Compassion in Dying
Commissioner for Older People for Northern Ireland
College of Occupational Therapists
CRPD Independent Mechanism for NI
Danske Bank

Office of Social Services
Dignity in Dying
Disability Action
Down District Council
Federation of Experts By Experience
General Medical Council
HSC Board & Public Health Agency (joint)
Information Commissioners Office
Include Youth
Individual A
Individual B
Individual C
Individual D
Individual E
Individual F
Individual G
Individual H
Individual I
Individual J
Individual K
Individual M
Individual N
Individual O
Individual P
Individual Q
Individual R
Individual S
Individual T
Individual U
Individuals L (joint)
Irish Advocacy Network
Judith Cochrane MLA

Law Centre (NI)
Law Society NI
Lead Nurse for Learning Disabilities – Western HSC Trust
Marie Curie
Medical Protection Society
Mencap
Mental Health Social Workers, South Eastern HSC Trust
Mindwise
Mind Yourself
Newtownabbey Borough Council
Northern HSC Trust
Northern HSC Trust Service User Group
NI Hospice
NI Legal Services Commission
NI Mental Health Occupational Therapy Managers Forum
NI Policing Board Performance Committee
NI Association for the Care and Resettlement of Offenders
NI Association for Mental Health
NI Ambulance Service
NI Association of Social Workers
NI Approved Social Worker Training Programme
NI Commissioner for Children and Young People
NI Council for Voluntary Action
NI Human Rights Commission
NI Judicial Appointments Commission
NI Practice and Education Council for Nursing and Midwifery
NI Rare Disease Partnership
NI Social Care Council
NOW
Parenting NI
Parkinson's UK
Positive Futures

Positive Futures Event Feedback
Probation Board NI
Police Service of NI
Royal College of General Practitioners NI
Royal College of Nursing NI
Royal College of Psychiatrists NI
Royal College of Speech and Language Therapists
Regional Approved Social Worker Forum
Regional Forensic Group NI
Regulation and Quality Improvement Authority
School of Nursing, University of Ulster
South Eastern HSC Trust
Southern HSC Trust
Sinn Fein
Society and College of Radiographers
Society of Chiropodists and Podiatrists
Start360
The Active Group
The Society of Trust & Estate Practitioners
UK Homecare Association
Victim Support NI
VOCAL
Volunteer Now
Voice of Young People in Care
VOYPIC Beechcroft event
Western HSC Trust, Adult Mental Health and Learning Disability
Western HSC Trust Nursing & Midwifery Governance Committee
youth@clc
Youthnet

Appendix C

DHSSPS Reference Group

Alzheimer's Society
British Association of Social Workers (NI)
British Psychological Society
CAUSE
Children's Law Centre
College of Occupational Therapists
Equality NI
Federation of Experts by Experience
GP Representative
Irish Advocacy Network
LAMP
Law Centre NI
Law Society of NI
Mencap
Mental Health Review Tribunal
Mind Yourself
Mindwise
NI Association of Mental Health
NI Commissioner for Children and Young People
NI Human Rights Commission
Patient Client Council
Positive Futures
Royal College of GPs
Royal College of Nursing
Royal College of Psychiatrists
Regulation and Quality Improvement Authority
VOYPIC